AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2022
October 2020 Meeting

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AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
t (312) 464-5000

October 28, 2020

Seema Verma, MPH
Administrator
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Administrator Verma:

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

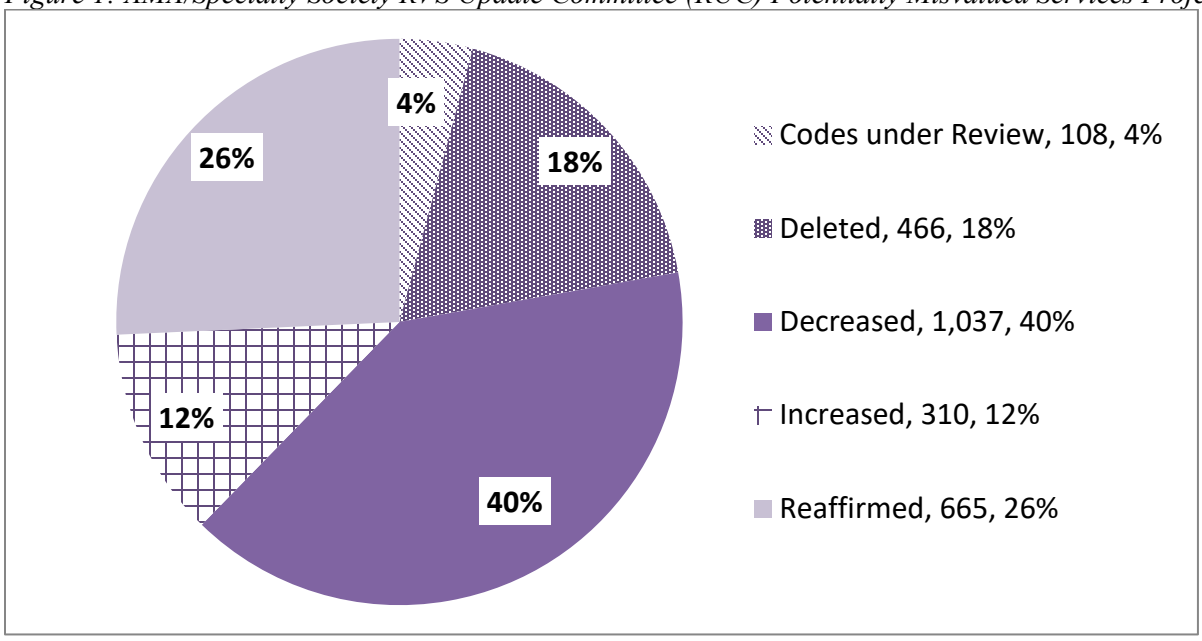
Enclosed are the RUC recommendations for all the CPT codes reviewed at the October 7-10, 2020 RUC meeting.

CPT 2022 New and Revised Codes – *October 2020 RUC Submission*
The submission contains RUC recommendations, including those for new and revised CPT codes. The RUC submits work value and/or practice expense inputs for 18 new/revised/related family CPT codes from the October meeting.

Existing Services Identified by RUC and CMS for Review
In addition to the new/revised CPT code submission, the RUC submits recommendations for 33 services identified by the RUC or CMS as potentially misvalued and reviewed at the October 2020 RUC meeting. The RUC recommends base unit/work relative values for 25 codes and direct practice expense inputs only for 8 codes.

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes
Since 2006, the RUC has identified 2,586 potentially misvalued services through objective screening criteria and has completed review of 2,478 of these services. The RUC has recommended that 61% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously over the past several years to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services.

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



Practice Expense Subcommittee

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

Practice Expense Units Screen

The seven CPT codes in the table below were identified as having more than one unit of service reported and the supply unit cost is greater than $100. The RUC reviewed the seven codes to evaluate whether the supplies or supplies in the kits identified were duplicative when reported in multiple units and recommends the following:

CPT Code	Supply Item(s)	RUC Recommendation
31298	SA106	**Not Duplicative**: Accept the specialty societies' explanation that SA106 is not duplicative when reported in multiple units for CPT code 31298. When performed bilaterally on a patient, two full balloon kits are being reimbursed which is appropriate as a total of four sinuses are being accessed. One balloon for each pair of sinuses, on each side of the patient (four total sinuses). Note that during the April 2020 RUC meeting, the RUC recommended that CMS separately identify and pay for high cost disposable supplies priced in excess of $500 using appropriate HCPCS codes.

CPT Code	Supply Item(s)	RUC Recommendation
36223 36224	SD207	**Duplicative:** Reduce the supply item units for SD207 from 1.0 to 0.5 because typically performed twice using a single closure device.
52442	SD291	**Not Duplicative**: Accept the specialty societies' explanation that SD291 is not duplicative when reported in multiple units for add-on CPT code 52442. The kit contains one delivery device with one implant. The delivery device and the implant is used once and cannot be reloaded (there is no reuse of the device and implant). The cost of each individual implant is $875 and the practice expense for placing 4 implants is exactly 4 times the practice expense of placing just 1 implant, which is approximately $3,500 for a box of four individually sterilized packaged implants.
63650	SD280 SD281	**Not Duplicative**: Accept the specialty societies' explanation that SD280 is not duplicative when reported in multiple units for CPT code 63560. The entire trial lead kit will be used during the procedure and the items in the kit cannot be reused. One trial lead kit is required per lead that is inserted. An additional kit will be required when an additional unit of 63650 is reported. The number of leads inserted per trial dictates the number of appropriate supply items required. **Delete SD281:** Agree with removing supply item SD281 as a PE input for CPT code 63650 as there is no current understanding of what is included in this supply item and all essential supply items are included in the trial lead kit.
64561	SA022	**Not Duplicative**: Accept the specialty societies' explanation that SA022 is not duplicative when reported in multiple units for CPT code 64561. This neurostimulator kit is used to implant near the sacral nerve. One kit is used and may be percutaneously implanted per side for testing purposes. The kit is not reused. If the procedure is performed bilaterally, two individual kits are required.
88377	SL196	**Duplicative:** Reduce the supply item units for SL196 from 3.0 to 2.0 because typically use two kit assays per patient per code.

Office Visits Included in Codes with a Surgical Global Period

The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. However, CMS proposes not to apply the office visit increases to the visits bundled into global surgery payment. An example of why this policy is flawed was raised during discussion of CPT code 67141. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes are being valued too low considering that office visits for the surgical global period are not going to change. The 99213 office visit in 2021 will be valued at 1.30 RVUs, therefore, the two office visits will be valued higher than this code. It is disadvantageous to the eye surgeons and an example of the why the policy from CMS is flawed. The

Agency implies that the physician work for office visits are not the same when performed in a surgical global period. As stated in the RUC comment letter to CMS on the CY 2021 Proposed Rule, **The RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the office visit increases to the office visits included in surgical global payment, as it has done historically.**

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for CPT 2022.
- RUC Recommendation Summary of Existing Codes Identified by CMS or the RAW.
- RUC Recommendation Progress and Status Reports for 2,586 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – for CPT nomenclature revisions.
- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the October 2020 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions: The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- BETOS Assignment Table: The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.
- Utilization Crosswalk Table: A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2022 conversion factor increase.
- New Technology List and Flow Chart: In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 688 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.
- RUC Recommendations on Modifications to Visits in the Global Period – October 2020.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



Peter K. Smith, MD

Enclosures

cc: RUC Participants
Perry Alexion, MD
Edith Hambrick, MD
Gift Tee
Karen Nakano, MD
Michael Soracoe

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

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CPT 2022 RUC and HCPAC Recommendations

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0191T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
01935	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01936	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01XX2	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H1	January 2021	4	ASA				☑		☐
01XX3	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H2	January 2021	4	ASA				☑		☐
01XX4	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H3	January 2021	4	ASA				☑		☐
01XX5	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H4	January 2021	4	ASA				☑		☐
01XX6	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H5	January 2021	4	ASA				☑		☐
01XX7	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H6	January 2021	4	ASA				☑		☐
0355T	YYY	D	Oct. 2020	58	Colon Capsule Endoscopy		Cat III						☐		☐
0356T	YYY	D	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion		Cat III						☐		☐
0376T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
0466T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0467T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0468T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0548T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0549T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0550T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0551T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0X12T	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
12001	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			0.84	0.84	Yes	☑		☐
12002	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.14	1.14	Yes	☑		☐
12004	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.44	1.44	Yes	☑		☐
12005	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.97	1.97	Yes	☑		☐
12006	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.39	2.39	Yes	☑		☐
12007	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.90	2.90	Yes	☑		☐
12011	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.07	1.07	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
12013	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.22	1.22	Yes	☑		☐
12014	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.57	1.57	Yes	☑		☐
12015	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.98	1.98	Yes	☑		☐
12016	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.68	2.68	Yes	☑		☐
12017	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.18	3.18	Yes	☑		☐
12018	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.61	3.61	Yes	☑		☐
21310	000	D	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture		January 2021						☑		☐
21315	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I1	January 2021	5	AAOHNS, ASPS				☑		☐
21320	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I2	January 2021	5	AAOHNS, ASPS				☑		☐
22600	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial			17.40	17.40	Yes	☑		☐
22610	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial			17.28	17.28	Yes	☑		☐
22612	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial			23.53	23.53	Yes	☑		☐
22614	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression		Editorial			6.43	6.43	Yes	☑		☐
22630	090	F	Oct. 2020	20	Arthrodesis Decompression	J1	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐
22632	ZZZ	F	Oct. 2020	20	Arthrodesis Decompression	J2	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐
22633	090	R	Oct. 2020	20	Arthrodesis Decompression	J3	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
22634	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression	J4	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐
33361	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K1	January 2021	7	ACC, SCAI				☑		☐
33362	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K2	January 2021	7	ACC, SCAI				☑		☐
33363	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K3	January 2021	7	ACC, SCAI				☑		☐
33364	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K4	January 2021	7	ACC, SCAI				☑		☐
33365	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K5	January 2021	7	ACC, SCAI				☑		☐
33366	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K6	January 2021	7	ACC, SCAI				☑		☐
33367	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K7	January 2021	7	ACC, SCAI				☑		☐
33368	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K8	January 2021	7	ACC, SCAI				☑		☐
33369	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K9	January 2021	7	ACC, SCAI				☑		☐
338X0	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L3	January 2021	8	ACC, SCAI, SIR				☑		☐
338X1	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L1	January 2021	8	ACC, SCAI, SIR				☑		☐
338X2	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L2	January 2021	8	ACC, SCAI, SIR				☑		☐
33XX3	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A1	October 2020	5	AATS, STS	18.50	18.50		☑		☑
33XX4	ZZZ	N	May 2020	12	Exclusion of Left Atrial Appendage	A2	October 2020	5	AATS, STS	3.00	2.50		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
33XX5	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A3	October 2020	5	AATS, STS	15.73	14.31		☑		☑
33XXX	ZZZ	N	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K10	January 2021	7	ACC, SCAI				☑		☐
35600	XXX	R	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B2	October 2020	6	AAPA, AATS, ANA, STS	4.94	3.73		☑	Interim and resurvey with ANA, AAPA	☑
35XX0	XXX	N	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B1	October 2020	6	AAPA, AATS, ANA, STS	5.63	4.04		☑	Interim and resurvey with ANA, AAPA	☑
42XXX	000	N	Oct. 2020	27	Drug Induced Sleep Endoscopy (DISE)	M1	January 2021	10	AAOHNS				☑		☐
434XX	090	N	May 2020	14	Per-Oral Endoscopic Myotomy (POEM)	C1	October 2020	7	AATS, ACG, AGA, ASGE, SAGES, STS ACG AGA ASGE SAGES STS	15.50	15.50		☑		☑
43850	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
43855	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
53XX1	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N1	January 2021	11	AUA				☑		☐
53XX2	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N2	January 2021	11	AUA				☑		☐
53XX3	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N3	January 2021	11	AUA				☑		☐
53XX4	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N4	January 2021	11	AUA				☑		☐
54340	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			9.71	9.71	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
54344	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			17.06	17.06	Yes	☑		☐
54348	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			18.32	18.32	Yes	☑		☐
54352	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			26.13	26.13	Yes	☑		☐
617X1	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O1	January 2021	12	AANS, CNS				☑		☐
617X2	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O2	January 2021	12	AANS, CNS				☑		☐
630X1	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J6	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐
630XX	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J5	January 2021	6	AANS, AAOS, CNS, ISASS, NASS				☑		☐
63194	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
63195	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
64568	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.00	9.00	Yes	☑		☐
64569	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			11.00	11.00	Yes	☑		☐
64570	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.10	9.10	Yes	☑		☐
64575	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.42	4.42	Yes	☑		☐
64580	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.19	4.19	Yes	☑		☐
64581	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			12.20	12.20	Yes	☑		☐
645X1	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P1	January 2021	13	AAOHNS				☑		☐
645X2	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P2	January 2021	13	AAOHNS				☑		☐
645X3	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P3	January 2021	13	AAOHNS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
646X0	010	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q1	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS				☑		☐
646X1	ZZZ	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q2	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS				☑		☐
66174	090	R	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R1	January 2021	15	AAO				☑		☐
66175	090	F	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R2	January 2021	15	AAO				☑		☐
66982	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S1	January 2021	16	AAO, ASCRS				☑		☐
66984	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S4	January 2021	16	AAO, ASCRS				☑		☐
66987	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S3	January 2021	16	AAO, ASCRS				☑		☐
66988	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S5	January 2021	16	AAO, ASCRS				☑		☐
669X1	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S2	January 2021	16	AAO, ASCRS				☑		☐
669X2	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S6	January 2021	16	AAO, ASCRS				☑		☐
67141	010	R	May 2020	16	Retinal Detachment Prophylaxis	D1	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
67145	010	R	May 2020	16	Retinal Detachment Prophylaxis	D2	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
68XXX	000	N	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion	T1	January 2021	17	AAO, AOA, ASCRS				☑		☐
69714	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U1	January 2021	18	AAOHNS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
69715	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐
69717	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U3	January 2021	18	AAOHNS				☑		☐
69718	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐
69X50	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U2	January 2021	18	AAOHNS				☑		☐
69X51	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U4	January 2021	18	AAOHNS				☑		☐
69X52	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U5	January 2021	18	AAOHNS				☑		☐
69X53	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U6	January 2021	18	AAOHNS				☑		☐
72275	XXX	D	Oct. 2020	40	Epidurography		Deleted						☑		☐
75573	XXX	R	May 2020	18	CT of the Heart		Editorial			2.55	2.55	Yes	☑		☐
76101	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
76102	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
77X01	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V1	January 2021	19	ACR				☑		☐
77X02	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V2	January 2021	19	ACR				☑		☐
77X03	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V3	January 2021	19	ACR				☑		☐
77X04	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V4	January 2021	19	ACR				☑		☐
80500	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐
80502	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
80XX0	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W1	January 2021	20	CAP				☑		☐
80XX1	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W2	January 2021	20	CAP				☑		☐
80XX2	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W3	January 2021	20	CAP				☑		☐
80XX3	ZZZ	N	Oct. 2020	50	Pathology Clinical Consult	W4	January 2021	20	CAP				☑		☐
815X0	XXX	N	Oct. 2020	45	MAAA Allograft Rejection Risk		CLFS						☐		☐
815X1	XXX	N	Oct. 2020	46	MAAA Breast Cancer Metastasis RNA Sequencing		CLFS						☐		☐
90785	ZZZ	R	Oct. 2020	55	Psychiatric Interactive Complexity Instructions		Editorial			0.33	0.33	Yes	☑		☐
91110	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X1	January 2021	21	ACG, AGA, ASGE				☑		☐
91111	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X2	January 2021	21	ACG, AGA, ASGE				☑		☐
9111X	XXX	N	Oct. 2020	58	Colon Capsule Endoscopy	X3	January 2021	21	ACG, AGA, ASGE				☑		☐
92065	XXX	R	May 2020	37	Orthoptic Training	E1	October 2020	9	AAO, AOA				☑	Refer to CPT	☐
92626	XXX	R	May 2020	38	Evaluation of Auditory Function		Editorial			1.40	1.40	Yes	☑		☐
92627	ZZZ	R	May 2020	38	Evaluation of Auditory Function		Editorial			0.33	0.33	Yes	☑		☐
933X0	ZZZ	N	May 2020	39	3D Imaging of Cardiac Structures	G1	October 2020	11	ACC, ASE	0.50	0.50		☑		☑
93530	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93531	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93532	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93533	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93561	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93562	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93653	000	R	Oct. 2020	61	Cardiac Ablation Services Bundling	Y1	January 2021	22	ACC, HRS				☑		☐
93654	000	R	Oct. 2020	61	Cardiac Ablation Services Bundling	Y2	January 2021	22	ACC, HRS				☑		☐
93655	ZZZ	F	Oct. 2020	61	Cardiac Ablation Services Bundling	Y3	January 2021	22	ACC, HRS				☑		☐
93656	000	R	Oct. 2020	61	Cardiac Ablation Services Bundling	Y4	January 2021	22	ACC, HRS				☑		☐
93657	ZZZ	F	Oct. 2020	61	Cardiac Ablation Services Bundling	Y5	January 2021	22	ACC, HRS				☑		☐
93662	ZZZ	R	May 2020	41	Intracardiac Echo		Editorial			0.00	0.00	Yes	☑		☐
93X1X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F1	October 2020	10	AAP, ACC, SCAI	3.99	3.99		☑		☑
93X2X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F2	October 2020	10	AAP, ACC, SCAI	6.10	6.10		☑		☑
93X3X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F3	October 2020	10	AAP, ACC, SCAI	6.00	6.00		☑		☑
93X4X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F4	October 2020	10	AAP, ACC, SCAI	7.91	7.91		☑		☑
93X5X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F5	October 2020	10	AAP, ACC, SCAI	11.74	9.99		☑		☑
93X6X	ZZZ	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F6	October 2020	10	AAP, ACC, SCAI	2.00	1.75		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
946X1	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z1	January 2021	23	ATS, CHEST				☑		☐
946X2	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z2	January 2021	23	ATS, CHEST				☑		☐
95943	XXX	D	Oct. 2020	65	Autonomic Function Testing		Deleted						☐		☐
989X1	XXX	N	Oct. 2020	11,12	Remote Monitoring	AA1	January 2021	24	AAP, AAPM&R, ANA, APTA				☑		☐
989X2	XXX	N	Oct. 2020	11,12	Remote Monitoring	AA2	January 2021	24	AAP, AAPM&R, ANA, APTA				☑		☐
989X3	XXX	N	Oct. 2020	11,12	Remote Monitoring	AA3	January 2021	24	AAP, AAPM&R, ANA, APTA				☑		☐
989X4	XXX	N	Oct. 2020	11,12	Remote Monitoring	AA4	January 2021	24	AAP, AAPM&R, ANA, APTA				☑		☐
989X5	ZZZ	N	Oct. 2020	11,12	Remote Monitoring	AA5	January 2021	24	AAP, AAPM&R, ANA, APTA				☑		☐
99354	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		2.33	2.33	Yes	☑		☐
99355	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.77	1.77	Yes	☑		☐
99356	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐
99357	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐
99358	XXX	R	May 2020	EC-G	Prolonged Services	U1	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA				☑	Refer to CPT	☐
99359	ZZZ	R	May 2020	EC-G	Prolonged Services	U2	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA				☑	Refer to CPT	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99439	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB6	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99487	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB9	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99489	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB10	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99490	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB5	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99491	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB7	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99X21	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB8	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐
99X22	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB1	January 2021	25	AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA				☑		☐

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

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	Anesthesia for Cardiac Electrophysiologic Procedures	13	12		X					
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	Treatment of Foot Infection	14	3.5						X	
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	Treatment of Foot Infection	14	5.28						X	
28001	Incision and drainage, bursa, foot	Treatment of Foot Infection	14	2.00						X	
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	Needle Biopsy of Lymph Nodes	15	1.59			X				
46030	Removal of anal seton, other marker	Placement/ Removal of Seton	16	2.00						X	
46020	Placement of seton	Placement/Removal of Seton	16	3.50						X	
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	Destruction by Neurolytic Agent	17	3.42					X		

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	Destruction by Neurolytic Agent	17	1.32					X		
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	Destruction by Neurolytic Agent	17	1.16					X		
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Destruction by Neurolytic Agent	17	3.42					X		
67318	Strabismus surgery, any procedure, superior oblique muscle	Strabismus Surgery	18	9.80							X
67316	Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)	Strabismus Surgery	18	10.31							X

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)	Strabismus Surgery	18	3.00							X
67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)	Strabismus Surgery	18	2.00							X
67314	Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)	Strabismus Surgery	18	5.93							X
67332	Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)	Strabismus Surgery	18	3.50							X
67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles	Strabismus Surgery	18	9.50							X

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	Strabismus Surgery	18	2.06							X
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle	Strabismus Surgery	18	5.93							X
67335	Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)	Strabismus Surgery	18	3.23							X
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	Strabismus Surgery	18	5.00							X
74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	X-Rays at Surgery Add-On	19	0.21	X						

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	External Cardiovascular Device Monitoring	20	PE Only		X					
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	External Cardiovascular Device Monitoring	20	0.52		X					
93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separatel	Electrophysiologic Evaluation	21	1.75		X					

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and ce	PE Subcommittee	24	New PE Inputs				X			
88377	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure	PE Subcommittee	24	New PE Inputs				X			
36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the e	PE Subcommittee	24	New PE Inputs				X			
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	PE Subcommittee	24	Maintain. No duplication in supplies.				X			

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2020

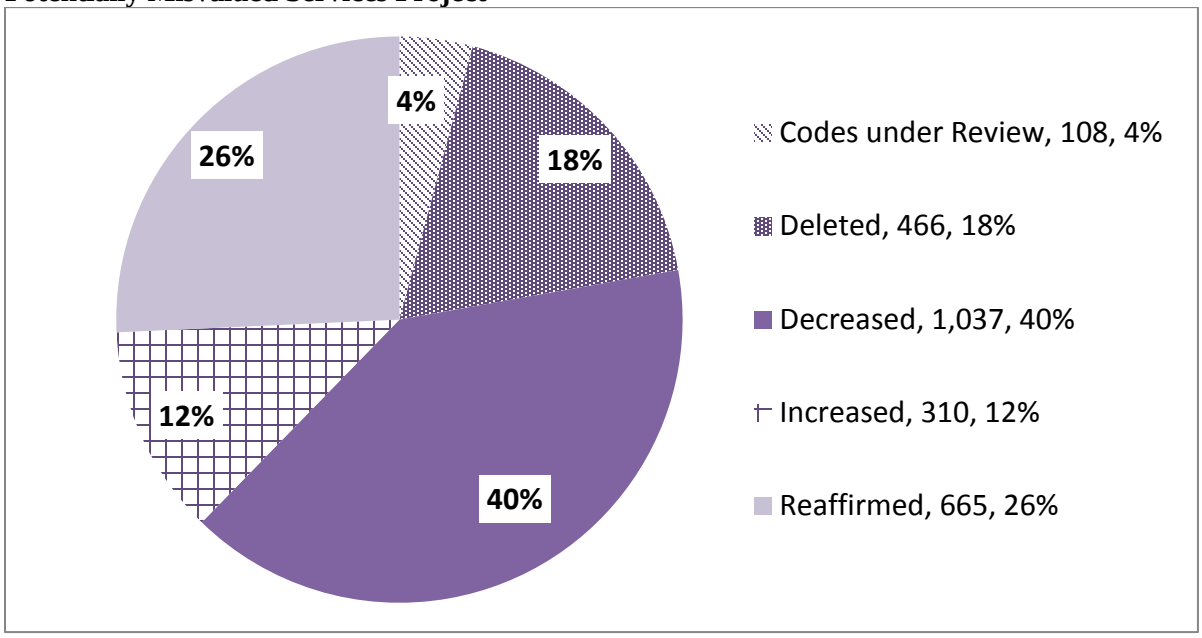
CPT Code	Long Descriptor	Issue	Tab	RUC Recommend-ation	CMS/ Other Source	High Volume Growth	Harvard Valued - Util Over 30,000	PE Units Screen	Work Neutrality	010-Day Global Post-Operative Visits	ZZZ Global Post-Operative Visits
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	PE Subcommittee	24	Maintain. No duplication in supplies.				X			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	PE Subcommittee	24	Maintain. No duplication in supplies.				X			
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	PE Subcommittee	24	Maintain. No duplication in supplies.				X			

The RUC Relativity Assessment Workgroup Progress Report

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

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining 2,586 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,503 services, redistributing $5 billion annually. Here are the outcomes for the committee's review of 2,586 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 688 services. In September 2010, the re-review cycle began and since then the RUC has recommended 48 services to be re-examined. The remaining services are rarely

performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 216 services every October after three years of Medicare claims data is available for each service.

Methodology Improvements

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

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

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

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

Site of Service Anomalies

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

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

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

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

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

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

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

In 2019, the RUC lowered the threshold for site-of-service anomalies based on the review of three years of data (2016, 2017 and 2018e) for services with utilization over 5,000 in the outpatient setting more than 50% of the time but includes inpatient hospital Evaluation and Management services within the global period. The RUC identified nine services, expanding to 10 services to include the family of services. The RUC referred three codes to the CPT Editorial Panel for revision and submitted seven recommendations for the 2021 Medicare Physician Payment Schedule.

In 2020, the RUC identified one code with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The RUC will review this service at its January 2021 meeting.

High Volume Growth

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

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

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 62 services to include the appropriate family of services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended review of two services after an additional utilization data is collected. The CPT® Editorial Panel deleted ten codes and the RUC submitted recommendations for 47 services for the 2015-2019 Medicare Physician Payment Schedule.

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

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

In October 2016, the RUC ran this screen for its fourth iteration and the query resulted in the identification of 12 services, which was expanded to 53 services. The RUC recommended removing two services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted four services. The RUC submitted recommendations for 41 services for the 2019-2021 Medicare Physician Payment Schedules. The RUC will review six services for the 2022 Medicare Physician Payment Schedule.

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

In October 2019, the RUC completed its sixth iteration of this screen for services with 2018e Medicare utilization of over 10,000 that have increased by at least 100% from 2013 through 2018. The RUC identified 12 services. The RUC removed three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review one code after additional utilization data is available. The RUC submitted recommendations for seven services for the 2021 Medicare Physician Payment Schedule and will review the remaining service for the 2022 Medicare Physician Payment Schedule.

In October 2020, the RUC completed its seventh iteration of this screen for services with 2019e Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019. The RUC identified six services and will review action plans on how to address these services in January 2021.

CMS Fastest Growing

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

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

High IWPUT

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

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

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

In October 2019, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified, and the RUC referred them to the CPT Editorial Panel for revision and the CPT Assistant for education.

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

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

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

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

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

In October 2019, the RUC reran this screen on Harvard valued services with 2018e Medicare utilization over 30,000. Three services were identified, which was expanded to four to include the family of services. The RUC referred one service to the CPT Editorial Panel for revision and submitted recommendations for 3 services for the 2022 Medicare Physician Payment Schedule.

In October 2020, the RUC ran this service on Harvard valued services with 2019e Medicare utilization over 30,000 and one service was identified. The RUC will review the action plan on how to address this service at the January 2021 meeting.

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

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

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

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

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

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

Utilization over 20,000
In October 2019, the RUC lowered the threshold for this screen of CMS/Other source codes with 2018e Medicare utilization over 20,000, which resulted in nine services and expanded to 15 to include the family of services. The CPT Editorial Panel deleted five codes. The RUC submitted recommendations for three services for the 2021 Medicare Physician Payment Schedule and will review 6 services for the 2022 Medicare Physician Payment Schedule. The RUC will review one service after additional utilization data is available.

In October 2020, the RUC ran a second iteration of this screen of CMS/Other source codes with 2019e Medicare Utilization over 20,000, which resulted in 11 services. The RUC will review action plans on how to address these services in January 2021.

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

Reported 75% or More Together
In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar "groups" to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the CPT® Editorial Panel deleted 35 individual component codes and replaced the component coding with 126 new and/or revised codes that described the bundles of services. The RUC will review one service after additional utilization data is available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-Operative Visits

010-Day Global Codes

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

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

090-Day Global Codes

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

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

High Level E/M in Global Period

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Final Rule for 2020
In the Final Rule for 2020, the public and CMS nominated 10 services as potentially misvalued. The RUC referred six services to the CPT Editorial Panel and submitted recommendations for 3 services for the 2021 Medicare Physician Payment Schedule. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate.

Proposed Rule for 2021
In the Proposed Rule for 2021, CMS received public nomination of one code as potentially misvalued. The RUC will review this service at the January 2021 RUC meeting.

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

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

One code family was identified for re-examination from CPT 2019. The Relativity Assessment Workgroup will review an action plan on how to address this family of services in January 2021.

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

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,586**
Codes Completed	**2,478**
Work and PE Maintained	665
Work Increased	310
Work Decreased	855
Direct Practice Expense Revised (beyond work changes)	182
Deleted from CPT®	466
Codes Under Review	**108**
Referred to CPT® Editorial Panel or CPT Assistant	36
RUC to Review for *CPT 2022*	30
RUC to review future review after additional data obtained	42

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

The RUC's efforts for 2009-2020 have resulted in more than $5 billion in annual redistribution within the Medicare Physician Payment Schedule.

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ASA

First Identified: October 2018 **2019 est Medicare Utilization:** 30,245

2007 Work RVU: 0.00 **2020 Work RVU:** 7.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

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

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

Most Recent RUC Meeting: October 2020 **Tab** 13 **Specialty Developing Recommendation:** ASA

First Identified: October 2016 **2019 est Medicare Utilization:** 89,969

2007 Work RVU: 0.00 **2020 Work RVU:** 7.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: 12

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

Result: Increase

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

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

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ASA

First Identified: October 2018 **2019 est Medicare Utilization:** 58,933

2007 Work RVU: 0.00 **2020 Work RVU:** 15.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

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

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

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

First Identified: September 2016 **2019 est Medicare Utilization:** 1,262,160

2007 Work RVU: **2020 Work RVU:** 5.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:**0.00

RUC Recommendation: 5 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

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

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

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

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

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

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

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

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

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: September 2016 **2019 est Medicare Utilization:** 1,186,122

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 4 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

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

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

First Identified: September 2016 **2019 est Medicare Utilization:** 517,650

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 3 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

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

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

First Identified: September 2016 **2019 est Medicare Utilization:** 492,977

2007 Work RVU: **2020 Work RVU:** 5.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 5 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Anesthesia for transurethral procedures **Screen:** High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 5.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Review action plan

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

01916 **Anesthesia for diagnostic arteriography/venography**

Global: XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2019 **2019 est Medicare Utilization:** 58,939

2007 Work RVU: 0.00 **2020 Work RVU:** 5.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Review action plan

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

0191T **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion**

Global: XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** No

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

First Identified: October 2019 **2019 est Medicare Utilization:** 57,829

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:**0.00

RUC Recommendation: Deleted from CPT

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

01930 **Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified**

Global: XXX **Issue:** Anesthesia for Interventional Radiology **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASA

First Identified: February 2008 **2019 est Medicare Utilization:** 17,980

2007 Work RVU: 0.00 **2020 Work RVU:** 5.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Remove from screen

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

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting:
Tab
Specialty Developing Recommendation:
First Identified: January 2021
2019 est Medicare Utilization:
2007 Work RVU:
2020 Work RVU: 5.00
2007 NF PE RVU:
2020 NF PE RVU: 0.00
2007 Fac PE RVU
2020 Fac PE RVU: 0.00
RUC Recommendation: Deleted from CPT
Referred to CPT October 2020
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: October 2019
Tab 17
Specialty Developing Recommendation: ASA
First Identified: October 2016
2019 est Medicare Utilization: 311,884
2007 Work RVU:
2020 Work RVU: 5.00
2007 NF PE RVU:
2020 NF PE RVU: 0.00
2007 Fac PE RVU
2020 Fac PE RVU: 0.00
RUC Recommendation: Deleted from CPT
Referred to CPT October 2020
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX2

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting:
Tab
Specialty Developing Recommendation:
First Identified: January 2021
2019 est Medicare Utilization:
2007 Work RVU:
2020 Work RVU:
2007 NF PE RVU:
2020 NF PE RVU:
2007 Fac PE RVU
2020 Fac PE RVU:
RUC Recommendation:
Referred to CPT October 2020
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01XX3

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

01XX4

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

01XX5

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

Status Report: CMS Requests and Relativity Assessment Issues

01XX6

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

01XX7

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

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

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

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

First Identified: October 2019 **2019 est Medicare Utilization:** 2,656

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Maintain

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,708

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Refer to CPT time uncertain

Referred to CPT Time uncertain

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

Result:

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

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Refer to CPT time uncertain

Referred to CPT Time uncertain

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

Result:

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

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Refer to CPT time uncertain

Referred to CPT Time uncertain

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

Result:

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: October 2019 **2019 est Medicare Utilization:** 5,679

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Maintain

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

Result: Maintain

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

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

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

First Identified: October 2019 **2019 est Medicare Utilization:** 12

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Maintain

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

Result: Maintain

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

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

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.40
2007 NF PE RVU: **2020 NF PE RVU:** 1.75
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan

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

Result:

0X12T

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

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

Result:

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.80
2007 NF PE RVU: **2020 NF PE RVU:** 0.57
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34

RUC Recommendation: 0.80

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

Result: Decrease

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.46
2007 NF PE RVU: **2020 NF PE RVU:** 2.08
2007 Fac PE RVU **2020 Fac PE RVU:** 0.48

RUC Recommendation: 1.63

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

Result: Decrease

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.61
2007 Fac PE RVU **2020 Fac PE RVU:** 0.33

RUC Recommendation: 1.00

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

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

2007 Work RVU: **2020 Work RVU:** 1.81
2007 NF PE RVU: **2020 NF PE RVU:** 6.44
2007 Fac PE RVU **2020 Fac PE RVU:** 0.70
Result: Decrease

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.18
2007 NF PE RVU: **2020 NF PE RVU:** 3.49
2007 Fac PE RVU **2020 Fac PE RVU:** 0.46
Result: Decrease

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

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

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

2007 Work RVU: **2020 Work RVU:** 2.26
2007 NF PE RVU: **2020 NF PE RVU:** 10.84
2007 Fac PE RVU **2020 Fac PE RVU:** 0.80
Result: Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.65
2007 NF PE RVU: **2020 NF PE RVU:** 6.22
2007 Fac PE RVU **2020 Fac PE RVU:** 0.58

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

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

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

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

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 1.27 **2020 Work RVU:** 1.03
2007 NF PE RVU: 2.14 **2020 NF PE RVU:** 1.64
2007 Fac PE RVU 0.5 **2020 Fac PE RVU:**0.44

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

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

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

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

2007 Work RVU: 1.27 **2020 Work RVU:**
2007 NF PE RVU: 2.41 **2020 NF PE RVU:**
2007 Fac PE RVU 0.4 **2020 Fac PE RVU:**

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 2.75
2007 NF PE RVU: **2020 NF PE RVU:** 14.52
2007 Fac PE RVU **2020 Fac PE RVU:**0.97

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: April 2016 **Tab** 13 **Specialty Developing Recommendation:** AAD

First Identified: October 2015

2019 est Medicare Utilization: 41,492

2007 Work RVU: 1.19 **2020 Work RVU:** 0.91
2007 NF PE RVU: 1.09 **2020 NF PE RVU:** 2.11
2007 Fac PE RVU 0.84 **2020 Fac PE RVU:** 0.53

RUC Recommendation: 0.91

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

Result: Decrease

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

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

Most Recent RUC Meeting: October 2010 **Tab** 07 **Specialty Developing Recommendation:** APMA

First Identified: February 2010

2019 est Medicare Utilization: 368,976

2007 Work RVU: 1.19 **2020 Work RVU:** 1.22
2007 NF PE RVU: 1.29 **2020 NF PE RVU:** 2.09
2007 Fac PE RVU 0.97 **2020 Fac PE RVU:** 1.52

RUC Recommendation: 1.50

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

Result: Increase

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

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

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

First Identified: October 2009

2019 est Medicare Utilization: 134,001

2007 Work RVU: 2.42 **2020 Work RVU:** 2.45
2007 NF PE RVU: 1.89 **2020 NF PE RVU:** 3.20
2007 Fac PE RVU 1.51 **2020 Fac PE RVU:** 2.44

RUC Recommendation: Maintain. 2.45

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

10120 **Incision and removal of foreign body, subcutaneous tissues; simple** **Global:** 010 **Issue:** **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

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

2007 Work RVU: 1.23 **2020 Work RVU:** 1.22
2007 NF PE RVU: 2.12 **2020 NF PE RVU:** 2.96
2007 Fac PE RVU 0.97 **2020 Fac PE RVU:** 1.59

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

10180 **Incision and drainage, complex, postoperative wound infection** **Global:** 010 **Issue:** **Screen:** RUC identified when reviewing comparison codes **Complete?** Yes

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

2007 Work RVU: 2.27 **2020 Work RVU:** 2.30
2007 NF PE RVU: 3.06 **2020 NF PE RVU:** 4.51
2007 Fac PE RVU 1.94 **2020 Fac PE RVU:** 2.32

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

11040 **Deleted from CPT** **Global:** **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

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

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 0.56 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11041 **Deleted from CPT** **Global:** **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

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

2007 Work RVU: 0.60 **2020 Work RVU:**
2007 NF PE RVU: 0.68 **2020 NF PE RVU:**
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 0.80 **2020 Work RVU:** 1.01
2007 NF PE RVU: 0.97 **2020 NF PE RVU:** 2.44
2007 Fac PE RVU 0.39 **2020 Fac PE RVU:**0.62

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

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

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

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

2007 Work RVU: 3.04 **2020 Work RVU:** 2.70
2007 NF PE RVU: 3.45 **2020 NF PE RVU:** 3.52
2007 Fac PE RVU 2.62 **2020 Fac PE RVU:**1.35

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

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

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

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

2007 Work RVU: 4.11 **2020 Work RVU:** 4.10
2007 NF PE RVU: 4.58 **2020 NF PE RVU:** 4.22
2007 Fac PE RVU 3.73 **2020 Fac PE RVU:**1.82

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.60
2007 Fac PE RVU **2020 Fac PE RVU:**0.18

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.03
2007 NF PE RVU: **2020 NF PE RVU:** 0.90
2007 Fac PE RVU **2020 Fac PE RVU:** 0.40

RUC Recommendation: 1.29 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 1.38
2007 Fac PE RVU **2020 Fac PE RVU:** 0.71

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 0.43 **2020 Work RVU:** 0.35
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 1.40
2007 Fac PE RVU 0.16 **2020 Fac PE RVU:** 0.08

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 0.61 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.7 **2020 NF PE RVU:** 1.55
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:**0.12

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 0.79 **2020 Work RVU:** 0.65
2007 NF PE RVU: 0.81 **2020 NF PE RVU:** 1.61
2007 Fac PE RVU 0.28 **2020 Fac PE RVU:**0.15

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

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

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

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

2007 Work RVU: 0.81 **2020 Work RVU:**
2007 NF PE RVU: 1.41 **2020 NF PE RVU:**
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 0.41 **2020 Work RVU:**
2007 NF PE RVU: 0.35 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.66
2007 NF PE RVU: **2020 NF PE RVU:** 2.10
2007 Fac PE RVU **2020 Fac PE RVU:** 0.38

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.38
2007 NF PE RVU: **2020 NF PE RVU:** 1.08
2007 Fac PE RVU **2020 Fac PE RVU:** 0.22

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.83
2007 NF PE RVU: **2020 NF PE RVU:** 2.65
2007 Fac PE RVU **2020 Fac PE RVU:** 0.48

RUC Recommendation: 0.83

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.45
2007 NF PE RVU: **2020 NF PE RVU:** 1.22
2007 Fac PE RVU **2020 Fac PE RVU:** 0.26

RUC Recommendation: 0.45

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

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

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

2007 Work RVU: **2020 Work RVU:** 1.01
2007 NF PE RVU: **2020 NF PE RVU:** 3.22
2007 Fac PE RVU **2020 Fac PE RVU:** 0.59

RUC Recommendation: 1.01

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

2007 Work RVU: **2020 Work RVU:** 0.54
2007 NF PE RVU: **2020 NF PE RVU:** 1.45
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 0.54

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

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

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

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

2007 Work RVU: 0.51 **2020 Work RVU:** 0.60
2007 NF PE RVU: 1.04 **2020 NF PE RVU:** 2.18
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:** 0.33

RUC Recommendation: 0.60

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

Result: Increase

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

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

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

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

2007 Work RVU: 0.85 **2020 Work RVU:** 0.90
2007 NF PE RVU: 1.21 **2020 NF PE RVU:** 2.46
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:** 0.51

RUC Recommendation: 0.90

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 1.05 **2020 Work RVU:** 1.05
2007 NF PE RVU: 1.42 **2020 NF PE RVU:** 2.83
2007 Fac PE RVU 0.47 **2020 Fac PE RVU:**0.60

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.24 **2020 Work RVU:** 1.25
2007 NF PE RVU: 1.69 **2020 NF PE RVU:** 3.02
2007 Fac PE RVU 0.53 **2020 Fac PE RVU:**0.70

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

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

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

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

2007 Work RVU: 0.67 **2020 Work RVU:** 0.80
2007 NF PE RVU: 0.91 **2020 NF PE RVU:** 2.11
2007 Fac PE RVU 0.26 **2020 Fac PE RVU:**0.25

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

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

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

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

2007 Work RVU: 0.99 **2020 Work RVU:** 0.96
2007 NF PE RVU: 1.18 **2020 NF PE RVU:** 2.45
2007 Fac PE RVU 0.41 **2020 Fac PE RVU:**0.40

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 1.14 **2020 Work RVU:** 1.20
2007 NF PE RVU: 1.4 **2020 NF PE RVU:** 2.78
2007 Fac PE RVU 0.49 **2020 Fac PE RVU:**0.56

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.41 **2020 Work RVU:** 1.46
2007 NF PE RVU: 1.53 **2020 NF PE RVU:** 2.79
2007 Fac PE RVU 0.58 **2020 Fac PE RVU:**0.53

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 0.73 **2020 Work RVU:** 0.80
2007 NF PE RVU: 1.18 **2020 NF PE RVU:** 2.40
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.45

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.05 **2020 Work RVU:** 1.10
2007 NF PE RVU: 1.34 **2020 NF PE RVU:** 2.69
2007 Fac PE RVU 0.49 **2020 Fac PE RVU:**0.62

RUC Recommendation: 1.43 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: January 2012 **2019 est Medicare Utilization:** 46,378

2007 Work RVU: 1.20 **2020 Work RVU:** 1.30
2007 NF PE RVU: 1.55 **2020 NF PE RVU:** 3.08
2007 Fac PE RVU 0.56 **2020 Fac PE RVU:**0.74

RUC Recommendation: 1.80

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

Result: Increase

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

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

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

First Identified: January 2012 **2019 est Medicare Utilization:** 8,180

2007 Work RVU: 1.62 **2020 Work RVU:** 1.68
2007 NF PE RVU: 1.9 **2020 NF PE RVU:** 3.41
2007 Fac PE RVU 0.73 **2020 Fac PE RVU:**0.96

RUC Recommendation: 2.00

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

Result: Increase

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

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

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

First Identified: October 2010 **2019 est Medicare Utilization:** 837,707

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.28 **2020 NF PE RVU:** 0.22
2007 Fac PE RVU 0.07 **2020 Fac PE RVU:**0.04

RUC Recommendation: 0.17

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

Result: Maintain

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

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

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

First Identified: Septemer 2011 **2019 est Medicare Utilization:** 2,111,275

2007 Work RVU: 0.32 **2020 Work RVU:** 0.32
2007 NF PE RVU: 0.37 **2020 NF PE RVU:** 0.58
2007 Fac PE RVU 0.11 **2020 Fac PE RVU:**0.07

RUC Recommendation: 0.32 (Interim)

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 0.47 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**0.13

RUC Recommendation: 0.54 (Interim)

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

Result: Maintain

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

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

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

2007 Work RVU: 1.10 **2020 Work RVU:** 1.05
2007 NF PE RVU: 1.11 **2020 NF PE RVU:** 2.00
2007 Fac PE RVU 0.4 **2020 Fac PE RVU:**0.43

RUC Recommendation: 1.10

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

Result: Maintain

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

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

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

2007 Work RVU: 2.40 **2020 Work RVU:** 1.58
2007 NF PE RVU: 2.37 **2020 NF PE RVU:** 2.75
2007 Fac PE RVU 1.79 **2020 Fac PE RVU:**1.21

RUC Recommendation: 1.99

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

Result: Decrease

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

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

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

2007 Work RVU: 3.48 **2020 Work RVU:**
2007 NF PE RVU: 3.28 **2020 NF PE RVU:**
2007 Fac PE RVU 2.95 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: April 2017 **Tab** 41i **Specialty Developing Recommendation:** APMA

First Identified: July 2016

2019 est Medicare Utilization: 62,237

2007 Work RVU: 1.31 **2020 Work RVU:** 1.25
2007 NF PE RVU: 1.69 **2020 NF PE RVU:** 2.13
2007 Fac PE RVU 0.77 **2020 Fac PE RVU:**0.44

RUC Recommendation: 1.25

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

Result: Decrease

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

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

Most Recent RUC Meeting: April 2010 **Tab** 31 **Specialty Developing Recommendation:** AAD

First Identified: October 2009

2019 est Medicare Utilization: 265,694

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0.72 **2020 NF PE RVU:** 0.99
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:**0.30

RUC Recommendation: 0.52

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

Result: Maintain

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

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

Most Recent RUC Meeting: April 2010 **Tab** 31 **Specialty Developing Recommendation:** AAD

First Identified: February 2010

2019 est Medicare Utilization: 73,970

2007 Work RVU: 0.80 **2020 Work RVU:** 0.80
2007 NF PE RVU: 0.75 **2020 NF PE RVU:** 1.08
2007 Fac PE RVU 0.37 **2020 Fac PE RVU:**0.47

RUC Recommendation: 0.80

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 1.48 **2020 Work RVU:** 1.10
2007 NF PE RVU: 1.1 **2020 NF PE RVU:** 1.46
2007 Fac PE RVU 0.55 **2020 Fac PE RVU:** 0.38

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

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

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

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

2007 Work RVU: 1.48 **2020 Work RVU:** 1.14
2007 NF PE RVU: 1.76 **2020 NF PE RVU:** 1.60
2007 Fac PE RVU 0.66 **2020 Fac PE RVU:** 0.50

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

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

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

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

2007 Work RVU: 1.78 **2020 Work RVU:** 1.34
2007 NF PE RVU: 1.97 **2020 NF PE RVU:** 1.77
2007 Fac PE RVU 0.81 **2020 Fac PE RVU:** 0.60

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 3.30 **2020 Work RVU:** 1.91
2007 NF PE RVU: 2.38 **2020 NF PE RVU:** 1.93
2007 Fac PE RVU 1.44 **2020 Fac PE RVU:** 0.79

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.72 **2020 Work RVU:** 0.84
2007 NF PE RVU: 1.92 **2020 NF PE RVU:** 1.59
2007 Fac PE RVU 0.76 **2020 Fac PE RVU:** 0.31

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.88 **2020 Work RVU:** 1.14
2007 NF PE RVU: 1.98 **2020 NF PE RVU:** 1.80
2007 Fac PE RVU 0.89 **2020 Fac PE RVU:** 0.37

RUC Recommendation: 1.14 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 2.26 **2020 Work RVU:** 1.44
2007 NF PE RVU: 2.26 **2020 NF PE RVU:** 1.98
2007 Fac PE RVU 0.99 **2020 Fac PE RVU:** 0.44

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 2.88 **2020 Work RVU:** 1.97
2007 NF PE RVU: 2.75 **2020 NF PE RVU:** 2.53
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**0.45

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 3.68 **2020 Work RVU:** 2.39
2007 NF PE RVU: 3.3 **2020 NF PE RVU:** 2.91
2007 Fac PE RVU 1.46 **2020 Fac PE RVU:**0.58

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 4.13 **2020 Work RVU:** 2.90
2007 NF PE RVU: 3.71 **2020 NF PE RVU:** 3.14
2007 Fac PE RVU 1.73 **2020 Fac PE RVU:**0.79

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 1.78 **2020 Work RVU:** 1.07
2007 NF PE RVU: 2.07 **2020 NF PE RVU:** 1.87
2007 Fac PE RVU 0.78 **2020 Fac PE RVU:**0.35

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 2.01 **2020 Work RVU:** 1.22
2007 NF PE RVU: 2.22 **2020 NF PE RVU:** 1.83
2007 Fac PE RVU 0.92 **2020 Fac PE RVU:**0.26

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 2.48 **2020 Work RVU:** 1.57
2007 NF PE RVU: 2.5 **2020 NF PE RVU:** 2.13
2007 Fac PE RVU 1.04 **2020 Fac PE RVU:**0.33

RUC Recommendation: 1.57 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 3.21 **2020 Work RVU:** 1.98
2007 NF PE RVU: 3.04 **2020 NF PE RVU:** 2.48
2007 Fac PE RVU 1.22 **2020 Fac PE RVU:**0.42

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 3.94 **2020 Work RVU:** 2.68
2007 NF PE RVU: 3.45 **2020 NF PE RVU:** 2.96
2007 Fac PE RVU 1.47 **2020 Fac PE RVU:**0.57

RUC Recommendation: 2.68 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 4.72 **2020 Work RVU:** 3.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.79 **2020 Fac PE RVU:**0.67

RUC Recommendation: 3.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 5.54 **2020 Work RVU:** 3.61
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.19 **2020 Fac PE RVU:**0.74

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 2.17 **2020 Work RVU:** 2.00
2007 NF PE RVU: 2.69 **2020 NF PE RVU:** 4.91
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**2.10

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: October 2009

2019 est Medicare Utilization: 280,457

2007 Work RVU: 2.49 **2020 Work RVU:** 2.52
2007 NF PE RVU: 4.19 **2020 NF PE RVU:** 5.80
2007 Fac PE RVU 1.92 **2020 Fac PE RVU:**2.67

RUC Recommendation: 2.52

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

Result: Maintain

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

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2019 est Medicare Utilization: 25,707

2007 Work RVU: 2.94 **2020 Work RVU:** 2.97
2007 NF PE RVU: 3.54 **2020 NF PE RVU:** 5.86
2007 Fac PE RVU 1.59 **2020 Fac PE RVU:**2.53

RUC Recommendation: 2.97

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

Result: Maintain

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

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2019 est Medicare Utilization: 4,889

2007 Work RVU: 3.44 **2020 Work RVU:** 3.50
2007 NF PE RVU: 5.21 **2020 NF PE RVU:** 6.91
2007 Fac PE RVU 2.14 **2020 Fac PE RVU:**2.82

RUC Recommendation: 3.60

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

2007 Work RVU: 4.06 **2020 Work RVU:** 4.23
2007 NF PE RVU: 5.51 **2020 NF PE RVU:** 7.27
2007 Fac PE RVU 2.47 **2020 Fac PE RVU:**3.08

RUC Recommendation: 4.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 4.68 **2020 Work RVU:** 5.00
2007 NF PE RVU: 6.05 **2020 NF PE RVU:** 7.99
2007 Fac PE RVU 2.88 **2020 Fac PE RVU:**3.51

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

2007 Work RVU: 2.39 **2020 Work RVU:** 2.10
2007 NF PE RVU: 2.87 **2020 NF PE RVU:** 4.82
2007 Fac PE RVU 1.29 **2020 Fac PE RVU:**1.85

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

2007 Work RVU: 2.76 **2020 Work RVU:** 2.79
2007 NF PE RVU: 3.57 **2020 NF PE RVU:** 5.44
2007 Fac PE RVU 1.63 **2020 Fac PE RVU:**2.54

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

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

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

2007 Work RVU: 3.16 **2020 Work RVU:** 3.19
2007 NF PE RVU: 3.74 **2020 NF PE RVU:** 6.95
2007 Fac PE RVU 1.69 **2020 Fac PE RVU:**2.51

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

12045 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 337

2007 Work RVU: 3.65 **2020 Work RVU:** 3.75
2007 NF PE RVU: 5.21 **2020 NF PE RVU:** 7.24
2007 Fac PE RVU 2.23 **2020 Fac PE RVU:**3.37

RUC Recommendation: 3.90 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12046 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 89

2007 Work RVU: 4.26 **2020 Work RVU:** 4.30
2007 NF PE RVU: 6.28 **2020 NF PE RVU:** 8.71
2007 Fac PE RVU 2.64 **2020 Fac PE RVU:**3.74

RUC Recommendation: 4.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12047 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 50

2007 Work RVU: 4.66 **2020 Work RVU:** 4.95
2007 NF PE RVU: 6.3 **2020 NF PE RVU:** 9.27
2007 Fac PE RVU 2.95 **2020 Fac PE RVU:**3.97

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12051 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 54,376

2007 Work RVU: 2.49 **2020 Work RVU:** 2.33
2007 NF PE RVU: 3.48 **2020 NF PE RVU:** 5.12
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**2.24

RUC Recommendation: 2.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12052 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

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

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 75,683

2007 Work RVU: 2.81 **2020 Work RVU:** 2.87
2007 NF PE RVU: 3.64 **2020 NF PE RVU:** 5.48
2007 Fac PE RVU 1.72 **2020 Fac PE RVU:**2.55

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

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

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,218

2007 Work RVU: 3.14 **2020 Work RVU:** 3.17
2007 NF PE RVU: 3.77 **2020 NF PE RVU:** 6.58
2007 Fac PE RVU 1.68 **2020 Fac PE RVU:**2.62

RUC Recommendation: 3.17

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

Result: Maintain

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

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,576

2007 Work RVU: 3.47 **2020 Work RVU:** 3.50
2007 NF PE RVU: 4.02 **2020 NF PE RVU:** 6.68
2007 Fac PE RVU 1.74 **2020 Fac PE RVU:**2.31

RUC Recommendation: 3.50

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

12055 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 281

2007 Work RVU: 4.44 **2020 Work RVU:** 4.50
2007 NF PE RVU: 4.87 **2020 NF PE RVU:** 8.63
2007 Fac PE RVU 2.13 **2020 Fac PE RVU:**3.37

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12056 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, **First Identified:** February 2010 **2019 est Medicare Utilization:** 41

2007 Work RVU: 5.25 **2020 Work RVU:** 5.30
2007 NF PE RVU: 6.62 **2020 NF PE RVU:** 10.12
2007 Fac PE RVU 2.89 **2020 Fac PE RVU:**4.88

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12057 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

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

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

2007 Work RVU: 5.97 **2020 Work RVU:** 6.00
2007 NF PE RVU: 6.47 **2020 NF PE RVU:** 10.32
2007 Fac PE RVU 3.53 **2020 Fac PE RVU:**5.23

RUC Recommendation: 6.28 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13100 **Repair, complex, trunk; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 6,433

2007 Work RVU: 3.14 **2020 Work RVU:** 3.00
2007 NF PE RVU: 4.15 **2020 NF PE RVU:** 6.37
2007 Fac PE RVU 2.35 **2020 Fac PE RVU:**2.46

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

13101 **Repair, complex, trunk; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 102,897

2007 Work RVU: 3.93 **2020 Work RVU:** 3.50
2007 NF PE RVU: 4.99 **2020 NF PE RVU:** 7.52
2007 Fac PE RVU 2.77 **2020 Fac PE RVU:**3.25

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13102 **Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 26,791

2007 Work RVU: 1.24 **2020 Work RVU:** 1.24
2007 NF PE RVU: 1.22 **2020 NF PE RVU:** 2.01
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**0.68

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,693

2007 Work RVU: 3.32 **2020 Work RVU:** 3.23
2007 NF PE RVU: 4.26 **2020 NF PE RVU:** 6.53
2007 Fac PE RVU 2.41 **2020 Fac PE RVU:**3.07

RUC Recommendation: 3.23 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

Status Report: CMS Requests and Relativity Assessment Issues

13121 **Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 207,941

2007 Work RVU: 4.36 **2020 Work RVU:** 4.00
2007 NF PE RVU: 5.32 **2020 NF PE RVU:** 7.81
2007 Fac PE RVU 3.02 **2020 Fac PE RVU:**3.07

RUC Recommendation: 4.00 **Referred to CPT** September 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

13122 **Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 31,342

2007 Work RVU: 1.44 **2020 Work RVU:** 1.44
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 2.11
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**0.79

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

13131 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm**

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

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 41,454

2007 Work RVU: 3.80 **2020 Work RVU:** 3.73
2007 NF PE RVU: 4.53 **2020 NF PE RVU:** 6.95
2007 Fac PE RVU 2.74 **2020 Fac PE RVU:**2.88

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

13132 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 309,273

2007 Work RVU: 6.48 **2020 Work RVU:** 4.78
2007 NF PE RVU: 6.42 **2020 NF PE RVU:** 8.30
2007 Fac PE RVU 4.38 **2020 Fac PE RVU:**3.52

RUC Recommendation: 4.78 **Referred to CPT** **Result:** Decrease

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

13133 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 17,262

2007 Work RVU: 2.19 **2020 Work RVU:** 2.19
2007 NF PE RVU: 1.72 **2020 NF PE RVU:** 2.52
2007 Fac PE RVU 1.02 **2020 Fac PE RVU:**1.23

RUC Recommendation: 2.19 **Referred to CPT** **Result:** Maintain

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

13150 **Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**

Global: **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 3.82 **2020 Work RVU:**
2007 NF PE RVU: 4.83 **2020 NF PE RVU:**
2007 Fac PE RVU 2.76 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

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

13151 **Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 33,842

2007 Work RVU: 4.46 **2020 Work RVU:** 4.34
2007 NF PE RVU: 4.99 **2020 NF PE RVU:** 7.28
2007 Fac PE RVU 3.17 **2020 Fac PE RVU:**3.24

RUC Recommendation: 4.34 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

13152 **Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 54,926

2007 Work RVU: 6.34 **2020 Work RVU:** 5.34
2007 NF PE RVU: 6.42 **2020 NF PE RVU:** 8.44
2007 Fac PE RVU 4.03 **2020 Fac PE RVU:** 3.82

RUC Recommendation: 5.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13153 **Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 938

2007 Work RVU: 2.38 **2020 Work RVU:** 2.38
2007 NF PE RVU: 1.96 **2020 NF PE RVU:** 2.73
2007 Fac PE RVU 1.11 **2020 Fac PE RVU:** 1.30

RUC Recommendation: 2.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14000 **Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 7,303

2007 Work RVU: 6.83 **2020 Work RVU:** 6.37
2007 NF PE RVU: 8.14 **2020 NF PE RVU:** 10.49
2007 Fac PE RVU 5.63 **2020 Fac PE RVU:** 6.90

RUC Recommendation: 6.19 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14001 **Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,637

2007 Work RVU: 9.60 **2020 Work RVU:** 8.78
2007 NF PE RVU: 9.86 **2020 NF PE RVU:** 12.52
2007 Fac PE RVU 7.22 **2020 Fac PE RVU:**8.26
Result: Decrease

RUC Recommendation: 8.58

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

14020 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 17,817

2007 Work RVU: 7.66 **2020 Work RVU:** 7.22
2007 NF PE RVU: 8.98 **2020 NF PE RVU:** 11.65
2007 Fac PE RVU 6.64 **2020 Fac PE RVU:**7.90
Result: Decrease

RUC Recommendation: 7.02

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

14021 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,350

2007 Work RVU: 11.18 **2020 Work RVU:** 9.72
2007 NF PE RVU: 10.63 **2020 NF PE RVU:** 13.67
2007 Fac PE RVU 8.41 **2020 Fac PE RVU:**9.33
Result: Decrease

RUC Recommendation: 9.52

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

14040 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 67,406

2007 Work RVU: 8.44 **2020 Work RVU:** 8.60
2007 NF PE RVU: 9.17 **2020 NF PE RVU:** 11.95
2007 Fac PE RVU 7.17 **2020 Fac PE RVU:**8.22
Result: Maintain

RUC Recommendation: 8.44

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

Status Report: CMS Requests and Relativity Assessment Issues

14041 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 45,011

2007 Work RVU: 12.67 **2020 Work RVU:** 10.83
2007 NF PE RVU: 11.37 **2020 NF PE RVU:** 14.32
2007 Fac PE RVU 8.88 **2020 Fac PE RVU:**9.81

RUC Recommendation: 10.63 **Referred to CPT** **Result:** Decrease

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

14060 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 90,113

2007 Work RVU: 9.07 **2020 Work RVU:** 9.23
2007 NF PE RVU: 9.02 **2020 NF PE RVU:** 11.63
2007 Fac PE RVU 7.39 **2020 Fac PE RVU:**8.73

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

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

14061 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 31,224

2007 Work RVU: 13.67 **2020 Work RVU:** 11.48
2007 NF PE RVU: 12.45 **2020 NF PE RVU:** 15.61
2007 Fac PE RVU 9.72 **2020 Fac PE RVU:**10.66

RUC Recommendation: 11.25 **Referred to CPT** **Result:** Decrease

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

14300 **Deleted from CPT**

Global: **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 13.26 **2020 Work RVU:**
2007 NF PE RVU: 11.77 **2020 NF PE RVU:**
2007 Fac PE RVU 9.28 **2020 Fac PE RVU:**

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

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

Status Report: CMS Requests and Relativity Assessment Issues

14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm**

Global: 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS

First Identified: September 2007 **2019 est Medicare Utilization:** 38,864

2007 Work RVU: **2020 Work RVU:** 12.65
2007 NF PE RVU: **2020 NF PE RVU:** 16.35
2007 Fac PE RVU **2020 Fac PE RVU:** 10.50

RUC Recommendation: 12.47

Referred to CPT February 2009 **Result:** Decrease

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

14302 **Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS

First Identified: September 2007 **2019 est Medicare Utilization:** 40,086

2007 Work RVU: **2020 Work RVU:** 3.73
2007 NF PE RVU: **2020 NF PE RVU:** 1.96
2007 Fac PE RVU **2020 Fac PE RVU:** 1.96

RUC Recommendation: 3.73

Referred to CPT February 2009 **Result:** Decrease

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

15002 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ASPS

First Identified: January 2014 **2019 est Medicare Utilization:** 24,066

2007 Work RVU: 3.65 **2020 Work RVU:** 3.65
2007 NF PE RVU: 4.12 **2020 NF PE RVU:** 5.75
2007 Fac PE RVU 1.65 **2020 Fac PE RVU:** 2.16

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

15004 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ASPS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 32,464

2007 Work RVU: 4.58 **2020 Work RVU:** 4.58
2007 NF PE RVU: 4.77 **2020 NF PE RVU:** 6.24
2007 Fac PE RVU 1.97 **2020 Fac PE RVU:**2.45

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

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

Result: Maintain

15100 **Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,549

2007 Work RVU: 9.74 **2020 Work RVU:** 9.90
2007 NF PE RVU: 11.91 **2020 NF PE RVU:** 13.06
2007 Fac PE RVU 7.57 **2020 Fac PE RVU:**8.81

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

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

Result: Maintain

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** Autograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,650

2007 Work RVU: 10.96 **2020 Work RVU:** 10.15
2007 NF PE RVU: 10.87 **2020 NF PE RVU:** 12.60
2007 Fac PE RVU 7.71 **2020 Fac PE RVU:**8.19

RUC Recommendation: Remove from screen

Referred to CPT

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

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

15170 **Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 5.99 **2020 Work RVU:**
2007 NF PE RVU: 3.79 **2020 NF PE RVU:**
2007 Fac PE RVU 2.37 **2020 Fac PE RVU:**

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

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

15171 **Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.55 **2020 Work RVU:**
2007 NF PE RVU: 0.68 **2020 NF PE RVU:**
2007 Fac PE RVU 0.6 **2020 Fac PE RVU:**

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

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

15175 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 7.99 **2020 Work RVU:**
2007 NF PE RVU: 5.4 **2020 NF PE RVU:**
2007 Fac PE RVU 3.96 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

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

Status Report: CMS Requests and Relativity Assessment Issues

15176 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 2.45 **2020 Work RVU:**
2007 NF PE RVU: 1.1 **2020 NF PE RVU:**
2007 Fac PE RVU 0.95 **2020 Fac PE RVU:**

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

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less**

Global: 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,947

2007 Work RVU: 7.95 **2020 Work RVU:** 8.09
2007 NF PE RVU: 9.5 **2020 NF PE RVU:** 12.78
2007 Fac PE RVU 6.69 **2020 Fac PE RVU:**8.28

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

15240 **Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ASPS, AAD **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,328

2007 Work RVU: 10.15 **2020 Work RVU:** 10.41
2007 NF PE RVU: 10.66 **2020 NF PE RVU:** 14.78
2007 Fac PE RVU 8.2 **2020 Fac PE RVU:**10.99

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15271 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 111,779

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 2.56
2007 Fac PE RVU **2020 Fac PE RVU:** 0.72

RUC Recommendation: 1.50 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15272 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 14,569

2007 Work RVU: **2020 Work RVU:** 0.33
2007 NF PE RVU: **2020 NF PE RVU:** 0.36
2007 Fac PE RVU **2020 Fac PE RVU:** 0.12

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15273 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,775

2007 Work RVU: **2020 Work RVU:** 3.50
2007 NF PE RVU: **2020 NF PE RVU:** 4.80
2007 Fac PE RVU **2020 Fac PE RVU:** 1.69

RUC Recommendation: 3.50 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15274 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 25,402

2007 Work RVU: **2020 Work RVU:** 0.80
2007 NF PE RVU: **2020 NF PE RVU:** 1.30
2007 Fac PE RVU **2020 Fac PE RVU:** 0.36

RUC Recommendation: 0.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15275 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 122,551

2007 Work RVU: **2020 Work RVU:** 1.83
2007 NF PE RVU: **2020 NF PE RVU:** 2.46
2007 Fac PE RVU **2020 Fac PE RVU:** 0.73

RUC Recommendation: 1.83 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15276 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 6,340

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.40
2007 Fac PE RVU **2020 Fac PE RVU:** 0.17

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15277 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,720

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 5.09
2007 Fac PE RVU **2020 Fac PE RVU:** 1.90

RUC Recommendation: 4.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15278 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,936

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.46
2007 Fac PE RVU **2020 Fac PE RVU:** 0.46

RUC Recommendation: 1.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15320 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 5.36 **2020 Work RVU:**
2007 NF PE RVU: 3.66 **2020 NF PE RVU:**
2007 Fac PE RVU 2.49 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15321 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.50 **2020 Work RVU:**
2007 NF PE RVU: 0.69 **2020 NF PE RVU:**
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**

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

15330 **Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 3.99 **2020 Work RVU:**
2007 NF PE RVU: 3.18 **2020 NF PE RVU:**
2007 Fac PE RVU 2.15 **2020 Fac PE RVU:**

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

15331 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.00 **2020 Work RVU:**
2007 NF PE RVU: 0.46 **2020 NF PE RVU:**
2007 Fac PE RVU 0.39 **2020 Fac PE RVU:**

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

15335 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 4.50 **2020 Work RVU:**
2007 NF PE RVU: 3.46 **2020 NF PE RVU:**
2007 Fac PE RVU 2.35 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15336 **Deleted from CPT** **Global:** **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.43 **2020 Work RVU:**
2007 NF PE RVU: 0.7 **2020 NF PE RVU:**
2007 Fac PE RVU 0.55 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15360 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 3.93 **2020 Work RVU:**
2007 NF PE RVU: 4.47 **2020 NF PE RVU:**
2007 Fac PE RVU 3.13 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15361 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.15 **2020 Work RVU:**
2007 NF PE RVU: 0.58 **2020 NF PE RVU:**
2007 Fac PE RVU 0.44 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15365 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 4.21 **2020 Work RVU:**
2007 NF PE RVU: 4.5 **2020 NF PE RVU:**
2007 Fac PE RVU 3.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15366 **Deleted from CPT**

Global: **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.45 **2020 Work RVU:**
2007 NF PE RVU: 0.7 **2020 NF PE RVU:**
2007 Fac PE RVU 0.56 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 **Deleted from CPT**

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

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

2007 Work RVU: 4.38 **2020 Work RVU:**
2007 NF PE RVU: 4.25 **2020 NF PE RVU:**
2007 Fac PE RVU 3.95 **2020 Fac PE RVU:**

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

15401 **Deleted from CPT**

Global: **Issue:** Xenograft **Screen:** High Volume Growth1 **Complete?** Yes

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

2007 Work RVU: 1.00 **2020 Work RVU:**
2007 NF PE RVU: 1.67 **2020 NF PE RVU:**
2007 Fac PE RVU 0.42 **2020 Fac PE RVU:**

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

15420 **Deleted from CPT**

Global: **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 4.89 **2020 Work RVU:**
2007 NF PE RVU: 4.86 **2020 NF PE RVU:**
2007 Fac PE RVU 3.83 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15421 **Deleted from CPT**

Global: **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

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

2007 Work RVU: 1.50 **2020 Work RVU:**
2007 NF PE RVU: 1.29 **2020 NF PE RVU:**
2007 Fac PE RVU 0.6 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

15570 **Formation of direct or tubed pedicle, with or without transfer; trunk**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 292

2007 Work RVU: 10.00 **2020 Work RVU:** 10.21
2007 NF PE RVU: 11.09 **2020 NF PE RVU:** 14.15
2007 Fac PE RVU 6.71 **2020 Fac PE RVU:**9.10

RUC Recommendation: 10.00 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

15572 **Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 691

2007 Work RVU: 9.94 **2020 Work RVU:** 10.12
2007 NF PE RVU: 9.59 **2020 NF PE RVU:** 13.49
2007 Fac PE RVU 6.53 **2020 Fac PE RVU:**9.46

RUC Recommendation: 9.94 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

15574 **Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,483

2007 Work RVU: 10.52 **2020 Work RVU:** 10.70
2007 NF PE RVU: 10.64 **2020 NF PE RVU:** 13.46
2007 Fac PE RVU 7.6 **2020 Fac PE RVU:**9.33

RUC Recommendation: 10.52 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,346

RUC Recommendation: 9.24 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 9.24 **2020 Work RVU:** 9.37
2007 NF PE RVU: 9.74 **2020 NF PE RVU:** 12.23
2007 Fac PE RVU 6.81 **2020 Fac PE RVU:**8.41
Result: Maintain

15730 **Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 05 **Specialty Developing Recommendation:** AAO **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,767

RUC Recommendation: 13.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 13.50
2007 NF PE RVU: **2020 NF PE RVU:** 27.69
2007 Fac PE RVU **2020 Fac PE RVU:**11.12
Result: Decrease

15731 **Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 05 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,362

RUC Recommendation: Not part of family **Referred to CPT** September 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 14.12 **2020 Work RVU:** 14.38
2007 NF PE RVU: 12.13 **2020 NF PE RVU:** 15.63
2007 Fac PE RVU 9.56 **2020 Fac PE RVU:**12.21
Result: Not Part of RAW

Status Report: CMS Requests and Relativity Assessment Issues

15732 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)**

Global: **Issue:** Muscle Flaps **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

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

First Identified: September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 19.70 **2020 Work RVU:**
2007 NF PE RVU: 17.27 **2020 NF PE RVU:**
2007 Fac PE RVU 12.01 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

15733 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

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

First Identified: January 2017 **2019 est Medicare Utilization:** 5,657

2007 Work RVU: **2020 Work RVU:** 15.68
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 11.99

RUC Recommendation: 15.68

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

Result: Decrease

15734 **Muscle, myocutaneous, or fasciocutaneous flap; trunk**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 14 **Specialty Developing Recommendation:**

First Identified: October 2015 **2019 est Medicare Utilization:** 24,232

2007 Work RVU: 19.62 **2020 Work RVU:** 23.00
2007 NF PE RVU: 17.58 **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.32 **2020 Fac PE RVU:** 15.90

RUC Recommendation: 23.00

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

15736 **Muscle, myocutaneous, or fasciocutaneous flap; upper extremity**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 14 **Specialty Developing Recommendation:** ASSH, ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,501

2007 Work RVU: 16.92 **2020 Work RVU:** 17.04
2007 NF PE RVU: 17.17 **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.96 **2020 Fac PE RVU:** 15.08

RUC Recommendation: 17.04 **Referred to CPT** September 2016 **Result:** Maintain

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

15738 **Muscle, myocutaneous, or fasciocutaneous flap; lower extremity**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 14 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 6,218

2007 Work RVU: 18.92 **2020 Work RVU:** 19.04
2007 NF PE RVU: 17.04 **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.45 **2020 Fac PE RVU:** 14.87

RUC Recommendation: 19.04 **Referred to CPT** September 2016 **Result:** Maintain

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

15740 **Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel**

Global: 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,046

2007 Work RVU: 11.57 **2020 Work RVU:** 11.80
2007 NF PE RVU: 11.01 **2020 NF PE RVU:** 15.18
2007 Fac PE RVU 8.58 **2020 Fac PE RVU:** 10.54

RUC Recommendation: 11.57 **Referred to CPT** February 2009 & February 2012 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

15769 **Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** AAOHNS, ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 6.68
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 6.04

RUC Recommendation: 6.68. Flagged for RAW review April 2022.

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

15771 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 6.73
2007 NF PE RVU: **2020 NF PE RVU:** 8.67
2007 Fac PE RVU **2020 Fac PE RVU:** 5.88

RUC Recommendation: 6.73

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

15772 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 2.29
2007 Fac PE RVU **2020 Fac PE RVU:** 1.14

RUC Recommendation: 2.50

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

Status Report: CMS Requests and Relativity Assessment Issues

15773 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate**

Global: 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 6.83
2007 NF PE RVU: **2020 NF PE RVU:** 8.72
2007 Fac PE RVU **2020 Fac PE RVU:** 5.93

RUC Recommendation: 6.83 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

15774 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.41
2007 NF PE RVU: **2020 NF PE RVU:** 2.25
2007 Fac PE RVU **2020 Fac PE RVU:** 1.10

RUC Recommendation: 2.41 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

15777 **Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,429

2007 Work RVU: **2020 Work RVU:** 3.65
2007 NF PE RVU: **2020 NF PE RVU:** 1.96
2007 Fac PE RVU **2020 Fac PE RVU:** 1.96

RUC Recommendation: 3.65 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15823 **Blepharoplasty, upper eyelid; with excessive skin weighting down lid**

Global: 090 **Issue:** Upper Eyelid Blepharoplasty **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 33 **Specialty Developing Recommendation:** AAO **First Identified:** October 2009 **2019 est Medicare Utilization:** 97,994

2007 Work RVU: 8.12 **2020 Work RVU:** 6.81
2007 NF PE RVU: 7.8 **2020 NF PE RVU:** 10.06
2007 Fac PE RVU 6.41 **2020 Fac PE RVU:**8.16

RUC Recommendation: 6.81 **Referred to CPT** **Result:** Decrease

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

16020 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, **First Identified:** October 2009 **2019 est Medicare Utilization:** 15,272

2007 Work RVU: 0.80 **2020 Work RVU:** 0.71
2007 NF PE RVU: 1.25 **2020 NF PE RVU:** 1.53
2007 Fac PE RVU 0.58 **2020 Fac PE RVU:**0.74

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

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

16025 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,908

2007 Work RVU: 1.85 **2020 Work RVU:** 1.74
2007 NF PE RVU: 1.72 **2020 NF PE RVU:** 2.37
2007 Fac PE RVU 0.94 **2020 Fac PE RVU:**1.16

RUC Recommendation: 1.85 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

16030 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACEP, ASPS, AAFP, AAPMR, **First Identified:** February 2010 **2019 est Medicare Utilization:** 879

2007 Work RVU: 2.08 **2020 Work RVU:** 2.08
2007 NF PE RVU: 2.12 **2020 NF PE RVU:** 3.09
2007 Fac PE RVU 1.08 **2020 Fac PE RVU:**1.39

RUC Recommendation: CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2012

Result: Maintain

17000 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,117,793

2007 Work RVU: 0.62 **2020 Work RVU:** 0.61
2007 NF PE RVU: 1.08 **2020 NF PE RVU:** 1.18
2007 Fac PE RVU 0.59 **2020 Fac PE RVU:**0.86

RUC Recommendation: 0.61

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

Result: Decrease

17003 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)**

Global: ZZZ **Issue:** Destruction of Premalignant Lesions **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,474,499

2007 Work RVU: 0.07 **2020 Work RVU:** 0.04
2007 NF PE RVU: 0.11 **2020 NF PE RVU:** 0.13
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:**0.02

RUC Recommendation: 0.04

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

17004 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** CMS High Expenditure Procedural Codes1 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 17 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 874,685

2007 Work RVU: 1.82 **2020 Work RVU:** 1.37
2007 NF PE RVU: 2.33 **2020 NF PE RVU:** 2.99
2007 Fac PE RVU 1.54 **2020 Fac PE RVU:**1.30

RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

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17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,933

2007 Work RVU: 4.62 **2020 Work RVU:** 3.69
2007 NF PE RVU: 4.63 **2020 NF PE RVU:** 5.63
2007 Fac PE RVU 3.33 **2020 Fac PE RVU:**3.75

RUC Recommendation: 3.61 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

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17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,449

2007 Work RVU: 9.19 **2020 Work RVU:** 4.79
2007 NF PE RVU: 7.24 **2020 NF PE RVU:** 7.34
2007 Fac PE RVU 5.41 **2020 Fac PE RVU:**4.78

RUC Recommendation: 4.68 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

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17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,081

2007 Work RVU: 13.22 **2020 Work RVU:** 7.49
2007 NF PE RVU: 9.34 **2020 NF PE RVU:** 9.79
2007 Fac PE RVU 7.49 **2020 Fac PE RVU:**6.66

RUC Recommendation: 6.37 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

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Status Report: CMS Requests and Relativity Assessment Issues

17110 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 2,556,286

2007 Work RVU: 0.67 **2020 Work RVU:** 0.70
2007 NF PE RVU: 1.66 **2020 NF PE RVU:** 2.39
2007 Fac PE RVU 0.74 **2020 Fac PE RVU:** 1.13

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

17111 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 122,909

2007 Work RVU: 0.94 **2020 Work RVU:** 0.97
2007 NF PE RVU: 1.83 **2020 NF PE RVU:** 2.66
2007 Fac PE RVU 0.89 **2020 Fac PE RVU:** 1.28

RUC Recommendation: Remove from screen

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

Result: Remove from screen

17250 **Chemical cauterization of granulation tissue (ie, proud flesh)**

Global: 000 **Issue:** RAW **Screen:** High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAFP, ACS, APMA

First Identified: October 2015

2019 est Medicare Utilization: 234,080

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 1.25 **2020 NF PE RVU:** 1.83
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:** 0.48

RUC Recommendation: Review in 2 years (Oct 2021).

Referred to CPT September 2016
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Result:

Status Report: CMS Requests and Relativity Assessment Issues

17261 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 140,325

2007 Work RVU: 1.19 **2020 Work RVU:** 1.22
2007 NF PE RVU: 1.84 **2020 NF PE RVU:** 2.80
2007 Fac PE RVU 0.9 **2020 Fac PE RVU:** 1.16

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17262 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 287,333

2007 Work RVU: 1.60 **2020 Work RVU:** 1.63
2007 NF PE RVU: 2.13 **2020 NF PE RVU:** 3.23
2007 Fac PE RVU 1.09 **2020 Fac PE RVU:** 1.41

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17271 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 53,690

2007 Work RVU: 1.51 **2020 Work RVU:** 1.54
2007 NF PE RVU: 2 **2020 NF PE RVU:** 2.98
2007 Fac PE RVU 1.05 **2020 Fac PE RVU:** 1.35

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17272 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 82,281

2007 Work RVU: 1.79 **2020 Work RVU:** 1.82
2007 NF PE RVU: 2.24 **2020 NF PE RVU:** 3.32
2007 Fac PE RVU 1.18 **2020 Fac PE RVU:** 1.52

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17281 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 86,818

2007 Work RVU: 1.74 **2020 Work RVU:** 1.77
2007 NF PE RVU: 2.12 **2020 NF PE RVU:** 3.13
2007 Fac PE RVU 1.16 **2020 Fac PE RVU:** 1.48

RUC Recommendation: 1.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17282 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 81,831

2007 Work RVU: 2.06 **2020 Work RVU:** 2.09
2007 NF PE RVU: 2.41 **2020 NF PE RVU:** 3.52
2007 Fac PE RVU 1.31 **2020 Fac PE RVU:** 1.67

RUC Recommendation: 2.09 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17311 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 829,586

2007 Work RVU: 6.20 **2020 Work RVU:** 6.20
2007 NF PE RVU: 10.79 **2020 NF PE RVU:** 12.07
2007 Fac PE RVU 3.16 **2020 Fac PE RVU:**3.64

RUC Recommendation: 6.20 **Referred to CPT** **Result:** Maintain

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

17312 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 509,267

2007 Work RVU: 3.30 **2020 Work RVU:** 3.30
2007 NF PE RVU: 6.92 **2020 NF PE RVU:** 7.69
2007 Fac PE RVU 1.68 **2020 Fac PE RVU:**1.94

RUC Recommendation: 3.30 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

17313 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 140,796

2007 Work RVU: 5.56 **2020 Work RVU:** 5.56
2007 NF PE RVU: 9.95 **2020 NF PE RVU:** 11.58
2007 Fac PE RVU 2.83 **2020 Fac PE RVU:**3.26

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 57,990

2007 Work RVU: 3.06 **2020 Work RVU:** 3.06
2007 NF PE RVU: 6.41 **2020 NF PE RVU:** 7.46
2007 Fac PE RVU 1.55 **2020 Fac PE RVU:**1.80

RUC Recommendation: 3.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

17315 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 19,946

2007 Work RVU: 0.87 **2020 Work RVU:** 0.87
2007 NF PE RVU: 1.15 **2020 NF PE RVU:** 1.26
2007 Fac PE RVU 0.44 **2020 Fac PE RVU:**0.51

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19020 **Mastotomy with exploration or drainage of abscess, deep**

Global: 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS

First Identified: September 2007 **2019 est Medicare Utilization:** 1,614

2007 Work RVU: 3.74 **2020 Work RVU:** 3.83
2007 NF PE RVU: 6.39 **2020 NF PE RVU:** 8.85
2007 Fac PE RVU 2.76 **2020 Fac PE RVU:** 4.24

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits

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

Result: PE Only

19081 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS

First Identified: January 2012 **2019 est Medicare Utilization:** 60,561

2007 Work RVU: **2020 Work RVU:** 3.29
2007 NF PE RVU: **2020 NF PE RVU:** 13.73
2007 Fac PE RVU **2020 Fac PE RVU:** 1.21

RUC Recommendation: 3.29

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

19082 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS

First Identified: January 2012 **2019 est Medicare Utilization:** 4,476

2007 Work RVU: **2020 Work RVU:** 1.65
2007 NF PE RVU: **2020 NF PE RVU:** 12.17
2007 Fac PE RVU **2020 Fac PE RVU:** 0.61

RUC Recommendation: 1.65

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

19083 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 118,588

RUC Recommendation: 3.10 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.10
2007 NF PE RVU: **2020 NF PE RVU:** 13.74
2007 Fac PE RVU **2020 Fac PE RVU:** 1.14
Result: Decrease

19084 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 15,269

RUC Recommendation: 1.55 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 1.55
2007 NF PE RVU: **2020 NF PE RVU:** 11.92
2007 Fac PE RVU **2020 Fac PE RVU:** 0.57
Result: Decrease

19085 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,634

RUC Recommendation: 3.64 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.64
2007 NF PE RVU: **2020 NF PE RVU:** 22.24
2007 Fac PE RVU **2020 Fac PE RVU:** 1.34
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

19086 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,195

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 18.86
2007 Fac PE RVU **2020 Fac PE RVU:** 0.68

RUC Recommendation: 1.82 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19102 **Biopsy of breast; percutaneous, needle core, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 2.00 **2020 Work RVU:**
2007 NF PE RVU: 3.68 **2020 NF PE RVU:**
2007 Fac PE RVU 0.64 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

19103 **Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.69 **2020 Work RVU:**
2007 NF PE RVU: 11.01 **2020 NF PE RVU:**
2007 Fac PE RVU 1.18 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19281 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 30,514

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 4.81
2007 Fac PE RVU **2020 Fac PE RVU:** 0.74
Result: Decrease

19282 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,292

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 3.83
2007 Fac PE RVU **2020 Fac PE RVU:** 0.37
Result: Decrease

19283 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,526

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 5.55
2007 Fac PE RVU **2020 Fac PE RVU:** 0.74
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

19284 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 338

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 4.78
2007 Fac PE RVU **2020 Fac PE RVU:** 0.37

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19285 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,714

2007 Work RVU: **2020 Work RVU:** 1.70
2007 NF PE RVU: **2020 NF PE RVU:** 11.12
2007 Fac PE RVU **2020 Fac PE RVU:** 0.63

RUC Recommendation: 1.70 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19286 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 2,002

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 10.14
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 0.85 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19287 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 266

2007 Work RVU: **2020 Work RVU:** 2.55
2007 NF PE RVU: **2020 NF PE RVU:** 19.33
2007 Fac PE RVU **2020 Fac PE RVU:** 0.95

RUC Recommendation: 3.02 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19288 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60

2007 Work RVU: **2020 Work RVU:** 1.28
2007 NF PE RVU: **2020 NF PE RVU:** 16.19
2007 Fac PE RVU **2020 Fac PE RVU:** 0.48

RUC Recommendation: 1.51 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 1.27 **2020 Work RVU:**
2007 NF PE RVU: 2.81 **2020 NF PE RVU:**
2007 Fac PE RVU 0.41 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.63 **2020 Work RVU:**
2007 NF PE RVU: 1.17 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Breast Biopsy **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 2.57 **2020 NF PE RVU:**
2007 Fac PE RVU 2.02 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

19303 **Mastectomy, simple, complete**

Global: 090 **Issue:** Mastectomy **Screen:** Site of Service Anomaly - 2015 / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 15 **Specialty Developing Recommendation:** ACS, ASBS **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,587

2007 Work RVU: 15.67 **2020 Work RVU:** 15.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.52 **2020 Fac PE RVU:**9.26

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19307 **Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle**

Global: 090 **Issue:** Modified Radical Mastectomy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 22 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 6,042

2007 Work RVU: 17.95 **2020 Work RVU:** 18.23

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 8.34 **2020 Fac PE RVU:** 12.38

RUC Recommendation: 17.99

Referred to CPT

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

Result: Decrease

19318 **Breast reduction**

Global: 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASPS

First Identified: September 2007

2019 est Medicare Utilization: 7,501

2007 Work RVU: 15.91 **2020 Work RVU:** 16.03

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 10.94 **2020 Fac PE RVU:** 12.82

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

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

Result: PE Only

19340 **Insertion of breast implant on same day of mastectomy (ie, immediate)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** CMS Request / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 05 **Specialty Developing Recommendation:** ASPS

First Identified: October 2009

2019 est Medicare Utilization: 7,433

2007 Work RVU: 6.32 **2020 Work RVU:** 13.99

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 3.07 **2020 Fac PE RVU:** 12.00

RUC Recommendation: 11.00

Referred to CPT

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

19357 **Tissue expander placement in breast reconstruction, including subsequent expansion(s)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** Site of Service Anomaly / 090-Day Global Post-Operative Visits / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,479

2007 Work RVU: 20.57 **2020 Work RVU:** 18.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.69 **2020 Fac PE RVU:** 21.61

RUC Recommendation: 15.36 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 **Deleted from CPT**

Global: **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

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

2007 Work RVU: 2.14 **2020 Work RVU:**
2007 NF PE RVU: 2.71 **2020 NF PE RVU:**
2007 Fac PE RVU 1.68 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

20005 **Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)**

Global: **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 3.55 **2020 Work RVU:**
2007 NF PE RVU: 3.54 **2020 NF PE RVU:**
2007 Fac PE RVU 2.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20220 **Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2018 **2019 est Medicare Utilization:** 12,355

2007 Work RVU: 1.27 **2020 Work RVU:** 1.65
2007 NF PE RVU: 4.07 **2020 NF PE RVU:** 5.26
2007 Fac PE RVU 0.75 **2020 Fac PE RVU:**0.77

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20225 **Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 14,341

2007 Work RVU: 1.87 **2020 Work RVU:** 2.45
2007 NF PE RVU: 21.49 **2020 NF PE RVU:** 9.24
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:**1.12

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20240 **Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 04 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** April 2014 **2019 est Medicare Utilization:** 6,533

2007 Work RVU: 3.25 **2020 Work RVU:** 2.61
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.44 **2020 Fac PE RVU:**1.28

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20245 **Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 04 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,354

2007 Work RVU: 8.77 **2020 Work RVU:** 6.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.38 **2020 Fac PE RVU:**3.10

RUC Recommendation: 6.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20525 **Removal of foreign body in muscle or tendon sheath; deep or complicated** **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,693

2007 Work RVU: 3.51 **2020 Work RVU:** 3.54
2007 NF PE RVU: 8.62 **2020 NF PE RVU:** 9.44
2007 Fac PE RVU 2.52 **2020 Fac PE RVU:**2.95

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

20526 **Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel** **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 102,673

2007 Work RVU: 0.94 **2020 Work RVU:** 0.94
2007 NF PE RVU: 0.93 **2020 NF PE RVU:** 1.15
2007 Fac PE RVU 0.5 **2020 Fac PE RVU:**0.55

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

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")** **Global:** 000 **Issue:** Injection of Tendon **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 27 **Specialty Developing Recommendation:** AAOS, AAPM&R, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 848,059

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.72
2007 Fac PE RVU 0.25 **2020 Fac PE RVU:**0.29

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20551 **Injection(s); single tendon origin/insertion**

Global: 000 **Issue:** Therapeutic Injection Carpal Tunnel **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 10 **Specialty Developing Recommendation:** AAPMR, AAOS, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 163,234

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 0.67 **2020 NF PE RVU:** 0.76
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.31

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20552 **Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**

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

Most Recent RUC Meeting: January 2016 **Tab** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 350,677

2007 Work RVU: 0.66 **2020 Work RVU:** 0.66
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.84
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.36

RUC Recommendation: 0.66 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20553 **Injection(s); single or multiple trigger point(s), 3 or more muscles**

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

Most Recent RUC Meeting: January 2016 **Tab** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,100

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 0.78 **2020 NF PE RVU:** 0.98
2007 Fac PE RVU 0.23 **2020 Fac PE RVU:**0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20600 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance**

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

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 444,325

2007 Work RVU: 0.66 **2020 Work RVU:** 0.66
2007 NF PE RVU: 0.66 **2020 NF PE RVU:** 0.69
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:**0.29

RUC Recommendation: 0.66 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20604 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 46,354

2007 Work RVU: **2020 Work RVU:** 0.89
2007 NF PE RVU: **2020 NF PE RVU:** 1.19
2007 Fac PE RVU **2020 Fac PE RVU:**0.34

RUC Recommendation: 0.89 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20605 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance**

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

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 466,622

2007 Work RVU: 0.68 **2020 Work RVU:** 0.68
2007 NF PE RVU: 0.76 **2020 NF PE RVU:** 0.72
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.31

RUC Recommendation: 0.68 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20606 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 56,334

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.29
2007 Fac PE RVU **2020 Fac PE RVU:** 0.41

RUC Recommendation: 1.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20610 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,722,382

2007 Work RVU: 0.79 **2020 Work RVU:** 0.79
2007 NF PE RVU: 0.98 **2020 NF PE RVU:** 0.86
2007 Fac PE RVU 0.42 **2020 Fac PE RVU:** 0.41

RUC Recommendation: 0.79 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20611 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,069,935

2007 Work RVU: **2020 Work RVU:** 1.10
2007 NF PE RVU: **2020 NF PE RVU:** 1.45
2007 Fac PE RVU **2020 Fac PE RVU:** 0.50

RUC Recommendation: 1.10 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20612 **Aspiration and/or injection of ganglion cyst(s) any location** **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 28,400

2007 Work RVU: 0.70 **2020 Work RVU:** 0.70
2007 NF PE RVU: 0.71 **2020 NF PE RVU:** 0.97
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.40

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

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20680 **Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 55,761

2007 Work RVU: 5.90 **2020 Work RVU:** 5.96
2007 NF PE RVU: 8.63 **2020 NF PE RVU:** 10.63
2007 Fac PE RVU 3.82 **2020 Fac PE RVU:**5.17

RUC Recommendation: 5.96 and adjustments to pre-service time package 3. **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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20692 **Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)** **Global:** 090 **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,150

2007 Work RVU: 6.40 **2020 Work RVU:** 16.27
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.65 **2020 Fac PE RVU:**13.21

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

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Status Report: CMS Requests and Relativity Assessment Issues

20694 **Removal, under anesthesia, of external fixation system**

Global: 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,209

2007 Work RVU: 4.20 **2020 Work RVU:** 4.28
2007 NF PE RVU: 6.69 **2020 NF PE RVU:** 7.20
2007 Fac PE RVU 3.92 **2020 Fac PE RVU:**4.67

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

20700 **Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.67
2007 Fac PE RVU **2020 Fac PE RVU:**0.67

RUC Recommendation: 1.50

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

Result: Increase

20701 **Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.13
2007 NF PE RVU: **2020 NF PE RVU:** 0.50
2007 Fac PE RVU **2020 Fac PE RVU:**0.50

RUC Recommendation: 1.13

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

Result: Increase

20702 **Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.10
2007 Fac PE RVU **2020 Fac PE RVU:**1.10

RUC Recommendation: 2.50

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

20703 **Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 0.80
2007 Fac PE RVU **2020 Fac PE RVU:** 0.80

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20704 **Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.60
2007 NF PE RVU: **2020 NF PE RVU:** 1.15
2007 Fac PE RVU **2020 Fac PE RVU:** 1.15

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20705 **Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.15
2007 NF PE RVU: **2020 NF PE RVU:** 0.95
2007 Fac PE RVU **2020 Fac PE RVU:** 0.95

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,436

2007 Work RVU: 5.77 **2020 Work RVU:** 3.00
2007 NF PE RVU: 8.65 **2020 NF PE RVU:** 8.13
2007 Fac PE RVU 5.5 **2020 Fac PE RVU:** 1.82

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

Status Report: CMS Requests and Relativity Assessment Issues

20902 **Bone graft, any donor area; major or large** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 4,599

2007 Work RVU: 7.98 **2020 Work RVU:** 4.58
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.63 **2020 Fac PE RVU:** 2.72

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)** **Global:** **Issue:** Tissue Grafting Procedures **Screen:** CMS Fastest Growing / Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 04 **Specialty Developing Recommendation:** AAOS, ASPS, AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,815

2007 Work RVU: 5.70 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.67 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted for 2020

21015 **Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 506

2007 Work RVU: 5.59 **2020 Work RVU:** 9.89
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.85 **2020 Fac PE RVU:** 8.71

RUC Recommendation: 9.71 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible** **Global:** 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 61 **Specialty Developing Recommendation:** AAOMS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,614

2007 Work RVU: 11.07 **2020 Work RVU:** 10.03
2007 NF PE RVU: 12.32 **2020 NF PE RVU:** 12.67
2007 Fac PE RVU 9.21 **2020 Fac PE RVU:** 8.94

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21495 **Open treatment of hyoid fracture**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 6.55 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 8.73 **2020 Fac PE RVU:**

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

21557 **Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 490

2007 Work RVU: 8.91 **2020 Work RVU:** 14.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.13 **2020 Fac PE RVU:**9.93

RUC Recommendation: 14.57 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

21800 **Closed treatment of rib fracture, uncomplicated, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.98 **2020 Work RVU:**
2007 NF PE RVU: 1.34 **2020 NF PE RVU:**
2007 Fac PE RVU 1.34 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

21805 **Open treatment of rib fracture without fixation, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 2.80 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.28 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21810 **Treatment of rib fracture requiring external fixation (flail chest)** **Global:** **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 6.92 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.03 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

21811 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs** **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 357

2007 Work RVU: **2020 Work RVU:** 10.79
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.08

RUC Recommendation: 19.55 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

21812 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs** **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 468

2007 Work RVU: **2020 Work RVU:** 13.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 5.15

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

21813 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs** **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 62

2007 Work RVU: **2020 Work RVU:** 17.61
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 6.86

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21820 **Closed treatment of sternum fracture**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2007 Work RVU: 1.31 **2020 Work RVU:** 1.36
2007 NF PE RVU: 1.82 **2020 NF PE RVU:** 2.55
2007 Fac PE RVU 1.77 **2020 Fac PE RVU:**2.52

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT October 2013 **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

21825 **Open treatment of sternum fracture with or without skeletal fixation**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 737

2007 Work RVU: 7.65 **2020 Work RVU:** 7.76
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.16 **2020 Fac PE RVU:**6.15

RUC Recommendation: Unrelated to the family

Referred to CPT October 2013 **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

21935 **Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 235

2007 Work RVU: 18.38 **2020 Work RVU:** 15.72
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.37 **2020 Fac PE RVU:**10.62

RUC Recommendation: 15.54

Referred to CPT June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,695

2007 Work RVU: 20.77 **2020 Work RVU:** 21.02
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.53 **2020 Fac PE RVU:** 16.75

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

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

Global: **Issue:** Closed treatment of vertebral process fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 23 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 2.08 **2020 Work RVU:**
2007 NF PE RVU: 2.27 **2020 NF PE RVU:**
2007 Fac PE RVU 1.89 **2020 Fac PE RVU:**

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

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

Global: 090 **Issue:** Closed Treatment Vertebral Fracture **Screen:** Negative IWPUT / Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 23 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** April 2017 **2019 est Medicare Utilization:** 6,942

2007 Work RVU: 3.69 **2020 Work RVU:** 3.45
2007 NF PE RVU: 2.85 **2020 NF PE RVU:** 4.52
2007 Fac PE RVU 2.4 **2020 Fac PE RVU:** 4.20

RUC Recommendation: 3.45. Flag for Rereview **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22510 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,686

2007 Work RVU: **2020 Work RVU:** 7.90
2007 NF PE RVU: **2020 NF PE RVU:** 43.10
2007 Fac PE RVU **2020 Fac PE RVU:** 3.70

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22511 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 4,104

2007 Work RVU: **2020 Work RVU:** 7.33
2007 NF PE RVU: **2020 NF PE RVU:** 43.22
2007 Fac PE RVU **2020 Fac PE RVU:** 3.54

RUC Recommendation: 8.05 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22512 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 2,505

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 19.91
2007 Fac PE RVU **2020 Fac PE RVU:** 1.42

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22513 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 24,396

2007 Work RVU: **2020 Work RVU:** 8.65
2007 NF PE RVU: **2020 NF PE RVU:** 179.02
2007 Fac PE RVU **2020 Fac PE RVU:** 4.70

RUC Recommendation: 8.90 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22514 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 26,776

2007 Work RVU: **2020 Work RVU:** 7.99
2007 NF PE RVU: **2020 NF PE RVU:** 178.97
2007 Fac PE RVU **2020 Fac PE RVU:** 4.46

RUC Recommendation: 8.24 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22515 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 15,688

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 100.84
2007 Fac PE RVU **2020 Fac PE RVU:** 1.66

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22520 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 9.17 **2020 Work RVU:**
2007 NF PE RVU: 56.83 **2020 NF PE RVU:**
2007 Fac PE RVU 4.84 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22521 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 8.60 **2020 Work RVU:**
2007 NF PE RVU: 52.87 **2020 NF PE RVU:**
2007 Fac PE RVU 4.69 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22522 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 4.30 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.59 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22523 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 9.21 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.6 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22524 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 8.81 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.4 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22525 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 4.47 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.12 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 908

2007 Work RVU: 24.61 **2020 Work RVU:** 24.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.57 **2020 Fac PE RVU:** 17.34

RUC Recommendation: Remove from screen. CPT Assistant article published.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 40,145

2007 Work RVU: **2020 Work RVU:** 25.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 16.72

RUC Recommendation: 24.50

Referred to CPT October 2009

Result: Decrease

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

22552 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,696

2007 Work RVU: **2020 Work RVU:** 6.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.09

RUC Recommendation: 6.50

Referred to CPT October 2009

Result: Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,675

2007 Work RVU: 17.54 **2020 Work RVU:** 17.69
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.97 **2020 Fac PE RVU:** 13.39

RUC Recommendation: 17.69 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22558 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** High Volume Growth2 / Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,376

2007 Work RVU: 23.33 **2020 Work RVU:** 23.53
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.86 **2020 Fac PE RVU:** 14.91

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

22585 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 17,132

2007 Work RVU: 5.52 **2020 Work RVU:** 5.52
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.62 **2020 Fac PE RVU:** 2.52

RUC Recommendation: Remove from screen **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22612 **Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,894

2007 Work RVU: 23.38 **2020 Work RVU:** 23.53
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.83 **2020 Fac PE RVU:** 16.20
Result: Maintain

RUC Recommendation: Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

22614 **Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 144,296

2007 Work RVU: 6.43 **2020 Work RVU:** 6.43
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.15 **2020 Fac PE RVU:** 3.09
Result: Decrease

RUC Recommendation: 6.43

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

22630 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,654

2007 Work RVU: 21.89 **2020 Work RVU:** 22.09
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.39 **2020 Fac PE RVU:** 16.38
Result: Maintain

RUC Recommendation: 22.09

Referred to CPT October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22632 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875

2007 Work RVU: 5.22 **2020 Work RVU:** 5.22
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.51 **2020 Fac PE RVU:** 2.47

RUC Recommendation: 5.22 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22633 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,096

2007 Work RVU: **2020 Work RVU:** 27.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 18.02

RUC Recommendation: 27.75 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22634 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,338

2007 Work RVU: **2020 Work RVU:** 8.16
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.90

RUC Recommendation: 8.16 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,692

2007 Work RVU: 13.44 **2020 Work RVU:** 13.44
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.28 **2020 Fac PE RVU:** 6.46

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

22849 **Reinsertion of spinal fixation device**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 4,231

2007 Work RVU: 19.08 **2020 Work RVU:** 19.17
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.39 **2020 Fac PE RVU:** 13.33

RUC Recommendation: Maintain **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22851 **Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)**

Global: **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS Fastest Growing / High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 06 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 6.70 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.18 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22859 **Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,934

2007 Work RVU: **2020 Work RVU:** 5.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.63

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - NPRM for 2021 **Complete?** No

Most Recent RUC Meeting: January 2016 **Tab** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,131

2007 Work RVU: **2020 Work RVU:** 13.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 10.90

RUC Recommendation: 4.88 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22868 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 532

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.90

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22900 **Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 628

2007 Work RVU: 6.14 **2020 Work RVU:** 8.32
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.3 **2020 Fac PE RVU:**6.12

RUC Recommendation: 8.21 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

23076 **Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 677

2007 Work RVU: 7.77 **2020 Work RVU:** 7.41
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.5 **2020 Fac PE RVU:**6.66

RUC Recommendation: 7.28 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 **Claviculectomy; partial**

Global: 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,767

2007 Work RVU: 7.23 **2020 Work RVU:** 7.39
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.22 **2020 Fac PE RVU:**8.04

RUC Recommendation: 7.23 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release**

Global: 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,826

2007 Work RVU: 7.63 **2020 Work RVU:** 7.77
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.88 **2020 Fac PE RVU:**8.39

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23350 **Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography**

Global: 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 35,070

2007 Work RVU: 1.00 **2020 Work RVU:** 1.00
2007 NF PE RVU: 3.23 **2020 NF PE RVU:** 3.26
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.38

RUC Recommendation: 1.00

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

Result: Maintain

23405 **Tenotomy, shoulder area; single tendon**

Global: 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,277

2007 Work RVU: 8.43 **2020 Work RVU:** 8.54
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.69 **2020 Fac PE RVU:**7.79

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

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

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,333

2007 Work RVU: 12.63 **2020 Work RVU:** 11.39
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.02 **2020 Fac PE RVU:**10.08

RUC Recommendation: 11.23

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

Result: Decrease

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

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 12,002

2007 Work RVU: 13.55 **2020 Work RVU:** 11.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.49 **2020 Fac PE RVU:**10.35

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 62 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 408

RUC Recommendation: 9.23 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 10.09 **2020 Work RVU:** 9.23
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.65 **2020 Fac PE RVU:**9.07
Result: Decrease

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,359

RUC Recommendation: 13.35 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 14.75 **2020 Work RVU:** 13.54
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.59 **2020 Fac PE RVU:**11.86
Result: Decrease

23430 **Tenodesis of long tendon of biceps** **Global:** 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,997

RUC Recommendation: 10.17 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 10.05 **2020 Work RVU:** 10.17
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.78 **2020 Fac PE RVU:**9.38
Result: Maintain

23440 **Resection or transplantation of long tendon of biceps** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,487

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

2007 Work RVU: 10.53 **2020 Work RVU:** 10.64
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.91 **2020 Fac PE RVU:**9.13
Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))**

Global: 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 67,382

2007 Work RVU: 22.47 **2020 Work RVU:** 22.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.89 **2020 Fac PE RVU:**15.62

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

23540 **Closed treatment of acromioclavicular dislocation; without manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 339

2007 Work RVU: 2.28 **2020 Work RVU:** 2.36
2007 NF PE RVU: 2.8 **2020 NF PE RVU:** 3.85
2007 Fac PE RVU 2.43 **2020 Fac PE RVU:**3.82

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

23600 **Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation**

Global: 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 14 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,747

2007 Work RVU: 3.00 **2020 Work RVU:** 3.00
2007 NF PE RVU: 4.43 **2020 NF PE RVU:** 5.88
2007 Fac PE RVU 3.58 **2020 Fac PE RVU:**5.35

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

23625 **Closed treatment of greater humeral tuberosity fracture; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 173

2007 Work RVU: 3.99 **2020 Work RVU:** 4.10
2007 NF PE RVU: 4.82 **2020 NF PE RVU:** 6.05
2007 Fac PE RVU 4.19 **2020 Fac PE RVU:**5.22

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

Status Report: CMS Requests and Relativity Assessment Issues

23650 **Closed treatment of shoulder dislocation, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,692

2007 Work RVU: 3.44 **2020 Work RVU:** 3.53
2007 NF PE RVU: 3.65 **2020 NF PE RVU:** 4.98
2007 Fac PE RVU 2.77 **2020 Fac PE RVU:**4.16

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

23655 **Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,327

2007 Work RVU: 4.64 **2020 Work RVU:** 4.76
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.17 **2020 Fac PE RVU:**5.97

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

23665 **Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 556

2007 Work RVU: 4.54 **2020 Work RVU:** 4.66
2007 NF PE RVU: 5.21 **2020 NF PE RVU:** 6.77
2007 Fac PE RVU 4.61 **2020 Fac PE RVU:**5.85

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

Status Report: CMS Requests and Relativity Assessment Issues

24505 **Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 890

2007 Work RVU: 5.25 **2020 Work RVU:** 5.39
2007 NF PE RVU: 6.42 **2020 NF PE RVU:** 7.90
2007 Fac PE RVU 5.27 **2020 Fac PE RVU:**6.50

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

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

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,283

2007 Work RVU: 4.28 **2020 Work RVU:** 4.37
2007 NF PE RVU: 4.61 **2020 NF PE RVU:** 5.44
2007 Fac PE RVU 3.45 **2020 Fac PE RVU:**4.49

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

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

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 382

2007 Work RVU: 5.50 **2020 Work RVU:** 5.64
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.26 **2020 Fac PE RVU:**6.91

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

25116 **Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum**

Global: 090 **Issue:** Forearm Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,034

2007 Work RVU: 7.38 **2020 Work RVU:** 7.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.13 **2020 Fac PE RVU:**8.40

RUC Recommendation: 7.56 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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25210 **Carpectomy; 1 bone**

Global: 090 **Issue:** Carpectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,150

2007 Work RVU: 6.01 **2020 Work RVU:** 6.12
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.49 **2020 Fac PE RVU:**6.92

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 919

2007 Work RVU: 7.89 **2020 Work RVU:** 8.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.3 **2020 Fac PE RVU:**8.70

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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Status Report: CMS Requests and Relativity Assessment Issues

25280 **Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,402

2007 Work RVU: 7.28 **2020 Work RVU:** 7.39
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.6 **2020 Fac PE RVU:**7.60

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

25310 **Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon**

Global: 090 **Issue:** Forearm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,690

2007 Work RVU: 8.26 **2020 Work RVU:** 8.08
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.99 **2020 Fac PE RVU:**8.34

RUC Recommendation: 7.94

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

Result: Decrease

25565 **Closed treatment of radial and ulnar shaft fractures; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 667

2007 Work RVU: 5.71 **2020 Work RVU:** 5.85
2007 NF PE RVU: 6.52 **2020 NF PE RVU:** 7.87
2007 Fac PE RVU 5.32 **2020 Fac PE RVU:**6.40

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

25605 **Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,527

2007 Work RVU: 7.02 **2020 Work RVU:** 6.25
2007 NF PE RVU: 7.15 **2020 NF PE RVU:** 8.09
2007 Fac PE RVU 6.21 **2020 Fac PE RVU:**7.24

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

25606 **Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 2,015

2007 Work RVU: 8.10 **2020 Work RVU:** 8.31
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.41 **2020 Fac PE RVU:**9.19

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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

25607 **Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 9,419

2007 Work RVU: 9.35 **2020 Work RVU:** 9.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.26 **2020 Fac PE RVU:**9.84

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

25608 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 7,290

2007 Work RVU: 10.86 **2020 Work RVU:** 11.07
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.88 **2020 Fac PE RVU:** 10.63

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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

25609 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** January 2014 **2019 est Medicare Utilization:** 18,114

2007 Work RVU: 14.12 **2020 Work RVU:** 14.38
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.77 **2020 Fac PE RVU:** 13.19

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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

25675 **Closed treatment of distal radioulnar dislocation with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 445

2007 Work RVU: 4.75 **2020 Work RVU:** 4.89
2007 NF PE RVU: 5.46 **2020 NF PE RVU:** 6.89
2007 Fac PE RVU 4.53 **2020 Fac PE RVU:** 5.70

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

26020 **Drainage of tendon sheath, digit and/or palm, each** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 2,453

2007 Work RVU: 4.97 **2020 Work RVU:** 6.84
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.21 **2020 Fac PE RVU:**7.87

RUC Recommendation: 7.79 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

26055 **Tendon sheath incision (eg, for trigger finger)** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 105,433

2007 Work RVU: 3.00 **2020 Work RVU:** 3.11
2007 NF PE RVU: 13.02 **2020 NF PE RVU:** 11.95
2007 Fac PE RVU 3.92 **2020 Fac PE RVU:**4.64

RUC Recommendation: 3.75 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each** **Global:** 090 **Issue:** RAW **Screen:** Site of Service Anomaly / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,997

2007 Work RVU: 4.36 **2020 Work RVU:** 4.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.73 **2020 Fac PE RVU:**6.05

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

26160 **Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 18,598

2007 Work RVU: 3.46 **2020 Work RVU:** 3.57
2007 NF PE RVU: 11.53 **2020 NF PE RVU:** 12.14
2007 Fac PE RVU 4.08 **2020 Fac PE RVU:**4.84

RUC Recommendation: 3.57 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,150

2007 Work RVU: 10.22 **2020 Work RVU:** 9.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.22 **2020 Fac PE RVU:** 11.60
Result: Decrease

RUC Recommendation: 10.03

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

26357 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 66

2007 Work RVU: 8.65 **2020 Work RVU:** 11.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 14.29 **2020 Fac PE RVU:** 12.45
Result: Increase

RUC Recommendation: 11.50

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

26358 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 42

2007 Work RVU: 9.22 **2020 Work RVU:** 12.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.19 **2020 Fac PE RVU:** 13.26
Result: Increase

RUC Recommendation: 13.10

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

Status Report: CMS Requests and Relativity Assessment Issues

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon**

Global: 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 10,824

2007 Work RVU: 6.76 **2020 Work RVU:** 6.90
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.68 **2020 Fac PE RVU:** 13.77

RUC Recommendation: 6.76 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

26700 **Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 471

2007 Work RVU: 3.74 **2020 Work RVU:** 3.83
2007 NF PE RVU: 3.65 **2020 NF PE RVU:** 4.99
2007 Fac PE RVU 2.89 **2020 Fac PE RVU:** 4.30

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

26750 **Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,976

2007 Work RVU: 1.74 **2020 Work RVU:** 1.80
2007 NF PE RVU: 2.42 **2020 NF PE RVU:** 3.18
2007 Fac PE RVU 2.07 **2020 Fac PE RVU:** 3.21

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

Status Report: CMS Requests and Relativity Assessment Issues

26755 **Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015 **2019 est Medicare Utilization:** 522

2007 Work RVU: 3.15 **2020 Work RVU:** 3.23
2007 NF PE RVU: 4.27 **2020 NF PE RVU:** 5.29
2007 Fac PE RVU 3 **2020 Fac PE RVU:**4.04

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26770 **Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015 **2019 est Medicare Utilization:** 5,900

2007 Work RVU: 3.07 **2020 Work RVU:** 3.15
2007 NF PE RVU: 3.3 **2020 NF PE RVU:** 4.33
2007 Fac PE RVU 2.44 **2020 Fac PE RVU:**3.66

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27048 **Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 05 **Specialty Developing Recommendation:** ACS, AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 339

2007 Work RVU: 6.44 **2020 Work RVU:** 8.85
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.76 **2020 Fac PE RVU:**6.88

RUC Recommendation: 8.74

Referred to CPT June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27062 **Excision; trochanteric bursa or calcification** **Global:** 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,884

2007 Work RVU: 5.66 **2020 Work RVU:** 5.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.05 **2020 Fac PE RVU:** 6.22

RUC Recommendation: 5.66 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27096 **Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed** **Global:** 000 **Issue:** Injection for Sacroiliac Joint **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 489,612

2007 Work RVU: 1.40 **2020 Work RVU:** 1.48
2007 NF PE RVU: 3.88 **2020 NF PE RVU:** 3.00
2007 Fac PE RVU 0.33 **2020 Fac PE RVU:** 0.78

RUC Recommendation: 1.48 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27130 **Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft** **Global:** 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 169,584

2007 Work RVU: 21.61 **2020 Work RVU:** 20.72
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.96 **2020 Fac PE RVU:** 14.38

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27134 **Revision of total hip arthroplasty; both components, with or without autograft or allograft** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,863

2007 Work RVU: 30.13 **2020 Work RVU:** 30.28
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.08 **2020 Fac PE RVU:** 19.15

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

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

Result: Maintain

27193 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation** **Global:** **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 5.98 **2020 Work RVU:**
2007 NF PE RVU: 4.98 **2020 NF PE RVU:**
2007 Fac PE RVU 4.98 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

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

Result: Deleted from CPT

27194 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia** **Global:** **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 10.08 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 7.4 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT

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

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

27197 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 11,080

2007 Work RVU: **2020 Work RVU:** 1.53
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.85

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27198 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 206

2007 Work RVU: **2020 Work RVU:** 4.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.30

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27220 **Closed treatment of acetabulum (hip socket) fracture(s); without manipulation**

Global: 090 **Issue:** Closed Treatment Fracture - Hip **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 08 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2017 **2019 est Medicare Utilization:** 3,070

2007 Work RVU: 6.72 **2020 Work RVU:** 5.50
2007 NF PE RVU: 5.61 **2020 NF PE RVU:** 5.83
2007 Fac PE RVU 5.52 **2020 Fac PE RVU:** 5.66

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27230 **Closed treatment of femoral fracture, proximal end, neck; without manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,509

2007 Work RVU: 5.69 **2020 Work RVU:** 5.81
2007 NF PE RVU: 5.38 **2020 NF PE RVU:** 6.95
2007 Fac PE RVU 5.06 **2020 Fac PE RVU:**6.74

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

27232 **Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 194

2007 Work RVU: 11.66 **2020 Work RVU:** 11.72
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.88 **2020 Fac PE RVU:**7.57

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

27236 **Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement** **Global:** 090 **Issue:** Open Treatment of Femoral Fracture **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2011 **2019 est Medicare Utilization:** 57,280

2007 Work RVU: 17.43 **2020 Work RVU:** 17.61
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.85 **2020 Fac PE RVU:**13.47

RUC Recommendation: 17.61 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27240 **Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 260

2007 Work RVU: 13.66 **2020 Work RVU:** 13.81
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.13 **2020 Fac PE RVU:** 11.02

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,947

2007 Work RVU: 17.08 **2020 Work RVU:** 18.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.91 **2020 Fac PE RVU:** 13.78

RUC Recommendation: 18.00

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

Result: Increase

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 83,430

2007 Work RVU: 21.09 **2020 Work RVU:** 18.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.19 **2020 Fac PE RVU:** 13.77

RUC Recommendation: 18.00

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia** **Global:** 000 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,180

2007 Work RVU: 7.21 **2020 Work RVU:** 3.82
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.54 **2020 Fac PE RVU:** 0.74

RUC Recommendation: 3.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27252 **Closed treatment of hip dislocation, traumatic; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 762

2007 Work RVU: 10.92 **2020 Work RVU:** 11.03
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.21 **2020 Fac PE RVU:** 8.62

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

27265 **Closed treatment of post hip arthroplasty dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,333

2007 Work RVU: 5.12 **2020 Work RVU:** 5.24
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.59 **2020 Fac PE RVU:** 5.38

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

Status Report: CMS Requests and Relativity Assessment Issues

27266 **Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,456

2007 Work RVU: 7.67 **2020 Work RVU:** 7.78
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.15 **2020 Fac PE RVU:**7.51

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

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

Global: 090 **Issue:** Arthodesis - Sacroiliac Joint **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 09 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** July 2017 **2019 est Medicare Utilization:** 3,753

2007 Work RVU: **2020 Work RVU:** 12.13
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**9.96

RUC Recommendation: 9.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)**

Global: 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 814

2007 Work RVU: 4.95 **2020 Work RVU:** 5.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.1 **2020 Fac PE RVU:**5.50

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27369 **Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography**

Global: 000 **Issue:** Knee Arthrography Injection **Screen:** Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 05 **Specialty Developing Recommendation:** ACR **First Identified:** June 2017 **2019 est Medicare Utilization:** 60,267

2007 Work RVU: **2020 Work RVU:** 0.77
2007 NF PE RVU: **2020 NF PE RVU:** 3.62
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 0.96 **Referred to CPT** February 2018 **Result:** Maintain

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

27370 **Injection of contrast for knee arthrography**

Global: **Issue:** Knee Arthrography Injection **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 05 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.96 **2020 Work RVU:**
2007 NF PE RVU: 3.47 **2020 NF PE RVU:**
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Bulletin #1 2010

Status Report: CMS Requests and Relativity Assessment Issues

27446 **Arthroplasty, knee, condyle and plateau; medial OR lateral compartment** **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than $10 million / Site of Service Anomaly - 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,803

2007 Work RVU: 16.26 **2020 Work RVU:** 17.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.81 **2020 Fac PE RVU:**12.57

RUC Recommendation: 17.48 **Referred to CPT** **Result:** Increase

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

27447 **Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)** **Global:** 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 312,130

2007 Work RVU: 23.04 **2020 Work RVU:** 20.72
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 14.14 **2020 Fac PE RVU:**14.35

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

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

27502 **Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 385

2007 Work RVU: 11.24 **2020 Work RVU:** 11.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.82 **2020 Fac PE RVU:**8.35

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27510 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 386

2007 Work RVU: 9.68 **2020 Work RVU:** 9.80
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.09 **2020 Fac PE RVU:** 7.93

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

27550 **Closed treatment of knee dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 531

2007 Work RVU: 5.84 **2020 Work RVU:** 5.98
2007 NF PE RVU: 5.84 **2020 NF PE RVU:** 7.89
2007 Fac PE RVU 4.85 **2020 Fac PE RVU:** 6.80

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

27552 **Closed treatment of knee dislocation; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 269

2007 Work RVU: 8.04 **2020 Work RVU:** 8.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.75 **2020 Fac PE RVU:** 8.35

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

Status Report: CMS Requests and Relativity Assessment Issues

27615 **Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm**

Global: 090 **Issue:** Radical Resecion of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 211

2007 Work RVU: 12.93 **2020 Work RVU:** 15.72
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.07 **2020 Fac PE RVU:**10.77

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

27619 **Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 552

2007 Work RVU: 8.47 **2020 Work RVU:** 6.91
2007 NF PE RVU: 9.65 **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.79 **2020 Fac PE RVU:**5.35

RUC Recommendation: 6.80 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27640 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,673

2007 Work RVU: 12.10 **2020 Work RVU:** 12.24
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.79 **2020 Fac PE RVU:**9.59

RUC Recommendation: 12.10 **Referred to CPT** June 2008 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27641 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 905

2007 Work RVU: 9.73 **2020 Work RVU:** 9.84
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.96 **2020 Fac PE RVU:**7.66

RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27650 **Repair, primary, open or percutaneous, ruptured Achilles tendon;** **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2007 Work RVU: 9.94 **2020 Work RVU:** 9.21
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.22 **2020 Fac PE RVU:**8.33

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27654 **Repair, secondary, Achilles tendon, with or without graft** **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,117

2007 Work RVU: 10.32 **2020 Work RVU:** 10.53
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.86 **2020 Fac PE RVU:**8.51

RUC Recommendation: 10.32 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,084

2007 Work RVU: 6.57 **2020 Work RVU:** 6.69
2007 NF PE RVU: 7.68 **2020 NF PE RVU:** 11.44
2007 Fac PE RVU 5.26 **2020 Fac PE RVU:**5.78

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

27687 **Gastrocnemius recession (eg, Strayer procedure)** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,093

2007 Work RVU: 6.30 **2020 Work RVU:** 6.41
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.12 **2020 Fac PE RVU:**5.76

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,376

2007 Work RVU: 8.96 **2020 Work RVU:** 9.17
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.15 **2020 Fac PE RVU:**7.95

RUC Recommendation: 8.96 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,579

2007 Work RVU: 10.28 **2020 Work RVU:** 10.49
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.51 **2020 Fac PE RVU:**9.27

RUC Recommendation: 10.28 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27752 **Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,229

2007 Work RVU: 6.15 **2020 Work RVU:** 6.27
2007 NF PE RVU: 6.48 **2020 NF PE RVU:** 7.91
2007 Fac PE RVU 5.54 **2020 Fac PE RVU:**6.68

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

Status Report: CMS Requests and Relativity Assessment Issues

27762 **Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 369

2007 Work RVU: 5.33 **2020 Work RVU:** 5.47
2007 NF PE RVU: 6.14 **2020 NF PE RVU:** 7.25
2007 Fac PE RVU 5.14 **2020 Fac PE RVU:**5.98

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

27792 **Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed**

Global: 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,279

2007 Work RVU: 7.91 **2020 Work RVU:** 8.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.71 **2020 Fac PE RVU:**8.32

RUC Recommendation: 9.71

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

Result: Maintain

27810 **Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,962

2007 Work RVU: 5.20 **2020 Work RVU:** 5.32
2007 NF PE RVU: 6.05 **2020 NF PE RVU:** 7.13
2007 Fac PE RVU 5.02 **2020 Fac PE RVU:**5.85

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

27814 **Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,858

2007 Work RVU: 11.10 **2020 Work RVU:** 10.62
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.25 **2020 Fac PE RVU:**9.53

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation**

Global: 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,490

2007 Work RVU: 5.57 **2020 Work RVU:** 5.69
2007 NF PE RVU: 6.14 **2020 NF PE RVU:** 7.21
2007 Fac PE RVU 5 **2020 Fac PE RVU:**5.76

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27825 **Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 659

2007 Work RVU: 6.60 **2020 Work RVU:** 6.69
2007 NF PE RVU: 6.42 **2020 NF PE RVU:** 7.76
2007 Fac PE RVU 5.25 **2020 Fac PE RVU:**6.29

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27840 **Closed treatment of ankle dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,234

2007 Work RVU: 4.65 **2020 Work RVU:** 4.77
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.73 **2020 Fac PE RVU:**5.16

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

28001 **Incision and drainage, bursa, foot** **Global:** 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 3,770

2007 Work RVU: 2.75 **2020 Work RVU:** 2.78
2007 NF PE RVU: 3.25 **2020 NF PE RVU:** 5.01
2007 Fac PE RVU 1.88 **2020 Fac PE RVU:**1.89

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28002 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space** **Global:** 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,661

2007 Work RVU: 5.78 **2020 Work RVU:** 5.34
2007 NF PE RVU: 5.44 **2020 NF PE RVU:** 6.86
2007 Fac PE RVU 3.74 **2020 Fac PE RVU:**3.31

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28003 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas** **Global:** 090 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 5,470

2007 Work RVU: 8.95 **2020 Work RVU:** 9.06
2007 NF PE RVU: 6.64 **2020 NF PE RVU:** 10.19
2007 Fac PE RVU 5.08 **2020 Fac PE RVU:**6.15

RUC Recommendation: 5.28 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28111 **Ostectomy, complete excision; first metatarsal head**

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,069

2007 Work RVU: 5.06 **2020 Work RVU:** 5.15
2007 NF PE RVU: 6.55 **2020 NF PE RVU:** 8.38
2007 Fac PE RVU 3.58 **2020 Fac PE RVU:**3.62

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,154

2007 Work RVU: 5.64 **2020 Work RVU:** 7.31
2007 NF PE RVU: 7.5 **2020 NF PE RVU:** 11.27
2007 Fac PE RVU 4.31 **2020 Fac PE RVU:**6.07

RUC Recommendation: 8.27

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

Result: Increase

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 14,469

2007 Work RVU: 7.56 **2020 Work RVU:** 6.76
2007 NF PE RVU: 7.27 **2020 NF PE RVU:** 9.71
2007 Fac PE RVU 5.17 **2020 Fac PE RVU:**5.16

RUC Recommendation: 7.72

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe**

Global: 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 11,425

2007 Work RVU: 4.88 **2020 Work RVU:** 5.00
2007 NF PE RVU: 5.46 **2020 NF PE RVU:** 8.36
2007 Fac PE RVU 3.62 **2020 Fac PE RVU:**4.11

RUC Recommendation: Remove 99238

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

Result: PE Only

28285 **Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)**

Global: 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 71,537

2007 Work RVU: 4.65 **2020 Work RVU:** 5.62
2007 NF PE RVU: 5.34 **2020 NF PE RVU:** 9.30
2007 Fac PE RVU 3.42 **2020 Fac PE RVU:**4.76

RUC Recommendation: 5.62

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

Result: Increase

28289 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,662

2007 Work RVU: 8.11 **2020 Work RVU:** 6.90
2007 NF PE RVU: 8.37 **2020 NF PE RVU:** 12.91
2007 Fac PE RVU 5.68 **2020 Fac PE RVU:**5.54

RUC Recommendation: 6.90

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

28290 **Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 5.72 **2020 Work RVU:**
2007 NF PE RVU: 6.75 **2020 NF PE RVU:**
2007 Fac PE RVU 4.55 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

28291 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,067

RUC Recommendation: 8.01

Referred to CPT October 2015

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

2007 Work RVU: **2020 Work RVU:** 8.01

2007 NF PE RVU: **2020 NF PE RVU:** 12.29

2007 Fac PE RVU **2020 Fac PE RVU:** 5.34

Result: Decrease

28292 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,950

RUC Recommendation: 7.44

Referred to CPT October 2015

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

2007 Work RVU: 8.72 **2020 Work RVU:** 7.44

2007 NF PE RVU: 8.21 **2020 NF PE RVU:** 12.73

2007 Fac PE RVU 5.72 **2020 Fac PE RVU:** 5.77

Result: Decrease

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

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

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

2007 Work RVU: 11.10 **2020 Work RVU:**

2007 NF PE RVU: 11.72 **2020 NF PE RVU:**

2007 Fac PE RVU 6.34 **2020 Fac PE RVU:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 8.63 **2020 Work RVU:**
2007 NF PE RVU: 7.88 **2020 NF PE RVU:**
2007 Fac PE RVU 4.7 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

28295 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 586

2007 Work RVU: **2020 Work RVU:** 8.57
2007 NF PE RVU: **2020 NF PE RVU:** 19.00
2007 Fac PE RVU **2020 Fac PE RVU:**6.63

RUC Recommendation: 8.57 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28296 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,559

2007 Work RVU: 9.31 **2020 Work RVU:** 8.25
2007 NF PE RVU: 8.54 **2020 NF PE RVU:** 17.17
2007 Fac PE RVU 5.29 **2020 Fac PE RVU:**5.80

RUC Recommendation: 8.25 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28297 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,793

2007 Work RVU: 9.31 **2020 Work RVU:** 9.29
2007 NF PE RVU: 9.34 **2020 NF PE RVU:** 19.90
2007 Fac PE RVU 6.04 **2020 Fac PE RVU:** 7.02

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28298 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,903

2007 Work RVU: 8.01 **2020 Work RVU:** 7.75
2007 NF PE RVU: 7.74 **2020 NF PE RVU:** 15.71
2007 Fac PE RVU 4.91 **2020 Fac PE RVU:** 5.74

RUC Recommendation: 7.75 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,743

2007 Work RVU: 11.39 **2020 Work RVU:** 9.29
2007 NF PE RVU: 9.24 **2020 NF PE RVU:** 18.85
2007 Fac PE RVU 6.01 **2020 Fac PE RVU:** 6.55

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28300 **Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation** **Global:** 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,519

2007 Work RVU: 9.61 **2020 Work RVU:** 9.73
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.81 **2020 Fac PE RVU:**7.55

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)** **Global:** 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,640

2007 Work RVU: 5.48 **2020 Work RVU:** 5.57
2007 NF PE RVU: 6.2 **2020 NF PE RVU:** 9.63
2007 Fac PE RVU 3.53 **2020 Fac PE RVU:**4.20

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

28470 **Closed treatment of metatarsal fracture; without manipulation, each** **Global:** 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2019 est Medicare Utilization:** 29,629

2007 Work RVU: 1.99 **2020 Work RVU:** 2.03
2007 NF PE RVU: 3.05 **2020 NF PE RVU:** 3.93
2007 Fac PE RVU 2.43 **2020 Fac PE RVU:**3.52

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

28660 **Closed treatment of interphalangeal joint dislocation; without anesthesia** **Global:** 010 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 689

2007 Work RVU: 1.25 **2020 Work RVU:** 1.28
2007 NF PE RVU: 1.27 **2020 NF PE RVU:** 1.91
2007 Fac PE RVU 0.79 **2020 Fac PE RVU:**1.11

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

Status Report: CMS Requests and Relativity Assessment Issues

28725 **Arthrodesis; subtalar**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,389

2007 Work RVU: 11.97 **2020 Work RVU:** 11.22
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.93 **2020 Fac PE RVU:**9.45

RUC Recommendation: 12.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,581

2007 Work RVU: 12.21 **2020 Work RVU:** 10.70
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.32 **2020 Fac PE RVU:**8.88

RUC Recommendation: 12.42 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

28740 **Arthrodesis, midtarsal or tarsometatarsal, single joint**

Global: 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,996

2007 Work RVU: 9.09 **2020 Work RVU:** 9.29
2007 NF PE RVU: 10.89 **2020 NF PE RVU:** 13.66
2007 Fac PE RVU 6.37 **2020 Fac PE RVU:**7.36

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

28820 **Amputation, toe; metatarsophalangeal joint**

Global: 090 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,702

2007 Work RVU: 4.89 **2020 Work RVU:** 5.82
2007 NF PE RVU: 7.6 **2020 NF PE RVU:** 9.55
2007 Fac PE RVU 3.74 **2020 Fac PE RVU:**4.75

RUC Recommendation: 4.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28825 **Amputation, toe; interphalangeal joint**

Global: 090 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,013

2007 Work RVU: 3.71 **2020 Work RVU:** 5.37
2007 NF PE RVU: 7.04 **2020 NF PE RVU:** 9.39
2007 Fac PE RVU 3.4 **2020 Fac PE RVU:**4.59
Result: Decrease

RUC Recommendation: 4.00

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

29075 **Application, cast; elbow to finger (short arm)**

Global: 000 **Issue:** Application of Forearm Cast **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 16 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** April 2011 **2019 est Medicare Utilization:** 68,396

2007 Work RVU: 0.77 **2020 Work RVU:** 0.77
2007 NF PE RVU: 1.25 **2020 NF PE RVU:** 1.53
2007 Fac PE RVU 0.68 **2020 Fac PE RVU:**0.86
Result: Maintain

RUC Recommendation: 0.77

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

29105 **Application of long arm splint (shoulder to hand)**

Global: 000 **Issue:** Application of Long Arm Splint **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 11 **Specialty Developing Recommendation:** AAOS, ACEP, ASSH **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,626

2007 Work RVU: 0.87 **2020 Work RVU:** 0.80
2007 NF PE RVU: 1.2 **2020 NF PE RVU:** 1.38
2007 Fac PE RVU 0.52 **2020 Fac PE RVU:**0.28
Result: Decrease

RUC Recommendation: 0.80

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

29200 **Strapping; thorax**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,693

2007 Work RVU: 0.65 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.52
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:**0.13
Result: Decrease

RUC Recommendation: 0.39

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

Status Report: CMS Requests and Relativity Assessment Issues

29220 **Deleted from CPT** **Global:** **Issue:** Strapping; low back **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.64 **2020 Work RVU:**
2007 NF PE RVU: 0.69 **2020 NF PE RVU:**
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT, no further action necessary

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29240 **Strapping; shoulder (eg, Velpeau)** **Global:** 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 16,307

2007 Work RVU: 0.71 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.81 **2020 NF PE RVU:** 0.47
2007 Fac PE RVU 0.37 **2020 Fac PE RVU:**0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29260 **Strapping; elbow or wrist** **Global:** 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 5,004

2007 Work RVU: 0.55 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.72 **2020 NF PE RVU:** 0.44
2007 Fac PE RVU 0.33 **2020 Fac PE RVU:**0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29280 **Strapping; hand or finger** **Global:** 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 3,404

2007 Work RVU: 0.51 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.77 **2020 NF PE RVU:** 0.44
2007 Fac PE RVU 0.33 **2020 Fac PE RVU:**0.16

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29445 **Application of rigid total contact leg cast** **Global:** 000 **Issue:** Application of Rigid Leg Cast **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 17 **Specialty Developing Recommendation:** AAOS, AHKNS, AOFAS, AOA, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 36,431

2007 Work RVU: 1.78 **2020 Work RVU:** 1.78
2007 NF PE RVU: 1.76 **2020 NF PE RVU:** 1.72
2007 Fac PE RVU 0.96 **2020 Fac PE RVU:**0.94

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

29520 **Strapping; hip** **Global:** 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,018

2007 Work RVU: 0.54 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.81 **2020 NF PE RVU:** 0.59
2007 Fac PE RVU 0.45 **2020 Fac PE RVU:**0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29530 **Strapping; knee** **Global:** 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 27,045

2007 Work RVU: 0.57 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.75 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:**0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29540 **Strapping; ankle and/or foot**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 213,060

2007 Work RVU: 0.51 **2020 Work RVU:** 0.39
2007 NF PE RVU: 0.45 **2020 NF PE RVU:** 0.39
2007 Fac PE RVU 0.31 **2020 Fac PE RVU:**0.09

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29550 **Strapping; toes**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 56,200

2007 Work RVU: 0.47 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.46 **2020 NF PE RVU:** 0.27
2007 Fac PE RVU 0.29 **2020 Fac PE RVU:**0.06

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29580 **Strapping; Unna boot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 265,752

2007 Work RVU: 0.55 **2020 Work RVU:** 0.55
2007 NF PE RVU: 0.67 **2020 NF PE RVU:** 1.17
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29581 **Application of multi-layer compression system; leg (below knee), including ankle and foot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 194,064

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** 1.92
2007 Fac PE RVU **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

29582 **Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

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

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

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

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

29584 **Application of multi-layer compression system; upper arm, forearm, hand, and fingers**

Global: 000 **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 27 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,715

2007 Work RVU: **2020 Work RVU:** 0.35
2007 NF PE RVU: **2020 NF PE RVU:** 2.01
2007 Fac PE RVU **2020 Fac PE RVU:** 0.11

RUC Recommendation: Develop CPT Assistant Article **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

Status Report: CMS Requests and Relativity Assessment Issues

29590 **Denis-Browne splint strapping**

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

Most Recent RUC Meeting: April 2012 **Tab** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.76 **2020 Work RVU:**
2007 NF PE RVU: 0.54 **2020 NF PE RVU:**
2007 Fac PE RVU 0.29 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 698

2007 Work RVU: 5.94 **2020 Work RVU:** 6.03
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.44 **2020 Fac PE RVU:**6.36

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

29822 **Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** October 2008 **2019 est Medicare Utilization:** 9,153

2007 Work RVU: 7.49 **2020 Work RVU:** 7.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.43 **2020 Fac PE RVU:**7.57

RUC Recommendation: 7.03 **Referred to CPT** September 2019 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29823 **Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization over 30,000-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 11 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 45,349

RUC Recommendation: 7.98

Referred to CPT September 2019

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

2007 Work RVU: 8.24 **2020 Work RVU:** 8.36

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 6.94 **2020 Fac PE RVU:** 8.13

Result: Decrease

29824 **Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)**

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

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAOS

First Identified: February 2010 **2019 est Medicare Utilization:** 39,895

RUC Recommendation: 8.82

Referred to CPT

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

2007 Work RVU: 8.82 **2020 Work RVU:** 8.98

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 7.3 **2020 Fac PE RVU:** 8.78

Result: Maintain

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAOS

First Identified: February 2010 **2019 est Medicare Utilization:** 78,655

RUC Recommendation: 3.00

Referred to CPT

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

2007 Work RVU: 9.05 **2020 Work RVU:** 3.00

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 7.21 **2020 Fac PE RVU:** 1.48

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing/ Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 69,465

2007 Work RVU: 15.44 **2020 Work RVU:** 15.59
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.01 **2020 Fac PE RVU:** 12.34

RUC Recommendation: 15.59. Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

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

Result: Maintain

29828 **Arthroscopy, shoulder, surgical; biceps tenodesis**

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

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 18,992

2007 Work RVU: **2020 Work RVU:** 13.16
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 10.84

RUC Recommendation: 13.16

Referred to CPT

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

Result: Maintain

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**

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

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 136

2007 Work RVU: 5.80 **2020 Work RVU:** 5.88
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.14 **2020 Fac PE RVU:** 6.12

RUC Recommendation: No NF PE inputs

Referred to CPT

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

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**

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

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 125

2007 Work RVU: 5.59 **2020 Work RVU:** 5.68
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.16 **2020 Fac PE RVU:**6.29
Result: PE Only

RUC Recommendation: No NF PE inputs

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

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**

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

Most Recent RUC Meeting: October 2009 **Tab** 13 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 1,031

2007 Work RVU: 5.11 **2020 Work RVU:** 5.19
2007 NF PE RVU: NA **2020 NF PE RVU:** 10.26
2007 Fac PE RVU 4.72 **2020 Fac PE RVU:**5.65
Result: PE Only

RUC Recommendation: New PE non-facility inputs

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

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**

Global: 090 **Issue:** ACL Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,173

2007 Work RVU: 14.14 **2020 Work RVU:** 14.30
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.75 **2020 Fac PE RVU:**11.30
Result: Maintain

RUC Recommendation: 14.14

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

29900 **Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy**

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

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 4

2007 Work RVU: 5.74 **2020 Work RVU:** 5.88
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.6 **2020 Fac PE RVU:**7.31
Result: PE Only

RUC Recommendation: No NF PE inputs

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

Status Report: CMS Requests and Relativity Assessment Issues

30140 **Submucous resection inferior turbinate, partial or complete, any method** **Global:** 000 **Issue:** Resection of Inferior Turbinate **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 14 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 49,954

2007 Work RVU: 3.48 **2020 Work RVU:** 3.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 4.66
2007 Fac PE RVU 6.29 **2020 Fac PE RVU:** 1.69

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

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30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)** **Global:** 090 **Issue:** Repair Nasal Stenosis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,626

2007 Work RVU: 12.20 **2020 Work RVU:** 12.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.58 **2020 Fac PE RVU:** 14.48

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method** **Global:** 000 **Issue:** Control Nasal Hemorrhage **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 88,372

2007 Work RVU: 1.21 **2020 Work RVU:** 1.10
2007 NF PE RVU: 1.32 **2020 NF PE RVU:** 2.81
2007 Fac PE RVU 0.31 **2020 Fac PE RVU:** 0.36

RUC Recommendation: 1.10 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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Status Report: CMS Requests and Relativity Assessment Issues

30903 **Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 48,496

2007 Work RVU: 1.54 **2020 Work RVU:** 1.54
2007 NF PE RVU: 2.8 **2020 NF PE RVU:** 4.68
2007 Fac PE RVU 0.47 **2020 Fac PE RVU:**0.47

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

30905 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 5,245

2007 Work RVU: 1.97 **2020 Work RVU:** 1.97
2007 NF PE RVU: 3.57 **2020 NF PE RVU:** 7.33
2007 Fac PE RVU 0.69 **2020 Fac PE RVU:**0.76

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

30906 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 800

2007 Work RVU: 2.45 **2020 Work RVU:** 2.45
2007 NF PE RVU: 3.91 **2020 NF PE RVU:** 7.22
2007 Fac PE RVU 1.07 **2020 Fac PE RVU:**1.10

RUC Recommendation: 2.45 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2010 **2019 est Medicare Utilization:** 660,545

2007 Work RVU: 1.10 **2020 Work RVU:** 1.10
2007 NF PE RVU: 3.37 **2020 NF PE RVU:** 4.25
2007 Fac PE RVU 0.84 **2020 Fac PE RVU:**0.59

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31237 **Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2011 **2019 est Medicare Utilization:** 137,754

2007 Work RVU: 2.98 **2020 Work RVU:** 2.60
2007 NF PE RVU: 5.03 **2020 NF PE RVU:** 4.26
2007 Fac PE RVU 1.72 **2020 Fac PE RVU:**1.59

RUC Recommendation: 2.60

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

Result: Decrease

31238 **Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012 **2019 est Medicare Utilization:** 29,505

2007 Work RVU: 3.26 **2020 Work RVU:** 2.74
2007 NF PE RVU: 5.04 **2020 NF PE RVU:** 3.99
2007 Fac PE RVU 1.9 **2020 Fac PE RVU:**1.65

RUC Recommendation: 2.74

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

Result: Decrease

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

Global: 010 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012 **2019 est Medicare Utilization:** 1,366

2007 Work RVU: 9.23 **2020 Work RVU:** 9.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.59 **2020 Fac PE RVU:**7.46

RUC Recommendation: 9.04

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

Result: Decrease

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012 **2019 est Medicare Utilization:** 6,458

2007 Work RVU: 2.61 **2020 Work RVU:** 2.61
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.59 **2020 Fac PE RVU:**1.56

RUC Recommendation: 2.61

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 470

2007 Work RVU: **2020 Work RVU:** 8.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.68

RUC Recommendation: 8.51 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31253 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,502

2007 Work RVU: **2020 Work RVU:** 9.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.16

RUC Recommendation: 9.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31254 **Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 13,255

2007 Work RVU: 4.64 **2020 Work RVU:** 4.27
2007 NF PE RVU: NA **2020 NF PE RVU:** 7.14
2007 Fac PE RVU 2.57 **2020 Fac PE RVU:** 2.13

RUC Recommendation: 4.27 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31255 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 11,287

2007 Work RVU: 6.95 **2020 Work RVU:** 5.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.69 **2020 Fac PE RVU:** 2.77

RUC Recommendation: 5.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31256 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 15,592

2007 Work RVU: 3.29 **2020 Work RVU:** 3.11
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.92 **2020 Fac PE RVU:** 1.63

RUC Recommendation: 3.11 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31257 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 5,920

2007 Work RVU: **2020 Work RVU:** 8.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.73

RUC Recommendation: 8.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31259 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 7,903

2007 Work RVU: **2020 Work RVU:** 8.48
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.93
Result: Decrease

RUC Recommendation: 8.48
Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

31267 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 28,703

2007 Work RVU: 5.45 **2020 Work RVU:** 4.68
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.96 **2020 Fac PE RVU:** 2.30
Result: Decrease

RUC Recommendation: 4.68
Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

31276 **Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 15,859

2007 Work RVU: 8.84 **2020 Work RVU:** 6.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.58 **2020 Fac PE RVU:** 3.20
Result: Decrease

RUC Recommendation: 6.75
Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31287 **Nasal/sinus endoscopy, surgical, with sphenoidotomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,280

2007 Work RVU: 3.91 **2020 Work RVU:** 3.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.22 **2020 Fac PE RVU:** 1.80

RUC Recommendation: 3.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31288 **Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,121

2007 Work RVU: 4.57 **2020 Work RVU:** 4.10
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.54 **2020 Fac PE RVU:** 2.05

RUC Recommendation: 4.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31295 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 28,533

2007 Work RVU: **2020 Work RVU:** 2.70
2007 NF PE RVU: **2020 NF PE RVU:** 50.47
2007 Fac PE RVU **2020 Fac PE RVU:** 1.45

RUC Recommendation: 2.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31296 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,725

2007 Work RVU: **2020 Work RVU:** 3.10
2007 NF PE RVU: **2020 NF PE RVU:** 50.74
2007 Fac PE RVU **2020 Fac PE RVU:** 1.62

RUC Recommendation: 3.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31297 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 2,120

2007 Work RVU: **2020 Work RVU:** 2.44
2007 NF PE RVU: **2020 NF PE RVU:** 50.34
2007 Fac PE RVU **2020 Fac PE RVU:** 1.34

RUC Recommendation: 2.44 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31298 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 19,499

2007 Work RVU: **2020 Work RVU:** 4.50
2007 NF PE RVU: **2020 NF PE RVU:** 96.99
2007 Fac PE RVU **2020 Fac PE RVU:** 2.22

RUC Recommendation: 4.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31500 **Intubation, endotracheal, emergency procedure**

Global: 000 **Issue:** Endotracheal Intubation **Screen:** CMS High Expenditure Procedural Codes2 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 27 **Specialty Developing Recommendation:** ACEP, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 263,123

2007 Work RVU: 2.33 **2020 Work RVU:** 3.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.52 **2020 Fac PE RVU:** 0.71

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2016

31551 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2

2007 Work RVU: **2020 Work RVU:** 21.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 19.15

RUC Recommendation: 21.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 12

2007 Work RVU: **2020 Work RVU:** 20.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 18.74

RUC Recommendation: 20.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 22.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 22.85

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2007 Work RVU: **2020 Work RVU:** 22.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 22.86

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope**

Global: 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,271

2007 Work RVU: 4.26 **2020 Work RVU:** 4.26
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.36 **2020 Fac PE RVU:** 2.26

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31575 **Laryngoscopy, flexible; diagnostic**

Global: 000 **Issue:**

Screen: MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2010

2019 est Medicare Utilization: 658,434

2007 Work RVU: 1.10 **2020 Work RVU:** 0.94

2007 NF PE RVU: 1.82 **2020 NF PE RVU:** 2.43

2007 Fac PE RVU 0.84 **2020 Fac PE RVU:** 0.84

RUC Recommendation: 1.00

Referred to CPT

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

Result: Decrease

31579 **Laryngoscopy, flexible or rigid telescopic, with stroboscopy**

Global: 000 **Issue:** Laryngoscopy

Screen: CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2008

2019 est Medicare Utilization: 86,928

2007 Work RVU: 2.26 **2020 Work RVU:** 1.88

2007 NF PE RVU: 3.5 **2020 NF PE RVU:** 3.32

2007 Fac PE RVU 1.37 **2020 Fac PE RVU:** 1.27

RUC Recommendation: 1.94

Referred to CPT

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

Result: Decrease

31580 **Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion**

Global: 090 **Issue:** Laryngoplasty

Screen: 090-Day Global Post-Operative Visits **Complete?** Yes

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

First Identified: April 2014

2019 est Medicare Utilization: 21

2007 Work RVU: 14.46 **2020 Work RVU:** 14.60

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 15.31 **2020 Fac PE RVU:** 19.69

RUC Recommendation: 14.60

Referred to CPT October 2015

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

31582 **Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 22.87 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 24.48 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

31584 **Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2007 Work RVU: 20.35 **2020 Work RVU:** 17.58
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.19 **2020 Fac PE RVU:**20.18

RUC Recommendation: 20.00

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

31587 **Laryngoplasty, cricoid split, without graft placement**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2007 Work RVU: 15.12 **2020 Work RVU:** 15.27
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.96 **2020 Fac PE RVU:**16.50

RUC Recommendation: 15.27

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

31588 **Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 14.62 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 13.07 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

31591 **Laryngoplasty, medialization, unilateral**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,148

2007 Work RVU: **2020 Work RVU:** 13.56
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 15.34

RUC Recommendation: 15.60 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31592 **Cricotracheal resection**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2007 Work RVU: **2020 Work RVU:** 25.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 20.67

RUC Recommendation: 25.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31600 **Tracheostomy, planned (separate procedure);**

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

Most Recent RUC Meeting: April 2016 **Tab** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 23,498

2007 Work RVU: 7.17 **2020 Work RVU:** 5.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.95 **2020 Fac PE RVU:** 2.32

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

31601 **Tracheostomy, planned (separate procedure); younger than 2 years**

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

Most Recent RUC Meeting: April 2016 **Tab** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 4

2007 Work RVU: 4.44 **2020 Work RVU:** 8.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.21 **2020 Fac PE RVU:** 3.83

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31603 **Tracheostomy, emergency procedure; transtracheal**

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

Most Recent RUC Meeting: April 2016 **Tab** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 801

2007 Work RVU: 4.14 **2020 Work RVU:** 6.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**2.29
Result: Increase

RUC Recommendation: 6.00

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

31605 **Tracheostomy, emergency procedure; cricothyroid membrane**

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

Most Recent RUC Meeting: April 2016 **Tab** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 278

2007 Work RVU: 3.57 **2020 Work RVU:** 6.45
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:**2.01
Result: Increase

RUC Recommendation: 6.45

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

31610 **Tracheostomy, fenestration procedure with skin flaps**

Global: 090 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 15 **Specialty Developing Recommendation:** AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,593

2007 Work RVU: 9.29 **2020 Work RVU:** 12.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.99 **2020 Fac PE RVU:**13.52
Result: Increase

RUC Recommendation: 12.00

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

31611 **Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)**

Global: 090 **Issue:** Speech Prosthesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2007 Work RVU: 5.92 **2020 Work RVU:** 6.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.92 **2020 Fac PE RVU:**8.28
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

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

Status Report: CMS Requests and Relativity Assessment Issues

31620 **Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])**

Global: **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 1.40 **2020 Work RVU:**
2007 NF PE RVU: 5.73 **2020 NF PE RVU:**
2007 Fac PE RVU 0.5 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

31622 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 52,315

2007 Work RVU: 2.78 **2020 Work RVU:** 2.53
2007 NF PE RVU: 5.55 **2020 NF PE RVU:** 4.09
2007 Fac PE RVU 1.02 **2020 Fac PE RVU:**0.99

RUC Recommendation: 2.78 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31623 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2016 **2019 est Medicare Utilization:** 26,278

2007 Work RVU: 2.88 **2020 Work RVU:** 2.63
2007 NF PE RVU: 6.32 **2020 NF PE RVU:** 4.81
2007 Fac PE RVU 1.02 **2020 Fac PE RVU:**0.97

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31624 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 118,565

2007 Work RVU: 2.88 **2020 Work RVU:** 2.63
2007 NF PE RVU: 5.67 **2020 NF PE RVU:** 4.30
2007 Fac PE RVU 1.02 **2020 Fac PE RVU:**1.01

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31625 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2013 **2019 est Medicare Utilization:** 19,149

2007 Work RVU: 3.36 **2020 Work RVU:** 3.11
2007 NF PE RVU: 5.73 **2020 NF PE RVU:** 6.42
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**1.12

RUC Recommendation: 3.36 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31626 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,173

2007 Work RVU: **2020 Work RVU:** 3.91
2007 NF PE RVU: **2020 NF PE RVU:** 19.49
2007 Fac PE RVU **2020 Fac PE RVU:**1.37

RUC Recommendation: 4.16 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31628 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 32,291

2007 Work RVU: 3.80 **2020 Work RVU:** 3.55
2007 NF PE RVU: 7.02 **2020 NF PE RVU:** 6.58
2007 Fac PE RVU 1.26 **2020 Fac PE RVU:**1.24

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31629 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,745

2007 Work RVU: 4.09 **2020 Work RVU:** 3.75
2007 NF PE RVU: 13.7 **2020 NF PE RVU:** 8.80
2007 Fac PE RVU 1.35 **2020 Fac PE RVU:**1.31

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31632 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,890

2007 Work RVU: 1.03 **2020 Work RVU:** 1.03
2007 NF PE RVU: 0.83 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:**0.31

RUC Recommendation: 1.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31633 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,196

2007 Work RVU: 1.32 **2020 Work RVU:** 1.32
2007 NF PE RVU: 0.94 **2020 NF PE RVU:** 0.85
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**0.41

RUC Recommendation: 1.32 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31645 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 35,233

2007 Work RVU: 3.16 **2020 Work RVU:** 2.88
2007 NF PE RVU: 5.05 **2020 NF PE RVU:** 4.38
2007 Fac PE RVU 1.09 **2020 Fac PE RVU:**1.09

RUC Recommendation: 2.88 **Referred to CPT** May 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31646 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,580

2007 Work RVU: 2.72 **2020 Work RVU:** 2.78
2007 NF PE RVU: 4.76 **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.97 **2020 Fac PE RVU:** 1.06

RUC Recommendation: 2.78 **Referred to CPT** May 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

31652 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 25,507

2007 Work RVU: **2020 Work RVU:** 4.46
2007 NF PE RVU: **2020 NF PE RVU:** 26.41
2007 Fac PE RVU **2020 Fac PE RVU:** 1.53

RUC Recommendation: 5.00 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31653 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 13,988

2007 Work RVU: **2020 Work RVU:** 4.96
2007 NF PE RVU: **2020 NF PE RVU:** 27.21
2007 Fac PE RVU **2020 Fac PE RVU:** 1.68

RUC Recommendation: 5.50 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31654 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])**

Global: ZZZ **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, ACCP

First Identified: October 2014 **2019 est Medicare Utilization:** 8,214

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 1.97
2007 Fac PE RVU **2020 Fac PE RVU:** 0.43

RUC Recommendation: 1.70

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

32201 **Pneumonostomy; with percutaneous drainage of abscess or cyst**

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

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.99 **2020 Work RVU:**
2007 NF PE RVU: 20.21 **2020 NF PE RVU:**
2007 Fac PE RVU 1.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

32405 **Biopsy, lung or mediastinum, percutaneous needle**

Global: 000 **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 05 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2017 **2019 est Medicare Utilization:** 70,068

2007 Work RVU: 1.93 **2020 Work RVU:** 1.68
2007 NF PE RVU: 0.64 **2020 NF PE RVU:** 9.51
2007 Fac PE RVU 0.61 **2020 Fac PE RVU:** 0.78

RUC Recommendation: Deleted from CPT

Referred to CPT February 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

32408 **Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed**

Global: **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

32420 **Pneumocentesis, puncture of lung for aspiration**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.18 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.66 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

32421 **Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32422 **Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

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

32440 **Removal of lung, pneumonectomy;**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 247

2007 Work RVU: 27.17 **2020 Work RVU:** 27.28
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.44 **2020 Fac PE RVU:** 11.78

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from screen

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

32480 **Removal of lung, other than pneumonectomy; single lobe (lobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 4,630

2007 Work RVU: 25.71 **2020 Work RVU:** 25.82
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.63 **2020 Fac PE RVU:** 11.05

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

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

Status Report: CMS Requests and Relativity Assessment Issues

32482 **Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 294

2007 Work RVU: 27.28 **2020 Work RVU:** 27.44
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.48 **2020 Fac PE RVU:** 12.11

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

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

32491 **Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 15

2007 Work RVU: 25.09 **2020 Work RVU:** 25.24
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.13 **2020 Fac PE RVU:** 11.50

RUC Recommendation: Request further information from CMS

Referred to CPT

Result: Remove from Screen

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

32551 **Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)**

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

Most Recent RUC Meeting: April 2012 **Tab** 10 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,044

2007 Work RVU: **2020 Work RVU:** 3.04
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.99

RUC Recommendation: 3.50

Referred to CPT February 2012

Result: Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

32554 **Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance** **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,649

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 4.32
2007 Fac PE RVU **2020 Fac PE RVU:** 0.58

RUC Recommendation: 1.82 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 **Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance** **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 229,865

2007 Work RVU: **2020 Work RVU:** 2.27
2007 NF PE RVU: **2020 NF PE RVU:** 6.39
2007 Fac PE RVU **2020 Fac PE RVU:** 0.76

RUC Recommendation: 2.27 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32556 **Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance** **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,833

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 16.27
2007 Fac PE RVU **2020 Fac PE RVU:** 0.78

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32557 **Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance** **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 38,244

2007 Work RVU: **2020 Work RVU:** 3.12
2007 NF PE RVU: **2020 NF PE RVU:** 14.16
2007 Fac PE RVU **2020 Fac PE RVU:** 1.01

RUC Recommendation: 3.62 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32663 **Thoracoscopy, surgical; with lobectomy (single lobe)**

Global: 090 **Issue:** RAW review **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** STS

First Identified: October 2008 **2019 est Medicare Utilization:** 9,229

2007 Work RVU: 24.56 **2020 Work RVU:** 24.64
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.44 **2020 Fac PE RVU:** 10.21

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

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

33010 **Pericardiocentesis; initial**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 6,698

2007 Work RVU: 2.24 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.85 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Result: Deleted from CPT

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

33011 **Pericardiocentesis; subsequent**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 87

2007 Work RVU: 2.24 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.89 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Result: Deleted from CPT

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

33015 **Tube pericardiostomy**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2017 **2019 est Medicare Utilization:** 1,147

2007 Work RVU: 8.44 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.98 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Result: Deleted from CPT

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

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.40
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.53

RUC Recommendation: 5.00

Referred to CPT September 2018
Result: Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33017 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.62
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.58

RUC Recommendation: 5.50

Referred to CPT September 2018
Result: Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33018 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 5.40
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.77

RUC Recommendation: 6.00

Referred to CPT September 2018
Result: Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33019 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.29
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.47

RUC Recommendation: 5.00

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

33020 **Pericardiotomy for removal of clot or foreign body (primary procedure)**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 10 **Specialty Developing Recommendation:** AATS, STS

First Identified: April 2018 **2019 est Medicare Utilization:** 122

2007 Work RVU: 14.87 **2020 Work RVU:** 14.31
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.71 **2020 Fac PE RVU:** 6.32

RUC Recommendation: 14.31

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

33025 **Creation of pericardial window or partial resection for drainage**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 10 **Specialty Developing Recommendation:** AATS, STS

First Identified: April 2017 **2019 est Medicare Utilization:** 4,535

2007 Work RVU: 13.65 **2020 Work RVU:** 13.20
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.25 **2020 Fac PE RVU:** 6.06

RUC Recommendation: 13.20

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 11,733

2007 Work RVU: 9.05 **2020 Work RVU:** 7.80
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.95 **2020 Fac PE RVU:** 4.40

RUC Recommendation: 8.05

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 103,628

RUC Recommendation: 8.77

Referred to CPT February 2011

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

2007 Work RVU: 8.12 **2020 Work RVU:** 8.52

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 4.95 **2020 Fac PE RVU:** 4.72

Result: Maintain

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 317

RUC Recommendation: 5.26

Referred to CPT February 2011

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

2007 Work RVU: 5.51 **2020 Work RVU:** 5.01

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 3.46 **2020 Fac PE RVU:** 3.20

Result: Decrease

33213 **Insertion of pacemaker pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC

First Identified: October 2008 **2019 est Medicare Utilization:** 1,113

RUC Recommendation: 5.53

Referred to CPT February 2011

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

2007 Work RVU: 6.36 **2020 Work RVU:** 5.28

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 3.87 **2020 Fac PE RVU:** 3.28

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

33221 **Insertion of pacemaker pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 268

2007 Work RVU: **2020 Work RVU:** 5.55
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.70

RUC Recommendation: 5.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33227 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,452

2007 Work RVU: **2020 Work RVU:** 5.25
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.40

RUC Recommendation: 5.50 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33228 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,395

2007 Work RVU: **2020 Work RVU:** 5.52
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.52

RUC Recommendation: 5.77 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33229 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,526

2007 Work RVU: **2020 Work RVU:** 5.79
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.80

RUC Recommendation: 6.04 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33230 **Insertion of implantable defibrillator pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 140

2007 Work RVU: **2020 Work RVU:** 6.07
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.70

RUC Recommendation: 6.32 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33231 **Insertion of implantable defibrillator pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 121

2007 Work RVU: **2020 Work RVU:** 6.34
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.91

RUC Recommendation: 6.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33233 **Removal of permanent pacemaker pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,743

2007 Work RVU: 3.33 **2020 Work RVU:** 3.14
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.29 **2020 Fac PE RVU:** 2.86

RUC Recommendation: 3.39 **Referred to CPT** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33240 **Insertion of implantable defibrillator pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 217

2007 Work RVU: 7.61 **2020 Work RVU:** 5.80
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.79 **2020 Fac PE RVU:** 3.50

RUC Recommendation: 6.06 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33241 **Removal of implantable defibrillator pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,043

2007 Work RVU: 3.26 **2020 Work RVU:** 3.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.99 **2020 Fac PE RVU:** 2.51

RUC Recommendation: 3.29 **Referred to CPT** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33249 **Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 42,661

2007 Work RVU: 15.02 **2020 Work RVU:** 14.92
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.89 **2020 Fac PE RVU:** 8.41

RUC Recommendation: 15.17 **Referred to CPT** February 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33262 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,000

2007 Work RVU: **2020 Work RVU:** 5.81
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.74

RUC Recommendation: 6.06 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33263 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 7,980

2007 Work RVU: **2020 Work RVU:** 6.08
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.85

RUC Recommendation: 6.33 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33264 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011 **2019 est Medicare Utilization:** 11,831

2007 Work RVU: **2020 Work RVU:** 6.35
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.00

RUC Recommendation: 6.60

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

33282 **Implantation of patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 4.70 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.1 **2020 Fac PE RVU:**

RUC Recommendation: 3.50

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.04 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.5 **2020 Fac PE RVU:**

RUC Recommendation: 3.00

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 17,344

2007 Work RVU: 41.19 **2020 Work RVU:** 41.32
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.58 **2020 Fac PE RVU:** 15.08

RUC Recommendation: 41.32

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

Result: Maintain

33430 **Replacement, mitral valve, with cardiopulmonary bypass**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS

First Identified: February 2008 **2019 est Medicare Utilization:** 7,658

2007 Work RVU: 50.75 **2020 Work RVU:** 50.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.71 **2020 Fac PE RVU:** 18.64

RUC Recommendation: 50.93

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

Result: Maintain

33533 **Coronary artery bypass, using arterial graft(s); single arterial graft**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 60,180

2007 Work RVU: 33.64 **2020 Work RVU:** 33.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.55 **2020 Fac PE RVU:** 12.78

RUC Recommendation: 34.98

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

33620 **Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:** 56

2007 Work RVU: **2020 Work RVU:** 30.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 10.93

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

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33621 **Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 16.18
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 7.03

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

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33622 **Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:** 1

2007 Work RVU: **2020 Work RVU:** 64.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 20.86

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

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

Status Report: CMS Requests and Relativity Assessment Issues

33741 **Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: September 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 14.00

Referred to CPT September 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

33745 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: September 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 20.00

Referred to CPT September 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

33746 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: September 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 10.50

Referred to CPT September 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,812

2007 Work RVU: 58.71 **2020 Work RVU:** 58.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 19.01 **2020 Fac PE RVU:** 19.20

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

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

Global: 090 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 667

2007 Work RVU: 89.08 **2020 Work RVU:** 89.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 23.74 **2020 Fac PE RVU:** 30.77

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33946 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2014 **2019 est Medicare Utilization:** 603

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.76

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33947 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,395

2007 Work RVU: **2020 Work RVU:** 6.63
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.94

RUC Recommendation: 6.63 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33948 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 4,436

2007 Work RVU: **2020 Work RVU:** 4.73
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.46

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33949 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 5,342

2007 Work RVU: **2020 Work RVU:** 4.60
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.37

RUC Recommendation: 4.60 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33951 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1

2007 Work RVU: **2020 Work RVU:** 8.15
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.32

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33952 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,439

RUC Recommendation: 8.43 **Referred to CPT** February 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 8.15
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.50
Result: Maintain

33953 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:**

RUC Recommendation: 9.83 **Referred to CPT** February 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 9.11
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.58
Result: Maintain

33954 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 354

RUC Recommendation: 9.43 **Referred to CPT** February 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 9.11
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.68
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

33956 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 352

2007 Work RVU: **2020 Work RVU:** 16.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.60

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33957 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 3.51
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.06

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33958 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 72

2007 Work RVU: **2020 Work RVU:** 3.51
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.06

RUC Recommendation: 4.05 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33959 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.47
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.31

RUC Recommendation: 4.69 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33960 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 19.33 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.09 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

33961 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 10.91 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.45 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33962 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 20

RUC Recommendation: 4.73

Referred to CPT February 2014

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

2007 Work RVU: **2020 Work RVU:** 4.47

2007 NF PE RVU: **2020 NF PE RVU:** NA

2007 Fac PE RVU **2020 Fac PE RVU:** 1.31

Result: Maintain

33963 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

RUC Recommendation: 9.00

Referred to CPT February 2014

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

2007 Work RVU: **2020 Work RVU:** 9.00

2007 NF PE RVU: **2020 NF PE RVU:** NA

2007 Fac PE RVU **2020 Fac PE RVU:** 2.55

Result: Maintain

33964 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 22

RUC Recommendation: 9.50

Referred to CPT February 2014

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

2007 Work RVU: **2020 Work RVU:** 9.50

2007 NF PE RVU: **2020 NF PE RVU:** NA

2007 Fac PE RVU **2020 Fac PE RVU:** 2.69

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

33965 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 3.51
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.06

RUC Recommendation: 3.51 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33966 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 383

2007 Work RVU: **2020 Work RVU:** 4.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.41

RUC Recommendation: 4.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33969 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 5.22
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.52

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33984 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 543

2007 Work RVU: **2020 Work RVU:** 5.46
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.54

RUC Recommendation: 6.38 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33985 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 1

2007 Work RVU: **2020 Work RVU:** 9.89
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.80

RUC Recommendation: 9.89 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33986 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 221

2007 Work RVU: **2020 Work RVU:** 10.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.92

RUC Recommendation: 10.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33987 **Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 41

2007 Work RVU: **2020 Work RVU:** 4.04
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.10

RUC Recommendation: 4.08 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33988 **Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 40

2007 Work RVU: **2020 Work RVU:** 15.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.19

RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33989 **Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 14

2007 Work RVU: **2020 Work RVU:** 9.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.69

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34701 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 824

2007 Work RVU: **2020 Work RVU:** 23.71
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 7.00

RUC Recommendation: 23.71 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34702 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 99

2007 Work RVU: **2020 Work RVU:** 36.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 9.64

RUC Recommendation: 36.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34703 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,118

2007 Work RVU: **2020 Work RVU:** 26.52
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 7.26
Result: Decrease

RUC Recommendation: 26.52

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

34704 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 141

2007 Work RVU: **2020 Work RVU:** 45.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 11.02
Result: Decrease

RUC Recommendation: 45.00

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

Status Report: CMS Requests and Relativity Assessment Issues

34705 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 13,089

2007 Work RVU: **2020 Work RVU:** 29.58
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 8.17
Result: Decrease

RUC Recommendation: 29.58

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

34706 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 641

2007 Work RVU: **2020 Work RVU:** 45.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 11.78
Result: Decrease

RUC Recommendation: 45.00

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

Status Report: CMS Requests and Relativity Assessment Issues

34707 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 652

2007 Work RVU: **2020 Work RVU:** 22.28
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 6.41
Result: Decrease

RUC Recommendation: 22.28

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

34708 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 85

2007 Work RVU: **2020 Work RVU:** 36.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 9.21
Result: Decrease

RUC Recommendation: 36.50

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

Status Report: CMS Requests and Relativity Assessment Issues

34709 **Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 3,632

2007 Work RVU: **2020 Work RVU:** 6.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.42
Result: Decrease

RUC Recommendation: 6.50

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

34710 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,186

2007 Work RVU: **2020 Work RVU:** 15.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.91
Result: Decrease

RUC Recommendation: 15.00

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

Status Report: CMS Requests and Relativity Assessment Issues

34711 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 367

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.30
Result: Decrease

RUC Recommendation: 6.00

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

34712 **Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,214

2007 Work RVU: **2020 Work RVU:** 12.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.49
Result: Decrease

RUC Recommendation: 12.00

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

34713 **Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 16,159

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.57
Result: Decrease

RUC Recommendation: 2.50

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

Status Report: CMS Requests and Relativity Assessment Issues

34714 **Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 487

2007 Work RVU: **2020 Work RVU:** 5.25
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.41
Result: Decrease

RUC Recommendation: 5.25
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

34715 **Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 206

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.31
Result: Decrease

RUC Recommendation: 6.00
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

34716 **Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 798

2007 Work RVU: **2020 Work RVU:** 7.19
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.98
Result: Decrease

RUC Recommendation: 7.19
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34800 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 21.46 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 8.72 **2020 Fac PE RVU:**

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

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

34802 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 23.71 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 9.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

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

34803 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 24.74 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 9.68 **2020 Fac PE RVU:**

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

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

Status Report: CMS Requests and Relativity Assessment Issues

34804 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 23.71 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 9.37 **2020 Fac PE RVU:**

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

34805 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 22.59 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 9.04 **2020 Fac PE RVU:**

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

34806 **Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

34812 **Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 9,013

2007 Work RVU: 6.74 **2020 Work RVU:** 4.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.1 **2020 Fac PE RVU:**0.92

RUC Recommendation: 4.13 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34820 **Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 82

2007 Work RVU: 9.74 **2020 Work RVU:** 7.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.04 **2020 Fac PE RVU:**1.53

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34825 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 12.72 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.89 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

34826 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 4.12 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.31 **2020 Fac PE RVU:**

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

34833 **Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 46

2007 Work RVU: 11.98 **2020 Work RVU:** 8.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.15 **2020 Fac PE RVU:**1.66

RUC Recommendation: 8.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34834 **Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 366

2007 Work RVU: 5.34 **2020 Work RVU:** 2.65
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.04 **2020 Fac PE RVU:**0.50

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 16.77 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 7.24 **2020 Fac PE RVU:**

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

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

Global: 090 **Issue:** Thromboendarterectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 21 **Specialty Developing Recommendation:** SVS **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,904

2007 Work RVU: 19.53 **2020 Work RVU:** 21.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.04 **2020 Fac PE RVU:**6.67

RUC Recommendation: 21.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 10.05 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.47 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

35452 **Transluminal balloon angioplasty, open; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 6.90 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.48 **2020 Fac PE RVU:**

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

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

35454 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 6.03 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.19 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

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

35456 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 7.34 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.64 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

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

Status Report: CMS Requests and Relativity Assessment Issues

35458 **Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 9.48 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.33 **2020 Fac PE RVU:**

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

35459 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 8.62 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.01 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35460 **Transluminal balloon angioplasty, open; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 6.03 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.15 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

35470 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 8.62 **2020 Work RVU:**
2007 NF PE RVU: 81.78 **2020 NF PE RVU:**
2007 Fac PE RVU 3.37 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 10.05 **2020 Work RVU:**
2007 NF PE RVU: 91.6 **2020 NF PE RVU:**
2007 Fac PE RVU 4.13 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 6.90 **2020 Work RVU:**
2007 NF PE RVU: 60.05 **2020 NF PE RVU:**
2007 Fac PE RVU 2.75 **2020 Fac PE RVU:**

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

Status Report: CMS Requests and Relativity Assessment Issues

35473 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 6.03 **2020 Work RVU:**
2007 NF PE RVU: 56.4 **2020 NF PE RVU:**
2007 Fac PE RVU 2.43 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 7.35 **2020 Work RVU:**
2007 NF PE RVU: 80.7 **2020 NF PE RVU:**
2007 Fac PE RVU 2.9 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 9.48 **2020 Work RVU:**
2007 NF PE RVU: 53.95 **2020 NF PE RVU:**
2007 Fac PE RVU 3.48 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 **Transluminal balloon angioplasty, percutaneous; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 6.03 **2020 Work RVU:**
2007 NF PE RVU: 42.45 **2020 NF PE RVU:**
2007 Fac PE RVU 2.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 11.06 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.11 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 7.60 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.46 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35492 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 6.64 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.3 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35493 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 8.09 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.89 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 10.42 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.64 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 9.48 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.45 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35701 **Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 823

2007 Work RVU: 9.11 **2020 Work RVU:** 7.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.93 **2020 Fac PE RVU:** 3.91

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35702 **Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 7.12
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.23

RUC Recommendation: 7.12 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35703 **Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 7.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.88

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35721 **Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery** **Global:** **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 484

2007 Work RVU: 7.66 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35741 **Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 199

2007 Work RVU: 8.61 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.49 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35761 **Exploration (not followed by surgical repair), with or without lysis of artery; other vessels**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,616

2007 Work RVU: 5.84 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.88 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36000 **Introduction of needle or intracatheter, vein**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.54 **2020 NF PE RVU:** 0.60
2007 Fac PE RVU 0.05 **2020 Fac PE RVU:**0.07

RUC Recommendation: CMS consider a bundled status for this code **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36010 **Introduction of catheter, superior or inferior vena cava**

Global: XXX **Issue:** Introduction of Catheter **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,377

2007 Work RVU: 2.43 **2020 Work RVU:** 2.18
2007 NF PE RVU: 17.17 **2020 NF PE RVU:** 12.48
2007 Fac PE RVU 0.77 **2020 Fac PE RVU:**0.63

RUC Recommendation: Remove from re-review. **Referred to CPT** February 2011 **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

36140 **Introduction of needle or intracatheter, upper or lower extremity artery**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 20,331

2007 Work RVU: 2.01 **2020 Work RVU:** 1.76
2007 NF PE RVU: 12.15 **2020 NF PE RVU:** 11.55
2007 Fac PE RVU 0.65 **2020 Fac PE RVU:**0.49

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

36145 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 2.01 **2020 Work RVU:**
2007 NF PE RVU: 11.87 **2020 NF PE RVU:**
2007 Fac PE RVU 0.64 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36215 **Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization greater than 30,000-Part2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 23 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,269

2007 Work RVU: 4.67 **2020 Work RVU:** 4.17
2007 NF PE RVU: 26.59 **2020 NF PE RVU:** 26.01
2007 Fac PE RVU 1.65 **2020 Fac PE RVU:** 1.42

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36216 **Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,580

2007 Work RVU: 5.27 **2020 Work RVU:** 5.27
2007 NF PE RVU: 28.57 **2020 NF PE RVU:** 26.35
2007 Fac PE RVU 1.82 **2020 Fac PE RVU:** 1.68

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 4,059

2007 Work RVU: 6.29 **2020 Work RVU:** 6.29
2007 NF PE RVU: 52.65 **2020 NF PE RVU:** 46.44
2007 Fac PE RVU 2.17 **2020 Fac PE RVU:** 2.02

RUC Recommendation: 6.29 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

36218 **Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Selective Catheter Placement **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,711

2007 Work RVU: 1.01 **2020 Work RVU:** 1.01
2007 NF PE RVU: 4.72 **2020 NF PE RVU:** 5.35
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:** 0.31

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36221 **Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,095

2007 Work RVU: **2020 Work RVU:** 3.92
2007 NF PE RVU: **2020 NF PE RVU:** 25.30
2007 Fac PE RVU **2020 Fac PE RVU:** 1.09

RUC Recommendation: 4.51 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36222 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 7,752

2007 Work RVU: **2020 Work RVU:** 5.28
2007 NF PE RVU: **2020 NF PE RVU:** 29.11
2007 Fac PE RVU **2020 Fac PE RVU:** 1.75

RUC Recommendation: 6.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36223 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 29,312

2007 Work RVU: **2020 Work RVU:** 5.75
2007 NF PE RVU: **2020 NF PE RVU:** 38.58
2007 Fac PE RVU **2020 Fac PE RVU:** 2.13

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36224 **Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,594

2007 Work RVU: **2020 Work RVU:** 6.25
2007 NF PE RVU: **2020 NF PE RVU:** 51.11
2007 Fac PE RVU **2020 Fac PE RVU:** 2.61

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36225 **Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,267

2007 Work RVU: **2020 Work RVU:** 5.75
2007 NF PE RVU: **2020 NF PE RVU:** 36.67
2007 Fac PE RVU **2020 Fac PE RVU:** 2.07

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36226 **Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 32,221

2007 Work RVU: **2020 Work RVU:** 6.25
2007 NF PE RVU: **2020 NF PE RVU:** 47.96
2007 Fac PE RVU **2020 Fac PE RVU:** 2.53

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36227 **Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 13,979

2007 Work RVU: **2020 Work RVU:** 2.09
2007 NF PE RVU: **2020 NF PE RVU:** 4.51
2007 Fac PE RVU **2020 Fac PE RVU:** 0.81

RUC Recommendation: 2.32 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36228 **Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,336

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 32.35
2007 Fac PE RVU **2020 Fac PE RVU:** 1.66

RUC Recommendation: 4.25 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36245 **Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: XXX **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 22 **Specialty Developing Recommendation:** ACC, ACR, SIR, SCAI, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:** 40,259

2007 Work RVU: 4.67 **2020 Work RVU:** 4.65
2007 NF PE RVU: 31.17 **2020 NF PE RVU:** 32.76
2007 Fac PE RVU 1.78 **2020 Fac PE RVU:** 1.46

RUC Recommendation: 4.90 **Referred to CPT** February 2010 and February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36246 **Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

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

Most Recent RUC Meeting: October 2012 **Tab** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,476

2007 Work RVU: 5.27 **2020 Work RVU:** 5.02
2007 NF PE RVU: 29.18 **2020 NF PE RVU:** 18.57
2007 Fac PE RVU 1.84 **2020 Fac PE RVU:**1.37

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

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

36247 **Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family**

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

Most Recent RUC Meeting: October 2012 **Tab** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,061

2007 Work RVU: 6.29 **2020 Work RVU:** 6.04
2007 NF PE RVU: 48.22 **2020 NF PE RVU:** 36.17
2007 Fac PE RVU 2.17 **2020 Fac PE RVU:**1.69

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Increase

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

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,334

2007 Work RVU: 1.01 **2020 Work RVU:** 1.01
2007 NF PE RVU: 3.81 **2020 NF PE RVU:** 2.80
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.29

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen

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

Status Report: CMS Requests and Relativity Assessment Issues

36251 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 3,603

2007 Work RVU: **2020 Work RVU:** 5.10
2007 NF PE RVU: **2020 NF PE RVU:** 33.79
2007 Fac PE RVU **2020 Fac PE RVU:** 1.54

RUC Recommendation: 5.45 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36252 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 8,044

2007 Work RVU: **2020 Work RVU:** 6.74
2007 NF PE RVU: **2020 NF PE RVU:** 34.65
2007 Fac PE RVU **2020 Fac PE RVU:** 2.27

RUC Recommendation: 7.38 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36253 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 1,646

2007 Work RVU: **2020 Work RVU:** 7.30
2007 NF PE RVU: **2020 NF PE RVU:** 54.87
2007 Fac PE RVU **2020 Fac PE RVU:** 2.26

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36254 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 162

RUC Recommendation: 8.15 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 7.90
2007 NF PE RVU: **2020 NF PE RVU:** 52.15
2007 Fac PE RVU **2020 Fac PE RVU:** 2.54
Result: Decrease

36410 **Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)**

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

Most Recent RUC Meeting: April 2010 **Tab** 36 **Specialty Developing Recommendation:** ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 155,240

RUC Recommendation: 0.18 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.3 **2020 NF PE RVU:** 0.29
2007 Fac PE RVU 0.05 **2020 Fac PE RVU:** 0.07
Result: Maintain

36475 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 109,583

RUC Recommendation: 5.30 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 6.72 **2020 Work RVU:** 5.30
2007 NF PE RVU: 47.57 **2020 NF PE RVU:** 32.56
2007 Fac PE RVU 2.39 **2020 Fac PE RVU:** 1.72
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

36476 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** October 2013 **2019 est Medicare Utilization:** 7,170

2007 Work RVU: 3.38 **2020 Work RVU:** 2.65
2007 NF PE RVU: 7.39 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU 1.08 **2020 Fac PE RVU:** 0.73
Result: Decrease

RUC Recommendation: 2.65

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

36478 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,677

2007 Work RVU: 6.72 **2020 Work RVU:** 5.30
2007 NF PE RVU: 42.85 **2020 NF PE RVU:** 23.95
2007 Fac PE RVU 2.41 **2020 Fac PE RVU:** 1.75
Result: Decrease

RUC Recommendation: 5.30

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

36479 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,461

2007 Work RVU: 3.38 **2020 Work RVU:** 2.65
2007 NF PE RVU: 7.59 **2020 NF PE RVU:** 6.11
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:** 0.79
Result: Decrease

RUC Recommendation: 2.65

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

Status Report: CMS Requests and Relativity Assessment Issues

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR

First Identified: NA

2019 est Medicare Utilization: 697

2007 Work RVU: 6.98 **2020 Work RVU:** 6.73
2007 NF PE RVU: NA **2020 NF PE RVU:** 47.25
2007 Fac PE RVU 2.46 **2020 Fac PE RVU:**2.16

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

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

36511 **Therapeutic apheresis; for white blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA

First Identified: January 2017

2019 est Medicare Utilization: 235

2007 Work RVU: 1.74 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.69 **2020 Fac PE RVU:**1.02

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36512 **Therapeutic apheresis; for red blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA

First Identified: January 2017

2019 est Medicare Utilization: 2,896

2007 Work RVU: 1.74 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.71 **2020 Fac PE RVU:**0.99

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36513 **Therapeutic apheresis; for platelets**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA

First Identified: January 2017

2019 est Medicare Utilization: 192

2007 Work RVU: 1.74 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.68 **2020 Fac PE RVU:**0.91

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

Status Report: CMS Requests and Relativity Assessment Issues

36514 **Therapeutic apheresis; for plasma pheresis**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 28,894

2007 Work RVU: 1.74 **2020 Work RVU:** 1.81
2007 NF PE RVU: 15.33 **2020 NF PE RVU:** 17.21
2007 Fac PE RVU 0.67 **2020 Fac PE RVU:**0.79

RUC Recommendation: 1.81. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36515 **Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion**

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

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 1.74 **2020 Work RVU:**
2007 NF PE RVU: 60.92 **2020 NF PE RVU:**
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36516 **Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,069

2007 Work RVU: 1.22 **2020 Work RVU:** 1.56
2007 NF PE RVU: 75.37 **2020 NF PE RVU:** 53.63
2007 Fac PE RVU 0.46 **2020 Fac PE RVU:**0.63

RUC Recommendation: 1.56. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

36522 **Photopheresis, extracorporeal**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 8,303

2007 Work RVU: 1.67 **2020 Work RVU:** 1.75
2007 NF PE RVU: 33.02 **2020 NF PE RVU:** 52.74
2007 Fac PE RVU 0.94 **2020 Fac PE RVU:**0.96

RUC Recommendation: 1.75. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36555 **Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 26

2007 Work RVU: 2.68 **2020 Work RVU:** 1.93
2007 NF PE RVU: 5.34 **2020 NF PE RVU:** 3.27
2007 Fac PE RVU 0.76 **2020 Fac PE RVU:**0.36

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36556 **Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 409,595

2007 Work RVU: 2.50 **2020 Work RVU:** 1.75
2007 NF PE RVU: 4.93 **2020 NF PE RVU:** 4.11
2007 Fac PE RVU 0.7 **2020 Fac PE RVU:**0.49

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36568 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016 **2019 est Medicare Utilization:** 3

2007 Work RVU: 1.92 **2020 Work RVU:** 2.11
2007 NF PE RVU: 7.03 **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**0.36

RUC Recommendation: 2.11

Referred to CPT September 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36569 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: July 2015 **2019 est Medicare Utilization:** 14,961

2007 Work RVU: 1.82 **2020 Work RVU:** 1.90
2007 NF PE RVU: 6.55 **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**0.65

RUC Recommendation: 1.90. Review at RAW in October 2021.

Referred to CPT September 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36572 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 25

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 10.37
2007 Fac PE RVU **2020 Fac PE RVU:**0.65

RUC Recommendation: 2.00

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

36573 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 88,728

RUC Recommendation: 1.90

Referred to CPT

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

2007 Work RVU: **2020 Work RVU:** 1.70
2007 NF PE RVU: **2020 NF PE RVU:** 9.49
2007 Fac PE RVU **2020 Fac PE RVU:** 0.56
Result: Decrease

36584 **Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016 **2019 est Medicare Utilization:** 4,270

RUC Recommendation: 1.47

Referred to CPT September 2017

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

2007 Work RVU: 1.20 **2020 Work RVU:** 1.20
2007 NF PE RVU: 6.16 **2020 NF PE RVU:** 8.61
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:** 0.42
Result: Decrease

36620 **Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASA

First Identified: July 2015 **2019 est Medicare Utilization:** 581,132

RUC Recommendation: 1.00

Referred to CPT

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

2007 Work RVU: 1.15 **2020 Work RVU:** 1.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:** 0.19
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

36818 **Arteriovenous anastomosis, open; by upper arm cephalic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 5,179

2007 Work RVU: 11.81 **2020 Work RVU:** 12.39
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.73 **2020 Fac PE RVU:**4.78

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36819 **Arteriovenous anastomosis, open; by upper arm basilic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 7,456

2007 Work RVU: 14.39 **2020 Work RVU:** 13.29
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.08 **2020 Fac PE RVU:**4.83

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,343

2007 Work RVU: 14.39 **2020 Work RVU:** 13.07
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.11 **2020 Fac PE RVU:**5.04

RUC Recommendation: 13.99 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36821 **Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: September 2007 **2019 est Medicare Utilization:** 30,775

2007 Work RVU: 9.15 **2020 Work RVU:** 11.90
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.49 **2020 Fac PE RVU:** 4.58

RUC Recommendation: 11.90

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

Result: Decrease

36822 **Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI

First Identified: February 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 5.51 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.23 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

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

Result: Deleted from CPT

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: September 2007 **2019 est Medicare Utilization:** 1,949

2007 Work RVU: 10.00 **2020 Work RVU:** 14.17
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.87 **2020 Fac PE RVU:** 5.57

RUC Recommendation: 15.93

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

36830 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: November 2012 **2019 est Medicare Utilization:** 20,101

2007 Work RVU: 12.00 **2020 Work RVU:** 12.03
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.98 **2020 Fac PE RVU:** 4.51

RUC Recommendation: 11.90

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

Result: Decrease

36834 **Deleted from CPT**

Global: **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AVA, ACS

First Identified: September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 11.11 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.68 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 5.17 **2020 Work RVU:**
2007 NF PE RVU: 49.54 **2020 NF PE RVU:**
2007 Fac PE RVU 2.99 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

36901 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 68,183

2007 Work RVU: **2020 Work RVU:** 3.36
2007 NF PE RVU: **2020 NF PE RVU:** 15.89
2007 Fac PE RVU **2020 Fac PE RVU:** 1.06

RUC Recommendation: 3.36 **Referred to CPT** October 2015 **Result:** Decrease

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

36902 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 199,617

2007 Work RVU: **2020 Work RVU:** 4.83
2007 NF PE RVU: **2020 NF PE RVU:** 31.51
2007 Fac PE RVU **2020 Fac PE RVU:** 1.47

RUC Recommendation: 4.83 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

36903 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,847

2007 Work RVU: **2020 Work RVU:** 6.39
2007 NF PE RVU: **2020 NF PE RVU:** 139.01
2007 Fac PE RVU **2020 Fac PE RVU:** 1.88

RUC Recommendation: 6.39 **Referred to CPT** October 2015 **Result:** Decrease

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

36904 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,595

2007 Work RVU: **2020 Work RVU:** 7.50
2007 NF PE RVU: **2020 NF PE RVU:** 46.24
2007 Fac PE RVU **2020 Fac PE RVU:** 2.23

RUC Recommendation: 7.50 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

36905 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,205

2007 Work RVU: **2020 Work RVU:** 9.00
2007 NF PE RVU: **2020 NF PE RVU:** 58.60
2007 Fac PE RVU **2020 Fac PE RVU:** 2.73

RUC Recommendation: 9.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36906 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,028

2007 Work RVU: **2020 Work RVU:** 10.42
2007 NF PE RVU: **2020 NF PE RVU:** 169.86
2007 Fac PE RVU **2020 Fac PE RVU:** 3.07

RUC Recommendation: 10.42 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36907 **Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 67,888

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 16.25
2007 Fac PE RVU **2020 Fac PE RVU:** 0.84

RUC Recommendation: 3.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36908 **Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,376

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 54.75
2007 Fac PE RVU **2020 Fac PE RVU:** 1.14

RUC Recommendation: 4.25 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36909 **Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,424

2007 Work RVU: **2020 Work RVU:** 4.12
2007 NF PE RVU: **2020 NF PE RVU:** 52.10
2007 Fac PE RVU **2020 Fac PE RVU:** 1.11

RUC Recommendation: 4.12 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 893

2007 Work RVU: 7.99 **2020 Work RVU:** 7.74
2007 NF PE RVU: NA **2020 NF PE RVU:** 167.70
2007 Fac PE RVU 2.89 **2020 Fac PE RVU:** 2.42

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37191 **Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 25,555

RUC Recommendation: 4.71 **Referred to CPT** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 4.46
2007 NF PE RVU: **2020 NF PE RVU:** 62.99
2007 Fac PE RVU **2020 Fac PE RVU:** 1.42
Result: Decrease

37192 **Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 32

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 7.10
2007 NF PE RVU: **2020 NF PE RVU:** 29.50
2007 Fac PE RVU **2020 Fac PE RVU:** 1.23
Result: Decrease

37193 **Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 7,478

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 7.10
2007 NF PE RVU: **2020 NF PE RVU:** 37.04
2007 Fac PE RVU **2020 Fac PE RVU:** 2.08
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

37201 **Transcatheter therapy, infusion for thrombolysis other than coronary**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 4.99 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.43 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37203 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 5.02 **2020 Work RVU:**
2007 NF PE RVU: 31.87 **2020 NF PE RVU:**
2007 Fac PE RVU 1.98 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37204 **Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 18.11 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.75 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37205 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 8.27 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.77 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37206 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 4.12 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.46 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37207 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 8.27 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.98 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37208 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 4.12 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.3 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37209 **Exchange of a previously placed intravascular catheter during thrombolytic therapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 2.27 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.72 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37210 **Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 10.60 **2020 Work RVU:**
2007 NF PE RVU: 46.03 **2020 NF PE RVU:**
2007 Fac PE RVU 3.13 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37211 **Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,642

2007 Work RVU: **2020 Work RVU:** 7.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.14

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37212 **Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,012

2007 Work RVU: **2020 Work RVU:** 6.81
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.93

RUC Recommendation: 7.06 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37213 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,217

2007 Work RVU: **2020 Work RVU:** 4.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.29

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37214 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,963

2007 Work RVU: **2020 Work RVU:** 2.49
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.68

RUC Recommendation: 3.04 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,377

2007 Work RVU: **2020 Work RVU:** 7.90
2007 NF PE RVU: **2020 NF PE RVU:** 72.50
2007 Fac PE RVU **2020 Fac PE RVU:** 2.06

RUC Recommendation: Refer to CPT. 8.15 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37221 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,798

2007 Work RVU: **2020 Work RVU:** 9.75
2007 NF PE RVU: **2020 NF PE RVU:** 99.34
2007 Fac PE RVU **2020 Fac PE RVU:** 2.56

RUC Recommendation: Refer to CPT. 10.00 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37222 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 3,550

2007 Work RVU: **2020 Work RVU:** 3.73
2007 NF PE RVU: **2020 NF PE RVU:** 16.71
2007 Fac PE RVU **2020 Fac PE RVU:** 0.88

RUC Recommendation: Refer to CPT. 3.73

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

37223 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 5,293

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 49.30
2007 Fac PE RVU **2020 Fac PE RVU:** 1.03

RUC Recommendation: Refer to CPT. 4.25

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 34,142

2007 Work RVU: **2020 Work RVU:** 8.75
2007 NF PE RVU: **2020 NF PE RVU:** 87.04
2007 Fac PE RVU **2020 Fac PE RVU:** 2.34

RUC Recommendation: Refer to CPT. 9.00

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,496

2007 Work RVU: **2020 Work RVU:** 11.75
2007 NF PE RVU: **2020 NF PE RVU:** 306.67
2007 Fac PE RVU **2020 Fac PE RVU:** 3.29
Result: Decrease

RUC Recommendation: Refer to CPT.

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 24,981

2007 Work RVU: **2020 Work RVU:** 10.24
2007 NF PE RVU: **2020 NF PE RVU:** 272.56
2007 Fac PE RVU **2020 Fac PE RVU:** 2.70
Result: Decrease

RUC Recommendation: Refer to CPT. 10.49

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 23,176

2007 Work RVU: **2020 Work RVU:** 14.25
2007 NF PE RVU: **2020 NF PE RVU:** 395.33
2007 Fac PE RVU **2020 Fac PE RVU:** 3.81
Result: Decrease

RUC Recommendation: Refer to CPT. 14.50

Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,531

2007 Work RVU: **2020 Work RVU:** 10.75
2007 NF PE RVU: **2020 NF PE RVU:** 127.53
2007 Fac PE RVU **2020 Fac PE RVU:** 2.77
Result: Decrease

RUC Recommendation: Refer to CPT. 11.00 **Referred to CPT** February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 39,373

2007 Work RVU: **2020 Work RVU:** 13.80
2007 NF PE RVU: **2020 NF PE RVU:** 305.51
2007 Fac PE RVU **2020 Fac PE RVU:** 3.81
Result: Decrease

RUC Recommendation: Refer to CPT. 14.05 **Referred to CPT** February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

37230 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,808

2007 Work RVU: **2020 Work RVU:** 13.55
2007 NF PE RVU: **2020 NF PE RVU:** 273.31
2007 Fac PE RVU **2020 Fac PE RVU:** 3.89
Result: Decrease

RUC Recommendation: Refer to CPT. 13.80 **Referred to CPT** February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37231 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,320

2007 Work RVU: **2020 Work RVU:** 14.75
2007 NF PE RVU: **2020 NF PE RVU:** 383.32
2007 Fac PE RVU **2020 Fac PE RVU:** 4.25

RUC Recommendation: Refer to CPT. 15.00 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,835

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 24.28
2007 Fac PE RVU **2020 Fac PE RVU:** 1.04

RUC Recommendation: Refer to CPT. 4.00 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37233 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,241

2007 Work RVU: **2020 Work RVU:** 6.50
2007 NF PE RVU: **2020 NF PE RVU:** 27.89
2007 Fac PE RVU **2020 Fac PE RVU:** 1.67

RUC Recommendation: Refer to CPT. 6.50 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37234 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 343

2007 Work RVU: **2020 Work RVU:** 5.50
2007 NF PE RVU: **2020 NF PE RVU:** 103.75
2007 Fac PE RVU **2020 Fac PE RVU:** 1.62

RUC Recommendation: Refer to CPT. 5.50 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37235 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 100

2007 Work RVU: **2020 Work RVU:** 7.80
2007 NF PE RVU: **2020 NF PE RVU:** 106.94
2007 Fac PE RVU **2020 Fac PE RVU:** 2.29

RUC Recommendation: Refer to CPT. 7.80 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37236 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 13,074

2007 Work RVU: **2020 Work RVU:** 8.75
2007 NF PE RVU: **2020 NF PE RVU:** 85.33
2007 Fac PE RVU **2020 Fac PE RVU:** 2.38

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37237 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 1,497

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 48.05
2007 Fac PE RVU **2020 Fac PE RVU:** 1.03

RUC Recommendation: 4.25 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37238 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 10,579

2007 Work RVU: **2020 Work RVU:** 6.04
2007 NF PE RVU: **2020 NF PE RVU:** 83.21
2007 Fac PE RVU **2020 Fac PE RVU:** 1.76

RUC Recommendation: 6.29 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37239 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 4,688

2007 Work RVU: **2020 Work RVU:** 2.97
2007 NF PE RVU: **2020 NF PE RVU:** 38.28
2007 Fac PE RVU **2020 Fac PE RVU:** 0.86

RUC Recommendation: 3.34 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37241 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,922

2007 Work RVU: **2020 Work RVU:** 8.75
2007 NF PE RVU: **2020 NF PE RVU:** 130.10
2007 Fac PE RVU **2020 Fac PE RVU:** 2.61

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37242 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,635

2007 Work RVU: **2020 Work RVU:** 9.80
2007 NF PE RVU: **2020 NF PE RVU:** 205.62
2007 Fac PE RVU **2020 Fac PE RVU:** 2.69

RUC Recommendation: 11.98 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37243 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,067

2007 Work RVU: **2020 Work RVU:** 11.74
2007 NF PE RVU: **2020 NF PE RVU:** 260.80
2007 Fac PE RVU **2020 Fac PE RVU:** 3.52

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37244 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,731

2007 Work RVU: **2020 Work RVU:** 13.75
2007 NF PE RVU: **2020 NF PE RVU:** 185.77
2007 Fac PE RVU **2020 Fac PE RVU:** 4.30

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37246 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,680

2007 Work RVU: **2020 Work RVU:** 7.00
2007 NF PE RVU: **2020 NF PE RVU:** 50.20
2007 Fac PE RVU **2020 Fac PE RVU:** 1.97

RUC Recommendation: 7.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37247 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 760

2007 Work RVU: **2020 Work RVU:** 3.50
2007 NF PE RVU: **2020 NF PE RVU:** 16.46
2007 Fac PE RVU **2020 Fac PE RVU:** 0.90

RUC Recommendation: 3.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37248 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 15,577

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** 36.11
2007 Fac PE RVU **2020 Fac PE RVU:** 1.82

RUC Recommendation: 6.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37249 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 3,865

2007 Work RVU: **2020 Work RVU:** 2.97
2007 NF PE RVU: **2020 NF PE RVU:** 12.26
2007 Fac PE RVU **2020 Fac PE RVU:** 0.83

RUC Recommendation: 2.97 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37250 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 07 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 2.10 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.77 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37251 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 1.60 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37252 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 60,377

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 31.12
2007 Fac PE RVU **2020 Fac PE RVU:**0.46

RUC Recommendation: 1.80 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37253 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 91,408

2007 Work RVU: **2020 Work RVU:** 1.44
2007 NF PE RVU: **2020 NF PE RVU:** 3.64
2007 Fac PE RVU **2020 Fac PE RVU:**0.37

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS

First Identified: September 2007 **2019 est Medicare Utilization:** 14,539

2007 Work RVU: 3.02 **2020 Work RVU:** 3.05
2007 NF PE RVU: 4.43 **2020 NF PE RVU:** 5.27
2007 Fac PE RVU 1.93 **2020 Fac PE RVU:**2.27

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

37619 **Ligation of inferior vena cava**

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

Most Recent RUC Meeting: April 2011 **Tab** 13 **Specialty Developing Recommendation:** ACS, SVS

First Identified: February 2011 **2019 est Medicare Utilization:** 33

2007 Work RVU: **2020 Work RVU:** 30.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**13.09

RUC Recommendation: 37.60

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

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

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

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 11.49 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.52 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

37760 **Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS

First Identified: September 2007 **2019 est Medicare Utilization:** 65

RUC Recommendation: 10.69

Referred to CPT February 2009

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

2007 Work RVU: 10.69 **2020 Work RVU:** 10.78

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 5.14 **2020 Fac PE RVU:** 4.77

Result: Maintain

37761 **Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg**

Global: 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS

First Identified: April 2009 **2019 est Medicare Utilization:** 350

RUC Recommendation: 9.00

Referred to CPT

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

2007 Work RVU: **2020 Work RVU:** 9.13

2007 NF PE RVU: **2020 NF PE RVU:** NA

2007 Fac PE RVU **2020 Fac PE RVU:** 4.46

Result: Increase

37765 **Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS

First Identified: February 2008 **2019 est Medicare Utilization:** 14,709

RUC Recommendation: 4.80

Referred to CPT

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

2007 Work RVU: 7.63 **2020 Work RVU:** 4.80

2007 NF PE RVU: NA **2020 NF PE RVU:** 6.87

2007 Fac PE RVU 4.36 **2020 Fac PE RVU:** 2.07

Result: Decrease

37766 **Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS

First Identified: February 2008 **2019 est Medicare Utilization:** 11,253

RUC Recommendation: 6.00

Referred to CPT

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

2007 Work RVU: 9.58 **2020 Work RVU:** 6.00

2007 NF PE RVU: NA **2020 NF PE RVU:** 7.57

2007 Fac PE RVU 5.01 **2020 Fac PE RVU:** 2.40

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

37785 **Ligation, division, and/or excision of varicose vein cluster(s), 1 leg** **Global:** 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 934

2007 Work RVU: 3.87 **2020 Work RVU:** 3.93
2007 NF PE RVU: 5.12 **2020 NF PE RVU:** 5.38
2007 Fac PE RVU 2.69 **2020 Fac PE RVU:**2.64

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

38220 **Diagnostic bone marrow; aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 7,044

2007 Work RVU: 1.08 **2020 Work RVU:** 1.20
2007 NF PE RVU: 3.46 **2020 NF PE RVU:** 3.39
2007 Fac PE RVU 0.5 **2020 Fac PE RVU:**0.63

RUC Recommendation: 1.20 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

38221 **Diagnostic bone marrow; biopsy(ies)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,465

2007 Work RVU: 1.37 **2020 Work RVU:** 1.28
2007 NF PE RVU: 3.64 **2020 NF PE RVU:** 3.10
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**0.63

RUC Recommendation: 1.28 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

38222 **Diagnostic bone marrow; biopsy(ies) and aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 120,998

2007 Work RVU: **2020 Work RVU:** 1.44
2007 NF PE RVU: **2020 NF PE RVU:** 3.39
2007 Fac PE RVU **2020 Fac PE RVU:**0.69

RUC Recommendation: 1.44 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Needle Biopsy of Lymph Nodes **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 33,584

2007 Work RVU: 1.14 **2020 Work RVU:** 1.14
2007 NF PE RVU: 2.04 **2020 NF PE RVU:** 2.30
2007 Fac PE RVU 0.75 **2020 Fac PE RVU:**0.77

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 571

2007 Work RVU: 6.08 **2020 Work RVU:** 7.95
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.3 **2020 Fac PE RVU:**5.64

RUC Recommendation: 7.85 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 12 **Specialty Developing Recommendation:** AUA **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,714

2007 Work RVU: 9.28 **2020 Work RVU:** 8.49
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.98 **2020 Fac PE RVU:**4.88

RUC Recommendation: 9.34 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** CMS Fastest Growing / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 12 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,981

2007 Work RVU: 14.70 **2020 Work RVU:** 12.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.97 **2020 Fac PE RVU:** 5.71

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease

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

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

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 12 **Specialty Developing Recommendation:** ACOG **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,251

2007 Work RVU: 16.86 **2020 Work RVU:** 15.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.86 **2020 Fac PE RVU:** 8.36

RUC Recommendation: 15.60 **Referred to CPT** **Result:** Decrease

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

38792 **Injection procedure; radioactive tracer for identification of sentinel node**

Global: 000 **Issue:** Radioactive Tracer **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 33,143

2007 Work RVU: 0.52 **2020 Work RVU:** 0.65
2007 NF PE RVU: NA **2020 NF PE RVU:** 1.63
2007 Fac PE RVU 0.45 **2020 Fac PE RVU:** 0.23

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Increase

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

39400 **Mediastinoscopy, includes biopsy(ies), when performed**

Global: **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 08 **Specialty Developing Recommendation:** STS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 8.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.68 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

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

Status Report: CMS Requests and Relativity Assessment Issues

39401 **Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 535

2007 Work RVU: **2020 Work RVU:** 5.44
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.24

RUC Recommendation: 5.44 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

39402 **Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,086

2007 Work RVU: **2020 Work RVU:** 7.25
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.78

RUC Recommendation: 7.50 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 **Biopsy of lip**

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

Most Recent RUC Meeting: September 2011 **Tab** 21 **Specialty Developing Recommendation:** AAO-HNS, AAD **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,762

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 1.75 **2020 NF PE RVU:** 2.22
2007 Fac PE RVU 0.61 **2020 Fac PE RVU:** 0.70

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

40650 **Repair lip, full thickness; vermilion only**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 355

2007 Work RVU: 3.69 **2020 Work RVU:** 3.78
2007 NF PE RVU: 6.58 **2020 NF PE RVU:** 8.81
2007 Fac PE RVU 3.26 **2020 Fac PE RVU:** 4.33

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2016

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

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

First Identified: January 2014

2019 est Medicare Utilization: 2,390

2007 Work RVU: 1.19 **2020 Work RVU:** 1.23
2007 NF PE RVU: 3.18 **2020 NF PE RVU:** 4.61
2007 Fac PE RVU 1.8 **2020 Fac PE RVU:**2.21

RUC Recommendation: Maintain

Referred to CPT

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

Result: Maintain

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

Global: 010 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) / 010-Day Global Post-Operative Visits2 **Complete?** Yes

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

First Identified: September 2007

2019 est Medicare Utilization: 1,609

2007 Work RVU: 2.57 **2020 Work RVU:** 2.63
2007 NF PE RVU: 4.23 **2020 NF PE RVU:** 5.70
2007 Fac PE RVU 2.7 **2020 Fac PE RVU:**3.07

RUC Recommendation: Maintain. Reduced 99238 to 0.5

Referred to CPT

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

Result: PE Only

40808 **Biopsy, vestibule of mouth**

Global: 010 **Issue:** Biopsy of Mouth Lesion **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 13 **Specialty Developing Recommendation:** AAOHNS, AAOMS

First Identified: April 2017

2019 est Medicare Utilization: 10,517

2007 Work RVU: 0.98 **2020 Work RVU:** 1.05
2007 NF PE RVU: 2.87 **2020 NF PE RVU:** 3.38
2007 Fac PE RVU 1.51 **2020 Fac PE RVU:**1.31

RUC Recommendation: 1.05

Referred to CPT

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

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

40812 **Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,703

2007 Work RVU: 2.33 **2020 Work RVU:** 2.37
2007 NF PE RVU: 3.92 **2020 NF PE RVU:** 5.56
2007 Fac PE RVU 2.37 **2020 Fac PE RVU:**2.82

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

40820 **Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,264

2007 Work RVU: 1.30 **2020 Work RVU:** 1.34
2007 NF PE RVU: 4.23 **2020 NF PE RVU:** 5.95
2007 Fac PE RVU 2.54 **2020 Fac PE RVU:**3.31

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

41530 **Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session**

Global: 000 **Issue:** Submucosal ablation of tongue base **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** July 2014 **2019 est Medicare Utilization:** 350

2007 Work RVU: **2020 Work RVU:** 3.50
2007 NF PE RVU: **2020 NF PE RVU:** 23.14
2007 Fac PE RVU **2020 Fac PE RVU:**6.69

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)**

Global: 090 **Issue:** Palatopharyngoplasty **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 518

2007 Work RVU: 9.63 **2020 Work RVU:** 9.78
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.33 **2020 Fac PE RVU:**8.70

RUC Recommendation: 9.63 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,439

2007 Work RVU: 17.99 **2020 Work RVU:** 17.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.11 **2020 Fac PE RVU:**10.69
Result: Maintain

RUC Recommendation: 18.12

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

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,561

2007 Work RVU: 20.87 **2020 Work RVU:** 19.53
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.46 **2020 Fac PE RVU:**11.72
Result: Maintain

RUC Recommendation: 21.00

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

42440 **Excision of submandibular (submaxillary) gland**

Global: 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,780

2007 Work RVU: 7.05 **2020 Work RVU:** 6.14
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.48 **2020 Fac PE RVU:**4.81
Result: Maintain

RUC Recommendation: 7.13

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

43191 **Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,988

2007 Work RVU: **2020 Work RVU:** 2.49
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**1.59
Result: Increase

RUC Recommendation: 2.78

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

Status Report: CMS Requests and Relativity Assessment Issues

43192 **Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 211

2007 Work RVU: **2020 Work RVU:** 2.79
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.68
Result: Increase

RUC Recommendation: 3.21

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

43193 **Esophagoscopy, rigid, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 210

2007 Work RVU: **2020 Work RVU:** 2.79
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.67
Result: Increase

RUC Recommendation: 3.36

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

43194 **Esophagoscopy, rigid, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 115

2007 Work RVU: **2020 Work RVU:** 3.51
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.50
Result: Increase

RUC Recommendation: 3.99

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

43195 **Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 569

2007 Work RVU: **2020 Work RVU:** 3.07
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.78
Result: Increase

RUC Recommendation: 3.21

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

Status Report: CMS Requests and Relativity Assessment Issues

43196 **Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 486

2007 Work RVU: **2020 Work RVU:** 3.31
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.88
Result: Increase

RUC Recommendation: 3.36 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43197 **Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,136

2007 Work RVU: **2020 Work RVU:** 1.52
2007 NF PE RVU: **2020 NF PE RVU:** 3.75
2007 Fac PE RVU **2020 Fac PE RVU:** 0.63
Result: Maintain

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

43198 **Esophagoscopy, flexible, transnasal; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 255

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 4.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.78
Result: Maintain

RUC Recommendation: 1.89 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43200 **Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,390

2007 Work RVU: 1.59 **2020 Work RVU:** 1.42
2007 NF PE RVU: 3.98 **2020 NF PE RVU:** 5.26
2007 Fac PE RVU 1.04 **2020 Fac PE RVU:** 0.89
Result: Maintain

RUC Recommendation: 1.59 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43201 **Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 220

2007 Work RVU: 2.09 **2020 Work RVU:** 1.72
2007 NF PE RVU: 4.86 **2020 NF PE RVU:** 4.93
2007 Fac PE RVU 1.12 **2020 Fac PE RVU:**1.02
Result: Decrease

RUC Recommendation: 1.90

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

43202 **Esophagoscopy, flexible, transoral; with biopsy, single or multiple** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,578

2007 Work RVU: 1.89 **2020 Work RVU:** 1.72
2007 NF PE RVU: 5.44 **2020 NF PE RVU:** 7.69
2007 Fac PE RVU 0.95 **2020 Fac PE RVU:**1.02
Result: Maintain

RUC Recommendation: 1.89

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

43204 **Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 13

2007 Work RVU: 3.76 **2020 Work RVU:** 2.33
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.63 **2020 Fac PE RVU:**1.31
Result: Decrease

RUC Recommendation: 2.89

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

43205 **Esophagoscopy, flexible, transoral; with band ligation of esophageal varices** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2007 Work RVU: 3.78 **2020 Work RVU:** 2.44
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.66 **2020 Fac PE RVU:**1.36
Result: Decrease

RUC Recommendation: 3.00

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43206 **Esophagoscopy, flexible, transoral; with optical endomicroscopy** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 21

RUC Recommendation: 2.39 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 2.29
2007 NF PE RVU: **2020 NF PE RVU:** 5.60
2007 Fac PE RVU **2020 Fac PE RVU:** 1.29
Result: Decrease

43211 **Esophagoscopy, flexible, transoral; with endoscopic mucosal resection** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 99

RUC Recommendation: 4.58 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 4.20
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.13
Result: Decrease

43212 **Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 585

RUC Recommendation: 3.73 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.40
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.52
Result: Decrease

43213 **Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 187

RUC Recommendation: 5.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 4.63
2007 NF PE RVU: **2020 NF PE RVU:** 29.72
2007 Fac PE RVU **2020 Fac PE RVU:** 2.21
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

43214 **Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215

RUC Recommendation: 3.78 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.40
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.75
Result: Decrease

43215 **Esophagoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 989

RUC Recommendation: 2.60 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 2.60 **2020 Work RVU:** 2.44
2007 NF PE RVU: NA **2020 NF PE RVU:** 8.16
2007 Fac PE RVU 1.22 **2020 Fac PE RVU:** 1.29
Result: Maintain

43216 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 195

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 2.40 **2020 Work RVU:** 2.30
2007 NF PE RVU: 1.55 **2020 NF PE RVU:** 8.62
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:** 1.29
Result: Maintain

43217 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 53

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 2.90 **2020 Work RVU:** 2.80
2007 NF PE RVU: 6.85 **2020 NF PE RVU:** 8.33
2007 Fac PE RVU 1.25 **2020 Fac PE RVU:** 1.52
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

43219 **Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent** **Global:** **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.80 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.4 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43220 **Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,069

2007 Work RVU: 2.10 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 26.53
2007 Fac PE RVU 1.01 **2020 Fac PE RVU:**1.14

RUC Recommendation: 2.10 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43226 **Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,841

2007 Work RVU: 2.34 **2020 Work RVU:** 2.24
2007 NF PE RVU: NA **2020 NF PE RVU:** 7.63
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:**1.19

RUC Recommendation: 2.34 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 **Esophagoscopy, flexible, transoral; with control of bleeding, any method** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 191

2007 Work RVU: 3.59 **2020 Work RVU:** 2.89
2007 NF PE RVU: NA **2020 NF PE RVU:** 14.48
2007 Fac PE RVU 1.55 **2020 Fac PE RVU:**1.54

RUC Recommendation: 3.26 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43228 **Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 3.76 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

43229 **Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,331

2007 Work RVU: **2020 Work RVU:** 3.49
2007 NF PE RVU: **2020 NF PE RVU:** 15.91
2007 Fac PE RVU **2020 Fac PE RVU:** 1.79

RUC Recommendation: 3.72 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

43231 **Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 502

2007 Work RVU: 3.19 **2020 Work RVU:** 2.80
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.42 **2020 Fac PE RVU:** 1.51

RUC Recommendation: 3.19 **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

43232 **Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 435

2007 Work RVU: 4.47 **2020 Work RVU:** 3.59
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.96 **2020 Fac PE RVU:** 1.81

RUC Recommendation: 3.83 **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

43233 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,577

2007 Work RVU: **2020 Work RVU:** 4.07
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.98

RUC Recommendation: 4.45 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43234 **Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.01 **2020 Work RVU:**
2007 NF PE RVU: 5.23 **2020 NF PE RVU:**
2007 Fac PE RVU 0.91 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43235 **Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** EGD **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 323,621

2007 Work RVU: 2.39 **2020 Work RVU:** 2.09
2007 NF PE RVU: 5.19 **2020 NF PE RVU:** 5.63
2007 Fac PE RVU 1.11 **2020 Fac PE RVU:** 1.19

RUC Recommendation: 2.26 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43236 **Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 16,281

2007 Work RVU: 2.92 **2020 Work RVU:** 2.39
2007 NF PE RVU: 6.47 **2020 NF PE RVU:** 7.99
2007 Fac PE RVU 1.33 **2020 Fac PE RVU:**1.33

RUC Recommendation: 2.57 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2009 and Jun 2010

43237 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,922

2007 Work RVU: 3.98 **2020 Work RVU:** 3.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.74 **2020 Fac PE RVU:**1.80

RUC Recommendation: 3.85 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43238 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,141

2007 Work RVU: 5.02 **2020 Work RVU:** 4.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.11 **2020 Fac PE RVU:**2.10

RUC Recommendation: 4.50 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43239 **Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** EGD with Biopsy **Screen:** MPC List / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 12 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,424,058

2007 Work RVU: 2.87 **2020 Work RVU:** 2.39
2007 NF PE RVU: 5.79 **2020 NF PE RVU:** 7.96
2007 Fac PE RVU 1.29 **2020 Fac PE RVU:**1.32

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43240 **Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,002

2007 Work RVU: 6.85 **2020 Work RVU:** 7.15
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.82 **2020 Fac PE RVU:**3.40

RUC Recommendation: 7.25 **Referred to CPT** February 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

43241 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,312

2007 Work RVU: 2.59 **2020 Work RVU:** 2.49
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.18 **2020 Fac PE RVU:**1.32

RUC Recommendation: 2.59 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43242 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,340

2007 Work RVU: 7.30 **2020 Work RVU:** 4.73
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.98 **2020 Fac PE RVU:** 2.36

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43243 **Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 647

2007 Work RVU: 4.56 **2020 Work RVU:** 4.27
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.94 **2020 Fac PE RVU:** 2.10

RUC Recommendation: 4.37 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43244 **Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,233

2007 Work RVU: 5.04 **2020 Work RVU:** 4.40
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.14 **2020 Fac PE RVU:** 2.21

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43245 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,047

2007 Work RVU: 3.18 **2020 Work RVU:** 3.08
2007 NF PE RVU: NA **2020 NF PE RVU:** 13.30
2007 Fac PE RVU 1.39 **2020 Fac PE RVU:**1.59

RUC Recommendation: 3.18 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 **Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,081

2007 Work RVU: 4.32 **2020 Work RVU:** 3.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.8 **2020 Fac PE RVU:**1.73

RUC Recommendation: 4.32 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43247 **Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,637

2007 Work RVU: 3.38 **2020 Work RVU:** 3.11
2007 NF PE RVU: NA **2020 NF PE RVU:** 7.08
2007 Fac PE RVU 1.48 **2020 Fac PE RVU:**1.62

RUC Recommendation: 3.27 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43248 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 110,879

2007 Work RVU: 3.15 **2020 Work RVU:** 2.91
2007 NF PE RVU: NA **2020 NF PE RVU:** 7.84
2007 Fac PE RVU 1.43 **2020 Fac PE RVU:**1.55

RUC Recommendation: 3.01 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43249 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 125,878

2007 Work RVU: 2.90 **2020 Work RVU:** 2.67
2007 NF PE RVU: NA **2020 NF PE RVU:** 28.07
2007 Fac PE RVU 1.32 **2020 Fac PE RVU:**1.44

RUC Recommendation: 2.77 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43250 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,775

2007 Work RVU: 3.20 **2020 Work RVU:** 2.97
2007 NF PE RVU: NA **2020 NF PE RVU:** 8.94
2007 Fac PE RVU 1.4 **2020 Fac PE RVU:**1.53

RUC Recommendation: 3.07 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,888

2007 Work RVU: 3.69 **2020 Work RVU:** 3.47
2007 NF PE RVU: NA **2020 NF PE RVU:** 9.71
2007 Fac PE RVU 1.6 **2020 Fac PE RVU:**1.79

RUC Recommendation: 3.57 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43253 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** February 2012 **2019 est Medicare Utilization:** 2,309

2007 Work RVU: **2020 Work RVU:** 4.73
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.36

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43254 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,797

2007 Work RVU: **2020 Work RVU:** 4.87
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.41

RUC Recommendation: 5.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43255 **Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 62,091

2007 Work RVU: 4.81 **2020 Work RVU:** 3.56
2007 NF PE RVU: NA **2020 NF PE RVU:** 14.74
2007 Fac PE RVU 2.05 **2020 Fac PE RVU:** 1.84

RUC Recommendation: 4.20 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43256 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 4.34 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.85 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 **Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 148

2007 Work RVU: 5.50 **2020 Work RVU:** 4.15
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.16 **2020 Fac PE RVU:** 2.06

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43258 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 4.54 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.94 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43259 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 34,294

2007 Work RVU: 5.19 **2020 Work RVU:** 4.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.17 **2020 Fac PE RVU:** 2.06

RUC Recommendation: 4.74 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,795

2007 Work RVU: 5.95 **2020 Work RVU:** 5.85
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.49 **2020 Fac PE RVU:** 2.84

RUC Recommendation: 5.95 **Referred to CPT** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 7,154

2007 Work RVU: 6.26 **2020 Work RVU:** 6.15
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.61 **2020 Fac PE RVU:** 2.97

RUC Recommendation: 6.25 **Referred to CPT** January 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43262 **Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 30,450

2007 Work RVU: 7.38 **2020 Work RVU:** 6.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.03 **2020 Fac PE RVU:**3.13

RUC Recommendation: 6.60 **Referred to CPT** January 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43263 **Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 67

2007 Work RVU: 7.28 **2020 Work RVU:** 6.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.02 **2020 Fac PE RVU:**3.13

RUC Recommendation: 7.28 **Referred to CPT** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43264 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 56,121

2007 Work RVU: 8.89 **2020 Work RVU:** 6.63
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.61 **2020 Fac PE RVU:**3.18

RUC Recommendation: 6.73 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43265 **Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,820

2007 Work RVU: 10.00 **2020 Work RVU:** 7.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.03 **2020 Fac PE RVU:** 3.74

RUC Recommendation: 8.03 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43266 **Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,767

2007 Work RVU: **2020 Work RVU:** 3.92
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.89

RUC Recommendation: 4.40 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 7.38 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.01 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct**

Global: **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 7.38 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 8.20 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.35 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43270 **Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,628

2007 Work RVU: **2020 Work RVU:** 4.01
2007 NF PE RVU: **2020 NF PE RVU:** 15.90
2007 Fac PE RVU **2020 Fac PE RVU:** 2.03

RUC Recommendation: 4.39 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43271 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 7.38 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.03 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43272 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 7.38 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.05 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 **Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)**

Global: ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,668

2007 Work RVU: **2020 Work RVU:** 2.24
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.98

RUC Recommendation: 2.24 **Referred to CPT** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43274 **Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 43,064

2007 Work RVU: **2020 Work RVU:** 8.48
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.98

RUC Recommendation: 8.74 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43275 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,287

2007 Work RVU: **2020 Work RVU:** 6.86
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.27

RUC Recommendation: 6.96 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43276 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 16,434

2007 Work RVU: **2020 Work RVU:** 8.84
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.14

RUC Recommendation: 9.10 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43277 **Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 6,694

RUC Recommendation: 7.11 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 6.90
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.29
Result: Decrease

43278 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 600

RUC Recommendation: 8.08 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 7.92
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.74
Result: Decrease

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

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,670

RUC Recommendation: 1.30 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 1.38 **2020 Work RVU:** 1.28
2007 NF PE RVU: 2.64 **2020 NF PE RVU:** 3.46
2007 Fac PE RVU 0.75 **2020 Fac PE RVU:** 0.86
Result: Decrease

43453 **Dilation of esophagus, over guide wire**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,698

RUC Recommendation: 1.51 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 1.51 **2020 Work RVU:** 1.41
2007 NF PE RVU: 6.12 **2020 NF PE RVU:** 23.50
2007 Fac PE RVU 0.8 **2020 Fac PE RVU:** 0.90
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

43456 **Dilation of esophagus, by balloon or dilator, retrograde**

Global: **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.57 **2020 Work RVU:**
2007 NF PE RVU: 13.55 **2020 NF PE RVU:**
2007 Fac PE RVU 1.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

43458 **Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia**

Global: **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 3.06 **2020 Work RVU:**
2007 NF PE RVU: 6.72 **2020 NF PE RVU:**
2007 Fac PE RVU 1.37 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

43760 **Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance**

Global: **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** July 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 1.10 **2020 Work RVU:**
2007 NF PE RVU: 4.77 **2020 NF PE RVU:**
2007 Fac PE RVU 0.44 **2020 Fac PE RVU:**

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

43762 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 49,049

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 5.58
2007 Fac PE RVU **2020 Fac PE RVU:** 0.23

RUC Recommendation: 0.75. Flag for Re-review. **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

43763 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,711

2007 Work RVU: **2020 Work RVU:** 1.41
2007 NF PE RVU: **2020 NF PE RVU:** 7.98
2007 Fac PE RVU **2020 Fac PE RVU:** 0.78

RUC Recommendation: 1.41. Flag for Re-review.

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

Result: Decrease

44143 **Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)**

Global: 090 **Issue:** RAW **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 10,216

2007 Work RVU: 27.63 **2020 Work RVU:** 27.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.6 **2020 Fac PE RVU:** 14.36

RUC Recommendation: 99214 visit appropriate. Remove from screen.

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

Result: Remove from screen

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,383

2007 Work RVU: 22.86 **2020 Work RVU:** 22.95
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.6 **2020 Fac PE RVU:** 11.20

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 9,951

2007 Work RVU: 31.79 **2020 Work RVU:** 31.92
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.17 **2020 Fac PE RVU:**14.61

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

44380 **Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,038

2007 Work RVU: 1.05 **2020 Work RVU:** 0.87
2007 NF PE RVU: NA **2020 NF PE RVU:** 4.24
2007 Fac PE RVU 0.6 **2020 Fac PE RVU:**0.65

RUC Recommendation: 0.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44381 **Ileoscopy, through stoma; with transendoscopic balloon dilation**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 150

2007 Work RVU: **2020 Work RVU:** 1.38
2007 NF PE RVU: **2020 NF PE RVU:** 26.34
2007 Fac PE RVU **2020 Fac PE RVU:**0.86

RUC Recommendation: 1.48 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44382 **Ileoscopy, through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy Ileoscopy Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,549

2007 Work RVU: 1.27 **2020 Work RVU:** 1.17
2007 NF PE RVU: NA **2020 NF PE RVU:** 6.84
2007 Fac PE RVU 0.67 **2020 Fac PE RVU:**0.80

RUC Recommendation: 1.27 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44383 **Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.94 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.36 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 124

2007 Work RVU: **2020 Work RVU:** 2.85
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**1.25

RUC Recommendation: 3.11 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,312

2007 Work RVU: 1.82 **2020 Work RVU:** 1.20
2007 NF PE RVU: 3.73 **2020 NF PE RVU:** 4.36
2007 Fac PE RVU 0.79 **2020 Fac PE RVU:**0.73

RUC Recommendation: 1.30 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44386 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,832

2007 Work RVU: 2.12 **2020 Work RVU:** 1.50
2007 NF PE RVU: 6.66 **2020 NF PE RVU:** 6.86
2007 Fac PE RVU 0.93 **2020 Fac PE RVU:**0.89

RUC Recommendation: 1.60 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,180

2007 Work RVU: 2.82 **2020 Work RVU:** 2.72
2007 NF PE RVU: 5.34 **2020 NF PE RVU:** 5.57
2007 Fac PE RVU 1.21 **2020 Fac PE RVU:**1.40

RUC Recommendation: 2.82 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

44389 **Colonoscopy through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,551

2007 Work RVU: 3.13 **2020 Work RVU:** 3.02
2007 NF PE RVU: 6.73 **2020 NF PE RVU:** 8.03
2007 Fac PE RVU 1.35 **2020 Fac PE RVU:**1.56

RUC Recommendation: 3.12 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44390 **Colonoscopy through stoma; with removal of foreign body(s)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011 **2019 est Medicare Utilization:** 18

2007 Work RVU: 3.82 **2020 Work RVU:** 3.74
2007 NF PE RVU: 7.32 **2020 NF PE RVU:** 7.08
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**1.93

RUC Recommendation: 3.82

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

Result: Maintain

44391 **Colonoscopy through stoma; with control of bleeding, any method**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011 **2019 est Medicare Utilization:** 159

2007 Work RVU: 4.31 **2020 Work RVU:** 4.12
2007 NF PE RVU: 8.78 **2020 NF PE RVU:** 14.69
2007 Fac PE RVU 1.83 **2020 Fac PE RVU:**2.07

RUC Recommendation: 4.22

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

Result: Decrease

44392 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011 **2019 est Medicare Utilization:** 297

2007 Work RVU: 3.81 **2020 Work RVU:** 3.53
2007 NF PE RVU: 6.78 **2020 NF PE RVU:** 6.52
2007 Fac PE RVU 1.55 **2020 Fac PE RVU:**1.72

RUC Recommendation: 3.63

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

44393 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 4.83 **2020 Work RVU:**
2007 NF PE RVU: 7.14 **2020 NF PE RVU:**
2007 Fac PE RVU 1.91 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44394 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,081

2007 Work RVU: 4.42 **2020 Work RVU:** 4.03
2007 NF PE RVU: 7.97 **2020 NF PE RVU:** 7.57
2007 Fac PE RVU 1.81 **2020 Fac PE RVU:**1.98

RUC Recommendation: 4.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44397 **Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 4.70 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.93 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44401 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 65

2007 Work RVU: **2020 Work RVU:** 4.34
2007 NF PE RVU: **2020 NF PE RVU:** 75.42
2007 Fac PE RVU **2020 Fac PE RVU:** 2.19

RUC Recommendation: 4.44 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44402 **Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2007 Work RVU: **2020 Work RVU:** 4.70
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.35

RUC Recommendation: 4.96 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44403 **Colonoscopy through stoma; with endoscopic mucosal resection**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2007 Work RVU: **2020 Work RVU:** 5.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.69

RUC Recommendation: 5.81 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44404 **Colonoscopy through stoma; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2007 Work RVU: **2020 Work RVU:** 3.02
2007 NF PE RVU: **2020 NF PE RVU:** 7.98
2007 Fac PE RVU **2020 Fac PE RVU:** 1.57

RUC Recommendation: 3.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44405 **Colonoscopy through stoma; with transendoscopic balloon dilation**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 57

2007 Work RVU: **2020 Work RVU:** 3.23
2007 NF PE RVU: **2020 NF PE RVU:** 12.33
2007 Fac PE RVU **2020 Fac PE RVU:** 1.70

RUC Recommendation: 3.33 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44406 **Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2007 Work RVU: **2020 Work RVU:** 4.10
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.08

RUC Recommendation: 4.41 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44407 **Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.96
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.46

RUC Recommendation: 5.06 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44408 **Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2007 Work RVU: **2020 Work RVU:** 4.14
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.10

RUC Recommendation: 4.24 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44901 **Incision and drainage of appendiceal abscess; percutaneous**

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

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: 25.61 **2020 NF PE RVU:**
2007 Fac PE RVU 1.07 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44970 **Laparoscopy, surgical, appendectomy** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2019 est Medicare Utilization:** 22,448

2007 Work RVU: 9.35 **2020 Work RVU:** 9.45
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.11 **2020 Fac PE RVU:** 5.82

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

45170 **Deleted from CPT** **Global:** **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 12.48 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.28 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)** **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2007 Work RVU: **2020 Work RVU:** 8.13
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 7.86

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45172 **Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)** **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,918

2007 Work RVU: **2020 Work RVU:** 12.13
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 9.36

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45300 **Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Diagnostic Proctosigmoidoscopy - Rigid **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 13 **Specialty Developing Recommendation:** ACS, ASCRS, SAGES **First Identified:** July 2016 **2019 est Medicare Utilization:** 23,267

2007 Work RVU: 0.38 **2020 Work RVU:** 0.80
2007 NF PE RVU: 1.63 **2020 NF PE RVU:** 2.61
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:** 0.47

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

45330 **Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 50,795

2007 Work RVU: 0.96 **2020 Work RVU:** 0.84
2007 NF PE RVU: 2.33 **2020 NF PE RVU:** 4.03
2007 Fac PE RVU 0.53 **2020 Fac PE RVU:** 0.66

RUC Recommendation: 0.84 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45331 **Sigmoidoscopy, flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 36,318

2007 Work RVU: 1.15 **2020 Work RVU:** 1.14
2007 NF PE RVU: 3.11 **2020 NF PE RVU:** 6.56
2007 Fac PE RVU 0.64 **2020 Fac PE RVU:** 0.79

RUC Recommendation: 1.14 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45332 **Sigmoidoscopy, flexible; with removal of foreign body(s)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 353

2007 Work RVU: 1.79 **2020 Work RVU:** 1.76
2007 NF PE RVU: 5.15 **2020 NF PE RVU:** 5.54
2007 Fac PE RVU 0.86 **2020 Fac PE RVU:** 1.04

RUC Recommendation: 1.85 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45333 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 734

2007 Work RVU: 1.79 **2020 Work RVU:** 1.55
2007 NF PE RVU: 5.06 **2020 NF PE RVU:** 7.15
2007 Fac PE RVU 0.85 **2020 Fac PE RVU:** 0.94

RUC Recommendation: 1.65 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45334 **Sigmoidoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,411

2007 Work RVU: 2.73 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 12.80
2007 Fac PE RVU 1.24 **2020 Fac PE RVU:** 1.15

RUC Recommendation: 2.10 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45335 **Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,141

2007 Work RVU: 1.46 **2020 Work RVU:** 1.04
2007 NF PE RVU: 3.74 **2020 NF PE RVU:** 6.41
2007 Fac PE RVU 0.75 **2020 Fac PE RVU:**0.74

RUC Recommendation: 1.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45337 **Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,691

2007 Work RVU: 2.36 **2020 Work RVU:** 2.10
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.06 **2020 Fac PE RVU:**0.97

RUC Recommendation: 2.20 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,383

2007 Work RVU: 2.34 **2020 Work RVU:** 2.05
2007 NF PE RVU: 5.37 **2020 NF PE RVU:** 5.76
2007 Fac PE RVU 1.07 **2020 Fac PE RVU:**1.16

RUC Recommendation: 2.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45339 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 3.14 **2020 Work RVU:**
2007 NF PE RVU: 4.03 **2020 NF PE RVU:**
2007 Fac PE RVU 1.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45340 **Sigmoidoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,316

2007 Work RVU: 1.89 **2020 Work RVU:** 1.25
2007 NF PE RVU: 7.18 **2020 NF PE RVU:** 11.51
2007 Fac PE RVU 0.89 **2020 Fac PE RVU:**0.83

RUC Recommendation: 1.35 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 **Sigmoidoscopy, flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,713

2007 Work RVU: 2.60 **2020 Work RVU:** 2.12
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**1.21

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45342 **Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 374

2007 Work RVU: 4.05 **2020 Work RVU:** 2.98
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.71 **2020 Fac PE RVU:** 1.59

RUC Recommendation: 3.08 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45345 **Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.92 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45346 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,183

2007 Work RVU: **2020 Work RVU:** 2.81
2007 NF PE RVU: **2020 NF PE RVU:** 75.13
2007 Fac PE RVU **2020 Fac PE RVU:** 1.49

RUC Recommendation: 2.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45347 **Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 637

2007 Work RVU: **2020 Work RVU:** 2.72
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.42

RUC Recommendation: 2.98 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45349 **Sigmoidoscopy, flexible; with endoscopic mucosal resection**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 632

2007 Work RVU: **2020 Work RVU:** 3.52
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.82

RUC Recommendation: 3.83 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45350 **Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,214

2007 Work RVU: **2020 Work RVU:** 1.68
2007 NF PE RVU: **2020 NF PE RVU:** 15.91
2007 Fac PE RVU **2020 Fac PE RVU:** 1.02

RUC Recommendation: 1.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45355 **Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple** **Global:** **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 3.51 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.43 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 **Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS High Expenditure Procedural Codes1 / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 345,987

2007 Work RVU: 3.69 **2020 Work RVU:** 3.26
2007 NF PE RVU: 6.2 **2020 NF PE RVU:** 5.75
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**1.68

RUC Recommendation: 3.36 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45379 **Colonoscopy, flexible; with removal of foreign body(s)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 930

2007 Work RVU: 4.68 **2020 Work RVU:** 4.28
2007 NF PE RVU: 7.78 **2020 NF PE RVU:** 7.36
2007 Fac PE RVU 1.92 **2020 Fac PE RVU:**2.12

RUC Recommendation: 4.37 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45380 **Colonoscopy, flexible; with biopsy, single or multiple** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,054,879

2007 Work RVU: 4.43 **2020 Work RVU:** 3.56
2007 NF PE RVU: 7.33 **2020 NF PE RVU:** 8.16
2007 Fac PE RVU 1.87 **2020 Fac PE RVU:** 1.82

RUC Recommendation: 3.66 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45381 **Colonoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 82,892

2007 Work RVU: 4.19 **2020 Work RVU:** 3.56
2007 NF PE RVU: 7.26 **2020 NF PE RVU:** 8.07
2007 Fac PE RVU 1.79 **2020 Fac PE RVU:** 1.82

RUC Recommendation: 3.67 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2010

45382 **Colonoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,121

2007 Work RVU: 5.68 **2020 Work RVU:** 4.66
2007 NF PE RVU: 10.04 **2020 NF PE RVU:** 14.85
2007 Fac PE RVU 2.37 **2020 Fac PE RVU:** 2.31

RUC Recommendation: 4.76 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45383 **Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 5.86 **2020 Work RVU:**
2007 NF PE RVU: 8.08 **2020 NF PE RVU:**
2007 Fac PE RVU 2.34 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45384 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 77,739

2007 Work RVU: 4.69 **2020 Work RVU:** 4.07
2007 NF PE RVU: 6.9 **2020 NF PE RVU:** 8.90
2007 Fac PE RVU 1.93 **2020 Fac PE RVU:**1.97

RUC Recommendation: 4.17 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45385 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List / Codes Reported Together 75%or More-Part4 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 971,282

2007 Work RVU: 5.30 **2020 Work RVU:** 4.57
2007 NF PE RVU: 7.94 **2020 NF PE RVU:** 7.58
2007 Fac PE RVU 2.18 **2020 Fac PE RVU:**2.26

RUC Recommendation: 4.57 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45386 **Colonoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,321

2007 Work RVU: 4.57 **2020 Work RVU:** 3.77
2007 NF PE RVU: 12.37 **2020 NF PE RVU:** 13.20
2007 Fac PE RVU 1.89 **2020 Fac PE RVU:** 1.90

RUC Recommendation: 3.87 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45387 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)** **Global:** **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 5.90 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 2.49 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45388 **Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 26,744

2007 Work RVU: **2020 Work RVU:** 4.88
2007 NF PE RVU: **2020 NF PE RVU:** 77.42
2007 Fac PE RVU **2020 Fac PE RVU:** 2.35

RUC Recommendation: 4.98 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45389 **Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 420

2007 Work RVU: **2020 Work RVU:** 5.24
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.53

RUC Recommendation: 5.50 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45390 **Colonoscopy, flexible; with endoscopic mucosal resection**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 23,129

2007 Work RVU: **2020 Work RVU:** 6.04
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.92

RUC Recommendation: 6.35 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45391 **Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 932

2007 Work RVU: 5.09 **2020 Work RVU:** 4.64
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.13 **2020 Fac PE RVU:** 2.30

RUC Recommendation: 4.95 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45392 **Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 86

2007 Work RVU: 6.54 **2020 Work RVU:** 5.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.65 **2020 Fac PE RVU:** 2.68

RUC Recommendation: 5.60 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45393 **Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,112

2007 Work RVU: **2020 Work RVU:** 4.68
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.05

RUC Recommendation: 4.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45398 **Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,509

2007 Work RVU: **2020 Work RVU:** 4.20
2007 NF PE RVU: **2020 NF PE RVU:** 17.55
2007 Fac PE RVU **2020 Fac PE RVU:** 2.01

RUC Recommendation: 4.30 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

46020 **Placement of seton**

Global: 010 **Issue:** Placement/Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,325

2007 Work RVU: 2.94 **2020 Work RVU:** 3.00
2007 NF PE RVU: 2.56 **2020 NF PE RVU:** 4.57
2007 Fac PE RVU 1.98 **2020 Fac PE RVU:**3.29

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

46030 **Removal of anal seton, other marker**

Global: 010 **Issue:** Placement/ Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** April 2020 **2019 est Medicare Utilization:** 339

2007 Work RVU: 1.24 **2020 Work RVU:** 1.26
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 2.65
2007 Fac PE RVU 0.74 **2020 Fac PE RVU:**1.11

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 992

2007 Work RVU: 3.48 **2020 Work RVU:** 3.59
2007 NF PE RVU: 4.46 **2020 NF PE RVU:** 9.04
2007 Fac PE RVU 3.08 **2020 Fac PE RVU:**5.33

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

46500 **Injection of sclerosing solution, hemorrhoids**

Global: 010 **Issue:** Hemorrhoid Injection **Screen:** 010-Day Global Post-Operative Visits / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 24 **Specialty Developing Recommendation:** ACS, ASCRS (colon) **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,575

2007 Work RVU: 1.64 **2020 Work RVU:** 1.74
2007 NF PE RVU: 2.48 **2020 NF PE RVU:** 6.53
2007 Fac PE RVU 1.18 **2020 Fac PE RVU:** 3.19

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47011 **Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.69 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

47135 **Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age**

Global: 090 **Issue:** Liver Allotransplantation **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 14 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,590

2007 Work RVU: 83.29 **2020 Work RVU:** 90.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 30.59 **2020 Fac PE RVU:** 45.00

RUC Recommendation: 91.78 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47136 **Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age**

Global: **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 52 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 70.39 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 26.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

47382 **Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency**

Global: 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 3,121

2007 Work RVU: 15.19 **2020 Work RVU:** 14.97
2007 NF PE RVU: NA **2020 NF PE RVU:** 109.03
2007 Fac PE RVU 5.83 **2020 Fac PE RVU:**5.21

RUC Recommendation: New PE Inputs **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: PE Only

47490 **Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation**

Global: 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 04 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,075

2007 Work RVU: 8.05 **2020 Work RVU:** 4.76
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.32 **2020 Fac PE RVU:**4.42

RUC Recommendation: 4.76 **Referred to CPT** June 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

47500 **Injection procedure for percutaneous transhepatic cholangiography**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2019 est Medicare Utilization:

2007 Work RVU: 1.96

2020 Work RVU:

2007 NF PE RVU: NA

2020 NF PE RVU:

2007 Fac PE RVU 0.62

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47505 **Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2019 est Medicare Utilization:

2007 Work RVU: 0.76

2020 Work RVU:

2007 NF PE RVU: NA

2020 NF PE RVU:

2007 Fac PE RVU 0.24

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47510 **Introduction of percutaneous transhepatic catheter for biliary drainage**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2019 est Medicare Utilization:

2007 Work RVU: 7.94

2020 Work RVU:

2007 NF PE RVU: NA

2020 NF PE RVU:

2007 Fac PE RVU 4.76

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47511 **Introduction of percutaneous transhepatic stent for internal and external biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 10.74 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.87 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

47525 **Change of percutaneous biliary drainage catheter**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 5.55 **2020 Work RVU:**
2007 NF PE RVU: 14.8 **2020 NF PE RVU:**
2007 Fac PE RVU 2.67 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

47530 **Revision and/or reinsertion of transhepatic tube**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 5.96 **2020 Work RVU:**
2007 NF PE RVU: 32.56 **2020 NF PE RVU:**
2007 Fac PE RVU 3.53 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

47531 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 8,621

RUC Recommendation: 1.30 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 1.30
2007 NF PE RVU: **2020 NF PE RVU:** 9.58
2007 Fac PE RVU **2020 Fac PE RVU:** 0.63
Result: Increase

47532 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 549

RUC Recommendation: 4.50 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 19.49
2007 Fac PE RVU **2020 Fac PE RVU:** 1.51
Result: Increase

47533 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,518

RUC Recommendation: 5.63 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 5.38
2007 NF PE RVU: **2020 NF PE RVU:** 29.94
2007 Fac PE RVU **2020 Fac PE RVU:** 1.86
Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

47534 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 4,467

RUC Recommendation: 7.85 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 7.60
2007 NF PE RVU: **2020 NF PE RVU:** 32.45
2007 Fac PE RVU **2020 Fac PE RVU:** 2.53
Result: Increase

47535 **Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 438

RUC Recommendation: 4.20 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.95
2007 NF PE RVU: **2020 NF PE RVU:** 23.90
2007 Fac PE RVU **2020 Fac PE RVU:** 1.39
Result: Increase

47536 **Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 14,577

RUC Recommendation: 2.86 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 2.61
2007 NF PE RVU: **2020 NF PE RVU:** 17.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.99
Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

47537 **Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,737

2007 Work RVU: **2020 Work RVU:** 1.84
2007 NF PE RVU: **2020 NF PE RVU:** 10.81
2007 Fac PE RVU **2020 Fac PE RVU:** 0.79

RUC Recommendation: 1.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47538 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,025

2007 Work RVU: **2020 Work RVU:** 4.75
2007 NF PE RVU: **2020 NF PE RVU:** 116.70
2007 Fac PE RVU **2020 Fac PE RVU:** 1.70

RUC Recommendation: 5.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47539 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 135

2007 Work RVU: **2020 Work RVU:** 8.75
2007 NF PE RVU: **2020 NF PE RVU:** 124.83
2007 Fac PE RVU **2020 Fac PE RVU:** 2.78

RUC Recommendation: 9.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47540 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2015 **2019 est Medicare Utilization:** 223

2007 Work RVU: **2020 Work RVU:** 9.03

2007 NF PE RVU: **2020 NF PE RVU:** 127.27

2007 Fac PE RVU **2020 Fac PE RVU:** 2.98

RUC Recommendation: 9.28

Referred to CPT February 2015

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47541 **Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2015 **2019 est Medicare Utilization:** 170

2007 Work RVU: **2020 Work RVU:** 6.75

2007 NF PE RVU: **2020 NF PE RVU:** 27.27

2007 Fac PE RVU **2020 Fac PE RVU:** 2.29

RUC Recommendation: 7.00

Referred to CPT February 2015

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47542 **Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2015 **2019 est Medicare Utilization:** 1,346

2007 Work RVU: **2020 Work RVU:** 2.85

2007 NF PE RVU: **2020 NF PE RVU:** 11.67

2007 Fac PE RVU **2020 Fac PE RVU:** 0.85

RUC Recommendation: 2.85

Referred to CPT February 2015

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47543 **Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 692

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 9.92
2007 Fac PE RVU **2020 Fac PE RVU:** 0.94
Result: Increase

47544 **Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 322

RUC Recommendation: 3.28 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.28
2007 NF PE RVU: **2020 NF PE RVU:** 24.74
2007 Fac PE RVU **2020 Fac PE RVU:** 0.99
Result: Increase

47560 **Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy**

Global: **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** **First Identified:** July 2013 **2019 est Medicare Utilization:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 4.88 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

47562 **Laparoscopy, surgical; cholecystectomy**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ACS

First Identified: September 2011 **2019 est Medicare Utilization:** 100,881

2007 Work RVU: 11.63 **2020 Work RVU:** 10.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.06 **2020 Fac PE RVU:**6.22

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

47563 **Laparoscopy, surgical; cholecystectomy with cholangiography**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:** 38,983

2007 Work RVU: 12.03 **2020 Work RVU:** 11.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.24 **2020 Fac PE RVU:**6.68

RUC Recommendation: No further action. 12.11

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

47600 **Cholecystectomy;**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 36 **Specialty Developing Recommendation:** ACS, SAGES

First Identified: September 2011 **2019 est Medicare Utilization:** 8,195

2007 Work RVU: 17.35 **2020 Work RVU:** 17.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.4 **2020 Fac PE RVU:**9.56

RUC Recommendation: 20.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

47605 **Cholecystectomy; with cholangiography**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,408

2007 Work RVU: 15.90 **2020 Work RVU:** 18.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.47 **2020 Fac PE RVU:**9.93

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

48102 **Biopsy of pancreas, percutaneous needle**

Global: 010 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 960

2007 Work RVU: 4.68 **2020 Work RVU:** 4.70
2007 NF PE RVU: 8.21 **2020 NF PE RVU:** 10.29
2007 Fac PE RVU 1.85 **2020 Fac PE RVU:**1.81

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

48511 **External drainage, pseudocyst of pancreas; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.99 **2020 Work RVU:**
2007 NF PE RVU: 20.43 **2020 NF PE RVU:**
2007 Fac PE RVU 1.27 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49021 **Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: 20.43 **2020 NF PE RVU:**
2007 Fac PE RVU 1.07 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

49041 **Drainage of subdiaphragmatic or subphrenic abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.99 **2020 Work RVU:**
2007 NF PE RVU: 19.33 **2020 NF PE RVU:**
2007 Fac PE RVU 1.27 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

49061 **Drainage of retroperitoneal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.69 **2020 Work RVU:**
2007 NF PE RVU: 19.38 **2020 NF PE RVU:**
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

49080 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 1.35 **2020 Work RVU:**
2007 NF PE RVU: 3.63 **2020 NF PE RVU:**
2007 Fac PE RVU 0.45 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.26 **2020 Work RVU:**
2007 NF PE RVU: 2.65 **2020 NF PE RVU:**
2007 Fac PE RVU 0.43 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49082 **Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,210

2007 Work RVU: **2020 Work RVU:** 1.24
2007 NF PE RVU: **2020 NF PE RVU:** 4.40
2007 Fac PE RVU **2020 Fac PE RVU:** 0.72

RUC Recommendation: 1.35 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 **Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 265,269

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 6.38
2007 Fac PE RVU **2020 Fac PE RVU:** 0.93

RUC Recommendation: 2.00 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49084 **Peritoneal lavage, including imaging guidance, when performed**

Global: 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,879

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.73

RUC Recommendation: 2.50 **Referred to CPT** June 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

49405 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,880

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 20.79
2007 Fac PE RVU **2020 Fac PE RVU:** 1.36

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49406 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,397

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 20.79
2007 Fac PE RVU **2020 Fac PE RVU:** 1.36

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49407 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 243

2007 Work RVU: **2020 Work RVU:** 4.25
2007 NF PE RVU: **2020 NF PE RVU:** 15.99
2007 Fac PE RVU **2020 Fac PE RVU:** 1.39

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49418 **Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,497

2007 Work RVU: **2020 Work RVU:** 3.96
2007 NF PE RVU: **2020 NF PE RVU:** 29.76
2007 Fac PE RVU **2020 Fac PE RVU:** 1.53

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 **Deleted from CPT**

Global: **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 2.22 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.11 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49421 **Insertion of tunneled intraperitoneal catheter for dialysis, open** **Global:** 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,848

2007 Work RVU: 5.87 **2020 Work RVU:** 4.21
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.15 **2020 Fac PE RVU:**1.49

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49422 **Removal of tunneled intraperitoneal catheter** **Global:** 000 **Issue:** Removal of Intraperitoneal Catheter **Screen:** Site of Service Anomaly - 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 14 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** October 2016 **2019 est Medicare Utilization:** 12,368

2007 Work RVU: 6.26 **2020 Work RVU:** 4.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.82 **2020 Fac PE RVU:**1.57

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49505 **Repair initial inguinal hernia, age 5 years or older; reducible** **Global:** 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 50,710

2007 Work RVU: 7.88 **2020 Work RVU:** 7.96
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.78 **2020 Fac PE RVU:**5.32

RUC Recommendation: Reaffirmed **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 10,329

2007 Work RVU: 9.97 **2020 Work RVU:** 9.09
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.46 **2020 Fac PE RVU:**5.81

RUC Recommendation: 10.05 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,809

2007 Work RVU: 12.36 **2020 Work RVU:** 11.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.18 **2020 Fac PE RVU:**6.67

RUC Recommendation: 12.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49565 **Repair recurrent incisional or ventral hernia; reducible** **Global:** 090 **Issue:** Repair Recurrent Hernia **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 24 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,211

2007 Work RVU: 12.29 **2020 Work RVU:** 12.37
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.19 **2020 Fac PE RVU:**7.12

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,947

2007 Work RVU: 7.96 **2020 Work RVU:** 7.08
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.77 **2020 Fac PE RVU:**5.10

RUC Recommendation: 8.04 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 9,327

2007 Work RVU: **2020 Work RVU:** 11.92
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**6.93

RUC Recommendation: 12.88 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 5,848

2007 Work RVU: **2020 Work RVU:** 14.94
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 8.58

RUC Recommendation: 16.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,253

2007 Work RVU: **2020 Work RVU:** 13.76
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 7.61

RUC Recommendation: 15.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49655 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 4,804

2007 Work RVU: **2020 Work RVU:** 16.84
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 9.27

RUC Recommendation: 18.11 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50021 **Drainage of perirenal or renal abscess; percutaneous** **Global:** **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: 21.23 **2020 NF PE RVU:**
2007 Fac PE RVU 1.07 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 25 **Specialty Developing Recommendation:** AUA

First Identified:

2019 est Medicare Utilization: 2,659

2007 Work RVU: 15.61 **2020 Work RVU:** 15.74

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 6.88 **2020 Fac PE RVU:**7.55

RUC Recommendation: Refer to CPT

Referred to CPT February 2021

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

50081 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 25 **Specialty Developing Recommendation:** AUA

First Identified: October 2019

2019 est Medicare Utilization: 5,937

2007 Work RVU: 23.32 **2020 Work RVU:** 23.50

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 9.68 **2020 Fac PE RVU:**10.69

RUC Recommendation: Refer to CPT

Referred to CPT February 2021

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

50200 **Renal biopsy; percutaneous, by trocar or needle**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR

First Identified: NA

2019 est Medicare Utilization: 38,395

2007 Work RVU: 2.63 **2020 Work RVU:** 2.38

2007 NF PE RVU: NA **2020 NF PE RVU:** 12.87

2007 Fac PE RVU 1.24 **2020 Fac PE RVU:**1.10

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

50360 **Renal allotransplantation, implantation of graft; without recipient nephrectomy** **Global:** 090 **Issue:** Renal Allotransplantation **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2012 **2019 est Medicare Utilization:** 12,479

2007 Work RVU: 40.45 **2020 Work RVU:** 39.88
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 16.32 **2020 Fac PE RVU:** 21.27

RUC Recommendation: 40.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50387 **Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation** **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,721

2007 Work RVU: 2.00 **2020 Work RVU:** 1.75
2007 NF PE RVU: 16.66 **2020 NF PE RVU:** 13.72
2007 Fac PE RVU 0.65 **2020 Fac PE RVU:** 0.53

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50392 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous** **Global:** **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.46 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50393 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 4.15 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.71 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

50394 **Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.76 **2020 Work RVU:**
2007 NF PE RVU: 2.45 **2020 NF PE RVU:**
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

50395 **Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous**

Global: **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.47 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50398 **Change of nephrostomy or pyelostomy tube**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 1.46 **2020 Work RVU:**
2007 NF PE RVU: 15.06 **2020 NF PE RVU:**
2007 Fac PE RVU 0.51 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

50430 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014 **2019 est Medicare Utilization:** 1,007

2007 Work RVU: **2020 Work RVU:** 2.90
2007 NF PE RVU: **2020 NF PE RVU:** 13.00
2007 Fac PE RVU **2020 Fac PE RVU:** 1.29

RUC Recommendation: 3.15

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

50431 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014 **2019 est Medicare Utilization:** 8,818

2007 Work RVU: **2020 Work RVU:** 1.10
2007 NF PE RVU: **2020 NF PE RVU:** 6.17
2007 Fac PE RVU **2020 Fac PE RVU:** 0.69

RUC Recommendation: 1.42

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

50432 **Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 28,285

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** 20.95
2007 Fac PE RVU **2020 Fac PE RVU:** 1.61

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50433 **Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 5,572

2007 Work RVU: **2020 Work RVU:** 5.05
2007 NF PE RVU: **2020 NF PE RVU:** 27.24
2007 Fac PE RVU **2020 Fac PE RVU:** 1.91

RUC Recommendation: 5.05 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50434 **Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,477

2007 Work RVU: **2020 Work RVU:** 3.75
2007 NF PE RVU: **2020 NF PE RVU:** 21.99
2007 Fac PE RVU **2020 Fac PE RVU:** 1.49

RUC Recommendation: 4.20 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50435 **Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,684

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 14.06
2007 Fac PE RVU **2020 Fac PE RVU:** 0.91

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50436 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 607

2007 Work RVU: **2020 Work RVU:** 2.78
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.30

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

50437 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,196

2007 Work RVU: **2020 Work RVU:** 4.85
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.97

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 197

2007 Work RVU: 21.18 **2020 Work RVU:** 21.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.93 **2020 Fac PE RVU:**9.85

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 2,422

2007 Work RVU: 25.26 **2020 Work RVU:** 25.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.99 **2020 Fac PE RVU:**10.57

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50590 **Lithotripsy, extracorporeal shock wave**

Global: 090 **Issue:** Lithotripsy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 42 **Specialty Developing Recommendation:** AUA

First Identified: September 2011 **2019 est Medicare Utilization:** 54,658

2007 Work RVU: 9.64 **2020 Work RVU:** 9.77
2007 NF PE RVU: 13.6 **2020 NF PE RVU:** 10.27
2007 Fac PE RVU 4.65 **2020 Fac PE RVU:**5.52

RUC Recommendation: 9.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

50605 **Ureterotomy for insertion of indwelling stent, all types**

Global: 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AUA, SIR

First Identified: October 2008 **2019 est Medicare Utilization:** 3,602

2007 Work RVU: 16.66 **2020 Work RVU:** 16.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.06 **2020 Fac PE RVU:**8.67

RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

50606 **Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 08 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014 **2019 est Medicare Utilization:** 104

RUC Recommendation: 3.16

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.16

2007 NF PE RVU: **2020 NF PE RVU:** 14.36

2007 Fac PE RVU **2020 Fac PE RVU:** 0.97

Result: Increase

50693 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014 **2019 est Medicare Utilization:** 4,504

RUC Recommendation: 4.60

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 3.96

2007 NF PE RVU: **2020 NF PE RVU:** 25.37

2007 Fac PE RVU **2020 Fac PE RVU:** 1.62

Result: Increase

50694 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014 **2019 est Medicare Utilization:** 981

RUC Recommendation: 6.00

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 5.25

2007 NF PE RVU: **2020 NF PE RVU:** 27.24

2007 Fac PE RVU **2020 Fac PE RVU:** 2.07

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

50695 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,321

2007 Work RVU: **2020 Work RVU:** 6.80
2007 NF PE RVU: **2020 NF PE RVU:** 32.54
2007 Fac PE RVU **2020 Fac PE RVU:** 2.59

RUC Recommendation: 7.55 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50705 **Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 65

2007 Work RVU: **2020 Work RVU:** 4.03
2007 NF PE RVU: **2020 NF PE RVU:** 49.62
2007 Fac PE RVU **2020 Fac PE RVU:** 0.68

RUC Recommendation: 4.03 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50706 **Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,459

2007 Work RVU: **2020 Work RVU:** 3.80
2007 NF PE RVU: **2020 NF PE RVU:** 22.82
2007 Fac PE RVU **2020 Fac PE RVU:** 1.16

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51040 **Cystostomy, cystotomy with drainage**

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 5,029

2007 Work RVU: 4.43 **2020 Work RVU:** 4.49
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.01 **2020 Fac PE RVU:**3.33

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

51102 **Aspiration of bladder; with insertion of suprapubic catheter**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 14,265

2007 Work RVU: **2020 Work RVU:** 2.70
2007 NF PE RVU: **2020 NF PE RVU:** 3.78
2007 Fac PE RVU **2020 Fac PE RVU:**1.20

RUC Recommendation: 2.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51700 **Bladder irrigation, simple, lavage and/or instillation**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 194,801

2007 Work RVU: 0.88 **2020 Work RVU:** 0.60
2007 NF PE RVU: 1.58 **2020 NF PE RVU:** 1.45
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:**0.21

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51701 **Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 168,108

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 1.45 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.18

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

51702 **Insertion of temporary indwelling bladder catheter; simple (eg, Foley)** **Global:** 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 234,004

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 1.94 **2020 NF PE RVU:** 1.18
2007 Fac PE RVU 0.27 **2020 Fac PE RVU:**0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

51703 **Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)** **Global:** 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 54,647

2007 Work RVU: 1.47 **2020 Work RVU:** 1.47
2007 NF PE RVU: 2.62 **2020 NF PE RVU:** 2.33
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**0.58

RUC Recommendation: 1.47 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

51720 **Bladder instillation of anticarcinogenic agent (including retention time)** **Global:** 000 **Issue:** Treatment of Bladder Lesion **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 33 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 160,447

2007 Work RVU: 1.50 **2020 Work RVU:** 0.87
2007 NF PE RVU: 1.72 **2020 NF PE RVU:** 1.42
2007 Fac PE RVU 0.71 **2020 Fac PE RVU:**0.30

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51726 **Complex cystometrogram (ie, calibrated electronic equipment);** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,438

2007 Work RVU: 1.71 **2020 Work RVU:** 1.71
2007 NF PE RVU: 7.41 **2020 NF PE RVU:** 6.37
2007 Fac PE RVU 7.41 **2020 Fac PE RVU:**NA

RUC Recommendation: 1.71 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2007 Work RVU: **2020 Work RVU:** 2.11
2007 NF PE RVU: **2020 NF PE RVU:** 7.54
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 85,150

2007 Work RVU: **2020 Work RVU:** 2.11
2007 NF PE RVU: **2020 NF PE RVU:** 7.69
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,880

2007 Work RVU: **2020 Work RVU:** 2.51
2007 NF PE RVU: **2020 NF PE RVU:** 7.89
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.51 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51736 **Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 11 **Specialty Developing Recommendation:** AUA **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,797

2007 Work RVU: 0.61 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.67 **2020 NF PE RVU:** 0.20
2007 Fac PE RVU 0.67 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 **Complex uroflowmetry (eg, calibrated electronic equipment)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 11 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 423,494

2007 Work RVU: 1.14 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.91 **2020 NF PE RVU:** 0.21
2007 Fac PE RVU 0.91 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51772 **Deleted from CPT** **Global:** **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.61 **2020 Work RVU:**
2007 NF PE RVU: 5.44 **2020 NF PE RVU:**
2007 Fac PE RVU 5.44 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51784 **Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique**

Global: XXX **Issue:** Electromyography Studies (EMG) **Screen:** Codes Reported Together 75% or More-Part2 / CMS High Expenditure Procedural Codes2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AUA

First Identified: October 2012 **2019 est Medicare Utilization:** 142,000

2007 Work RVU: 1.53 **2020 Work RVU:** 0.75
2007 NF PE RVU: 3.95 **2020 NF PE RVU:** 1.08
2007 Fac PE RVU 3.95 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.75. Maintain, CPT Assistant addressed issues identified.

Referred to CPT February 2014 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51792 **Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)**

Global: 000 **Issue:** Urinary Reflex Studies with EMG **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AUA

First Identified: October 2012 **2019 est Medicare Utilization:** 7,152

2007 Work RVU: 1.10 **2020 Work RVU:** 1.10
2007 NF PE RVU: 5.74 **2020 NF PE RVU:** 5.83
2007 Fac PE RVU 5.74 **2020 Fac PE RVU:**NA

RUC Recommendation: CPT edits and CPT Assistant article complete.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51795 **Deleted from CPT**

Global: **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:**

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.53 **2020 Work RVU:**
2007 NF PE RVU: 7.15 **2020 NF PE RVU:**
2007 Fac PE RVU 7.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51797 **Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:**

First Identified: February 2008 **2019 est Medicare Utilization:** 116,064

2007 Work RVU: 1.60 **2020 Work RVU:** 0.80
2007 NF PE RVU: 5.55 **2020 NF PE RVU:** 3.73
2007 Fac PE RVU 5.55 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.80

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

51798 **Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging**

Global: XXX **Issue:** Voiding Pressure Studies **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 25 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 2,169,510

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.4 **2020 NF PE RVU:** 0.28
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

52000 **Cystourethroscopy (separate procedure)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 35 **Specialty Developing Recommendation:** AUA, ACOG

First Identified: October 2010 **2019 est Medicare Utilization:** 897,375

2007 Work RVU: 2.23 **2020 Work RVU:** 1.53
2007 NF PE RVU: 3.4 **2020 NF PE RVU:** 4.28
2007 Fac PE RVU 0.91 **2020 Fac PE RVU:**0.62

RUC Recommendation: 1.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

52214 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AUA

First Identified: June 2008

2019 est Medicare Utilization: 16,853

2007 Work RVU: 3.70 **2020 Work RVU:** 3.50
2007 NF PE RVU: 33.55 **2020 NF PE RVU:** 16.90
2007 Fac PE RVU 1.47 **2020 Fac PE RVU:**1.18

RUC Recommendation: 3.50

Referred to CPT

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52224 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AUA

First Identified: February 2008

2019 est Medicare Utilization: 36,291

2007 Work RVU: 3.14 **2020 Work RVU:** 4.05
2007 NF PE RVU: 32.11 **2020 NF PE RVU:** 17.22
2007 Fac PE RVU 1.28 **2020 Fac PE RVU:**1.37

RUC Recommendation: 4.05

Referred to CPT

Result: Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52234 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AUA

First Identified: September 2011

2019 est Medicare Utilization: 28,317

2007 Work RVU: 4.62 **2020 Work RVU:** 4.62
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.83 **2020 Fac PE RVU:**1.93

RUC Recommendation: Reivew action plan to determine if CPT Assistant article and CPT changes were effective. 4.62

Referred to CPT

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

Status Report: CMS Requests and Relativity Assessment Issues

52235 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,411

2007 Work RVU: 5.44 **2020 Work RVU:** 5.44
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.13 **2020 Fac PE RVU:**2.25

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52240 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,956

2007 Work RVU: 9.71 **2020 Work RVU:** 7.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.6 **2020 Fac PE RVU:**2.95

RUC Recommendation: Reivew action plan to determine if CPT Assistant article and CPT changes were effective. 8.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52281 **Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 62,618

2007 Work RVU: 2.80 **2020 Work RVU:** 2.75
2007 NF PE RVU: 6.65 **2020 NF PE RVU:** 6.09
2007 Fac PE RVU 1.21 **2020 Fac PE RVU:**1.30

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52287 **Cystourethroscopy, with injection(s) for chemodenervation of the bladder** **Global:** 000 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 51,037

2007 Work RVU: **2020 Work RVU:** 3.20
2007 NF PE RVU: **2020 NF PE RVU:** 6.68
2007 Fac PE RVU **2020 Fac PE RVU:** 1.30

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 **Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 13 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 151,015

2007 Work RVU: 2.83 **2020 Work RVU:** 2.82
2007 NF PE RVU: 7.42 **2020 NF PE RVU:** 9.81
2007 Fac PE RVU 1.19 **2020 Fac PE RVU:** 1.32

RUC Recommendation: 2.82 **Referred to CPT** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

52334 **Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde** **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 289

2007 Work RVU: 4.82 **2020 Work RVU:** 3.37
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.89 **2020 Fac PE RVU:** 1.51

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 2,487

2007 Work RVU: 6.11 **2020 Work RVU:** 5.35
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.44 **2020 Fac PE RVU:**2.22
Result: Decrease

RUC Recommendation: 5.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 191

2007 Work RVU: 6.61 **2020 Work RVU:** 5.85
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.59 **2020 Fac PE RVU:**2.39
Result: Decrease

RUC Recommendation: 5.85

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 21

2007 Work RVU: 7.31 **2020 Work RVU:** 6.55
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.84 **2020 Fac PE RVU:**2.62
Result: Decrease

RUC Recommendation: 6.55

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,393

2007 Work RVU: 7.81 **2020 Work RVU:** 7.05
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.09 **2020 Fac PE RVU:**2.79
Result: Decrease

RUC Recommendation: 7.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 480

2007 Work RVU: 8.31 **2020 Work RVU:** 7.55
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.27 **2020 Fac PE RVU:**2.96
Result: Decrease

RUC Recommendation: 7.55 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 212

2007 Work RVU: 9.34 **2020 Work RVU:** 8.58
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.62 **2020 Fac PE RVU:**3.32
Result: Decrease

RUC Recommendation: 8.58 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

52351 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic** **Global:** 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,929

2007 Work RVU: 5.85 **2020 Work RVU:** 5.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.36 **2020 Fac PE RVU:**2.32
Result: Decrease

RUC Recommendation: 5.75 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

52352 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)** **Global:** 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,811

2007 Work RVU: 6.87 **2020 Work RVU:** 6.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.77 **2020 Fac PE RVU:**2.69
Result: Decrease

RUC Recommendation: 6.75 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52353 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 13 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 11,180

2007 Work RVU: 7.96 **2020 Work RVU:** 7.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.14 **2020 Fac PE RVU:** 2.95

RUC Recommendation: 7.50 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 9,144

2007 Work RVU: 7.33 **2020 Work RVU:** 8.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.94 **2020 Fac PE RVU:** 3.12

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,007

2007 Work RVU: 8.81 **2020 Work RVU:** 9.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.44 **2020 Fac PE RVU:** 3.45

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52356 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 13 **Specialty Developing Recommendation:** AUA **First Identified:** January 2013 **2019 est Medicare Utilization:** 78,507

2007 Work RVU: **2020 Work RVU:** 8.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.08
Result: Decrease

RUC Recommendation: 8.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 115

2007 Work RVU: 10.06 **2020 Work RVU:** 8.69
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.18 **2020 Fac PE RVU:** 4.09
Result: Decrease

RUC Recommendation: 8.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52442 **Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PE Subcommittee **Screen:** PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AUA, AACU **First Identified:** April 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.01
2007 NF PE RVU: **2020 NF PE RVU:** 27.06
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34
Result: Maintain

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,173

2007 Work RVU: 9.39 **2020 Work RVU:** 8.14
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.52 **2020 Fac PE RVU:**5.04

RUC Recommendation: 8.14 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

52601 **Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)** **Global:** 090 **Issue:** Transurethral Electrosurgical Resection of Prostate (TURP) **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2015 **2019 est Medicare Utilization:** 44,942

2007 Work RVU: 15.13 **2020 Work RVU:** 13.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.99 **2020 Fac PE RVU:**6.39

RUC Recommendation: 13.16 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,396

2007 Work RVU: 6.89 **2020 Work RVU:** 4.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.35 **2020 Fac PE RVU:**3.79

RUC Recommendation: 4.79 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

52648 **Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)**

Global: 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 18,059

2007 Work RVU: 12.00 **2020 Work RVU:** 12.15
2007 NF PE RVU: 66.1 **2020 NF PE RVU:** 34.28
2007 Fac PE RVU 5.44 **2020 Fac PE RVU:**6.40

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Remove from Screen

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53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,071

2007 Work RVU: 15.21 **2020 Work RVU:** 13.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.55 **2020 Fac PE RVU:**7.29

RUC Recommendation: 13.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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53850 **Transurethral destruction of prostate tissue; by microwave thermotherapy**

Global: 090 **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 43 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,363

2007 Work RVU: 9.98 **2020 Work RVU:** 5.42
2007 NF PE RVU: 82.87 **2020 NF PE RVU:** 38.30
2007 Fac PE RVU 4.46 **2020 Fac PE RVU:**4.06

RUC Recommendation: 10.08 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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Status Report: CMS Requests and Relativity Assessment Issues

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,217

RUC Recommendation: 14.39 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 14.39 **2020 Work RVU:** 14.52
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.51 **2020 Fac PE RVU:**7.18
Result: Maintain

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,286

RUC Recommendation: 15.18 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 16.48 **2020 Work RVU:** 15.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.35 **2020 Fac PE RVU:**7.94
Result: Decrease

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach** **Global:** 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,671

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 5.25 **2020 Work RVU:** 5.30
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.03 **2020 Fac PE RVU:**3.45
Result: PE Only

54530 **Orchiectomy, radical, for tumor; inguinal approach** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,190

RUC Recommendation: 8.46 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 9.31 **2020 Work RVU:** 8.46
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.72 **2020 Fac PE RVU:**5.17
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

55700 **Biopsy, prostate; needle or punch, single or multiple, any approach**

Global: 000 **Issue:** Biopsy of Prostate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 36 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 156,362

2007 Work RVU: 2.58 **2020 Work RVU:** 2.50
2007 NF PE RVU: 4.08 **2020 NF PE RVU:** 4.31
2007 Fac PE RVU 0.82 **2020 Fac PE RVU:**0.99

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

55706 **Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,297

2007 Work RVU: **2020 Work RVU:** 6.28
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:**3.80

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

55840 **Prostatectomy, retropubic radical, with or without nerve sparing;**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 1,610

2007 Work RVU: 24.45 **2020 Work RVU:** 21.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.19 **2020 Fac PE RVU:**9.98

RUC Recommendation: 21.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

55842 **Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 150

2007 Work RVU: 26.31 **2020 Work RVU:** 21.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.83 **2020 Fac PE RVU:**9.98

RUC Recommendation: 24.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55845 **Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes**

Global: 090 **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 31 **Specialty Developing Recommendation:** AUA

First Identified: July 2013

2019 est Medicare Utilization: 1,030

2007 Work RVU: 30.52 **2020 Work RVU:** 25.18

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 12.01 **2020 Fac PE RVU:** 11.28

RUC Recommendation: 29.07

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed**

Global: 090 **Issue:** Laparoscopic Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 27 **Specialty Developing Recommendation:** AUA

First Identified: September 2007

2019 est Medicare Utilization: 20,334

2007 Work RVU: 32.25 **2020 Work RVU:** 26.80

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 12.87 **2020 Fac PE RVU:** 11.80

RUC Recommendation: 26.80

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**

Global: 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 25 **Specialty Developing Recommendation:** AUA

First Identified: September 2007

2019 est Medicare Utilization: 1,648

2007 Work RVU: 20.25 **2020 Work RVU:** 13.60

2007 NF PE RVU: NA **2020 NF PE RVU:** 160.37

2007 Fac PE RVU 9.59 **2020 Fac PE RVU:** 6.90

RUC Recommendation: 13.45

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

55875 **Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy**

Global: 090 **Issue:** RAW **Screen:** RUC request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2019 est Medicare Utilization:** 6,399

2007 Work RVU: 13.31 **2020 Work RVU:** 13.46
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.38 **2020 Fac PE RVU:**7.35

RUC Recommendation: Review data at RAW **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Not Part of RAW

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)**

Global: 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,187

2007 Work RVU: 3.03 **2020 Work RVU:** 3.08
2007 NF PE RVU: 2.5 **2020 NF PE RVU:** 3.69
2007 Fac PE RVU 1.79 **2020 Fac PE RVU:**2.41

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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56620 **Vulvectomy simple; partial**

Global: 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** D **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,143

2007 Work RVU: 8.44 **2020 Work RVU:** 7.53
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.7 **2020 Fac PE RVU:**7.21

RUC Recommendation: 7.35 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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57150 **Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease**

Global: 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 15 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 24,482

2007 Work RVU: 0.55 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.97 **2020 NF PE RVU:** 0.95
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**0.19

RUC Recommendation: 0.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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Status Report: CMS Requests and Relativity Assessment Issues

57155 **Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,111

2007 Work RVU: 6.79 **2020 Work RVU:** 5.15
2007 NF PE RVU: NA **2020 NF PE RVU:** 5.33
2007 Fac PE RVU 4.3 **2020 Fac PE RVU:**2.56

RUC Recommendation: 5.40 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 **Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,369

2007 Work RVU: **2020 Work RVU:** 2.69
2007 NF PE RVU: **2020 NF PE RVU:** 3.25
2007 Fac PE RVU **2020 Fac PE RVU:**1.42

RUC Recommendation: 2.69 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57160 **Fitting and insertion of pessary or other intravaginal support device** **Global:** 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 15 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 85,733

2007 Work RVU: 0.89 **2020 Work RVU:** 0.89
2007 NF PE RVU: 1.02 **2020 NF PE RVU:** 0.94
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.33

RUC Recommendation: 0.89 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57240 **Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2015 **2019 est Medicare Utilization:** 9,026

2007 Work RVU: 11.42 **2020 Work RVU:** 10.08
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.22 **2020 Fac PE RVU:**5.96

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57250 **Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,757

2007 Work RVU: 11.42 **2020 Work RVU:** 10.08
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.93 **2020 Fac PE RVU:**6.00

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57260 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 9,740

2007 Work RVU: 14.36 **2020 Work RVU:** 13.25
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.08 **2020 Fac PE RVU:**7.18

RUC Recommendation: 13.25 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57265 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,370

2007 Work RVU: 15.86 **2020 Work RVU:** 15.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.1 **2020 Fac PE RVU:**7.86

RUC Recommendation: 15.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57282 **Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 7,042

2007 Work RVU: 7.84 **2020 Work RVU:** 7.97
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.48 **2020 Fac PE RVU:**6.03

RUC Recommendation: 13.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57283 **Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,777

2007 Work RVU: 11.58 **2020 Work RVU:** 11.66
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.74 **2020 Fac PE RVU:**6.81

RUC Recommendation: 13.51 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,737

2007 Work RVU: 11.49 **2020 Work RVU:** 11.15
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.73 **2020 Fac PE RVU:**8.02

RUC Recommendation: 10.97 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 25,452

2007 Work RVU: 14.01 **2020 Work RVU:** 12.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.21 **2020 Fac PE RVU:**7.37

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57425 **Laparoscopy, surgical, colpopexy (suspension of vaginal apex)** **Global:** 090 **Issue:** Laparoscopic Colopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 27 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 9,468

2007 Work RVU: 16.93 **2020 Work RVU:** 17.03
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.71 **2020 Fac PE RVU:**8.80

RUC Recommendation: 18.02 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

58100 **Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)** **Global:** 000 **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 68,910

2007 Work RVU: 1.53 **2020 Work RVU:** 1.21
2007 NF PE RVU: 1.27 **2020 NF PE RVU:** 1.40
2007 Fac PE RVU 0.69 **2020 Fac PE RVU:**0.46

RUC Recommendation: 1.21 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58110 **Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2017 **2019 est Medicare Utilization:** 672

2007 Work RVU: 0.77 **2020 Work RVU:** 0.77
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.57
2007 Fac PE RVU 0.29 **2020 Fac PE RVU:**0.30

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58555 **Hysteroscopy, diagnostic (separate procedure)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 1,494

2007 Work RVU: 3.33 **2020 Work RVU:** 2.65
2007 NF PE RVU: 2.32 **2020 NF PE RVU:** 6.19
2007 Fac PE RVU 1.47 **2020 Fac PE RVU:**1.35

RUC Recommendation: 3.07 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 47,694

2007 Work RVU: 4.74 **2020 Work RVU:** 4.17
2007 NF PE RVU: 2.52 **2020 NF PE RVU:** 34.80
2007 Fac PE RVU 2.05 **2020 Fac PE RVU:**1.93

RUC Recommendation: 4.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58559 **Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 121

2007 Work RVU: 6.16 **2020 Work RVU:** 5.20
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.56 **2020 Fac PE RVU:**2.32

RUC Recommendation: 5.54 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58560 **Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 44

2007 Work RVU: 6.99 **2020 Work RVU:** 5.75
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.88 **2020 Fac PE RVU:**2.51
Result: Decrease

RUC Recommendation: 6.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

58561 **Hysteroscopy, surgical; with removal of leiomyomata**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,396

2007 Work RVU: 9.99 **2020 Work RVU:** 6.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4 **2020 Fac PE RVU:**2.84
Result: Decrease

RUC Recommendation: 7.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 206

2007 Work RVU: 5.20 **2020 Work RVU:** 4.00
2007 NF PE RVU: 2.63 **2020 NF PE RVU:** 6.69
2007 Fac PE RVU 2.21 **2020 Fac PE RVU:**1.85
Result: Decrease

RUC Recommendation: 4.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 2,831

2007 Work RVU: 6.16 **2020 Work RVU:** 4.47
2007 NF PE RVU: 51.38 **2020 NF PE RVU:** 50.46
2007 Fac PE RVU 2.58 **2020 Fac PE RVU:**2.03

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2007 Work RVU: 11.54 **2020 Work RVU:** 11.59
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.07 **2020 Fac PE RVU:**6.08

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)**

Global: 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 13,081

2007 Work RVU: 11.30 **2020 Work RVU:** 11.35
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.84 **2020 Fac PE RVU:**5.71

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58823 **Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 3.37 **2020 Work RVU:**
2007 NF PE RVU: 20.75 **2020 NF PE RVU:**
2007 Fac PE RVU 1.08 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,825

2007 Work RVU: 26.80 **2020 Work RVU:** 32.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.06 **2020 Fac PE RVU:**21.24

RUC Recommendation: 32.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,615

2007 Work RVU: 13.48 **2020 Work RVU:** 14.37
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.91 **2020 Fac PE RVU:**5.57

RUC Recommendation: 14.37 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 823

2007 Work RVU: 15.29 **2020 Work RVU:** 18.01
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.96 **2020 Fac PE RVU:**7.77

RUC Recommendation: 18.54 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59412 **External cephalic version, with or without tocolysis**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 29

2007 Work RVU: 1.71 **2020 Work RVU:** 1.71
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.77 **2020 Fac PE RVU:**0.81
Result: Maintain

RUC Recommendation: 1.71

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 **Delivery of placenta (separate procedure)**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 56

2007 Work RVU: 1.61 **2020 Work RVU:** 1.61
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.59 **2020 Fac PE RVU:**0.61
Result: Maintain

RUC Recommendation: 1.61

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59425 **Antepartum care only; 4-6 visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 666

2007 Work RVU: 6.22 **2020 Work RVU:** 6.31
2007 NF PE RVU: 4.21 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU 1.81 **2020 Fac PE RVU:**2.43
Result: Decrease

RUC Recommendation: 6.31

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59426 **Antepartum care only; 7 or more visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 710

2007 Work RVU: 11.04 **2020 Work RVU:** 11.16
2007 NF PE RVU: 7.6 **2020 NF PE RVU:** 10.16
2007 Fac PE RVU 3.17 **2020 Fac PE RVU:**4.31
Result: Decrease

RUC Recommendation: 11.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59430 **Postpartum care only (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 1,138

2007 Work RVU: 2.13 **2020 Work RVU:** 2.47
2007 NF PE RVU: 1.19 **2020 NF PE RVU:** 2.87
2007 Fac PE RVU 0.88 **2020 Fac PE RVU:**0.96
Result: Increase

RUC Recommendation: 2.47

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,365

2007 Work RVU: 30.34 **2020 Work RVU:** 35.64
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 16.92 **2020 Fac PE RVU:**22.86
Result: Increase

RUC Recommendation: 36.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59514 **Cesarean delivery only;** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,266

2007 Work RVU: 15.95 **2020 Work RVU:** 16.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.78 **2020 Fac PE RVU:**6.16
Result: Increase

RUC Recommendation: 16.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59515 **Cesarean delivery only; including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 760

2007 Work RVU: 18.26 **2020 Work RVU:** 21.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.43 **2020 Fac PE RVU:**9.58
Result: Increase

RUC Recommendation: 22.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 89

2007 Work RVU: 28.21 **2020 Work RVU:** 33.87
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.52 **2020 Fac PE RVU:**21.51

RUC Recommendation: 34.40 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 65

2007 Work RVU: 15.04 **2020 Work RVU:** 16.09
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.6 **2020 Fac PE RVU:**6.07

RUC Recommendation: 16.09 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2007 Work RVU: 16.59 **2020 Work RVU:** 19.73
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.49 **2020 Fac PE RVU:**7.87

RUC Recommendation: 20.26 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 22

2007 Work RVU: 31.78 **2020 Work RVU:** 36.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 17.74 **2020 Fac PE RVU:**22.95

RUC Recommendation: 36.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 13

2007 Work RVU: 17.50 **2020 Work RVU:** 16.66
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.27 **2020 Fac PE RVU:**6.28

RUC Recommendation: 16.66 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 6

2007 Work RVU: 19.70 **2020 Work RVU:** 22.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.14 **2020 Fac PE RVU:**10.05

RUC Recommendation: 22.53 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,841

2007 Work RVU: 12.29 **2020 Work RVU:** 11.19
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.96 **2020 Fac PE RVU:**7.13

RUC Recommendation: 12.29 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 308

2007 Work RVU: 14.67 **2020 Work RVU:** 14.79

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 7.22 **2020 Fac PE RVU:**9.39

RUC Recommendation: 14.67

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

60520 **Thymectomy, partial or total; transcervical approach (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 437

2007 Work RVU: 17.07 **2020 Work RVU:** 17.16

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 7.95 **2020 Fac PE RVU:**9.32

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

60521 **Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 254

2007 Work RVU: 19.11 **2020 Work RVU:** 19.18

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 9.22 **2020 Fac PE RVU:**8.92

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

60522 **Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 120

2007 Work RVU: 23.37 **2020 Work RVU:** 23.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.89 **2020 Fac PE RVU:** 10.68

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61055 **Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 293

2007 Work RVU: 2.10 **2020 Work RVU:** 2.10
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.37 **2020 Fac PE RVU:** 1.06

RUC Recommendation: Editorial change

Referred to CPT October 2013

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61781 **Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS

First Identified: October 2009 **2019 est Medicare Utilization:** 15,851

2007 Work RVU: **2020 Work RVU:** 3.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.72

RUC Recommendation: 3.75

Referred to CPT October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61782 **Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,750

2007 Work RVU: **2020 Work RVU:** 3.18
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.37

RUC Recommendation: 3.18 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61783 **Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,207

2007 Work RVU: **2020 Work RVU:** 3.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.76

RUC Recommendation: 3.75 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61793 **Deleted from CPT**

Global: **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 17.75 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 10.08 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61795 **Deleted from CPT** **Global:** **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 4.03 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.87 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 6,704

2007 Work RVU: **2020 Work RVU:** 13.93
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 10.23

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 8,122

2007 Work RVU: **2020 Work RVU:** 3.48
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.60

RUC Recommendation: 3.48 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 3,528

2007 Work RVU: **2020 Work RVU:** 19.85
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 12.84

RUC Recommendation: 19.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:**

First Identified: NA **2019 est Medicare Utilization:** 570

2007 Work RVU: **2020 Work RVU:** 4.81
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 2.21

RUC Recommendation: 4.81 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 16 **Specialty Developing Recommendation:**

First Identified: February 2008 **2019 est Medicare Utilization:** 5,499

2007 Work RVU: **2020 Work RVU:** 2.25
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.34

RUC Recommendation: 2.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 14 **Specialty Developing Recommendation:** AANS/CNS

First Identified: September 2007 **2019 est Medicare Utilization:** 5,787

2007 Work RVU: 7.37 **2020 Work RVU:** 6.05
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.85 **2020 Fac PE RVU:** 6.76

RUC Recommendation: 6.44 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 66 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 302

2007 Work RVU: 6.41 **2020 Work RVU:** 5.00
2007 NF PE RVU: 11.78 **2020 NF PE RVU:** 12.03
2007 Fac PE RVU 3.11 **2020 Fac PE RVU:**3.43

RUC Recommendation: 6.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

62270 **Spinal puncture, lumbar, diagnostic;**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 09 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 79,126

2007 Work RVU: 1.37 **2020 Work RVU:** 1.22
2007 NF PE RVU: 2.82 **2020 NF PE RVU:** 2.59
2007 Fac PE RVU 0.55 **2020 Fac PE RVU:**0.41

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

62272 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,301

2007 Work RVU: 1.35 **2020 Work RVU:** 1.58
2007 NF PE RVU: 3.47 **2020 NF PE RVU:** 3.32
2007 Fac PE RVU 0.68 **2020 Fac PE RVU:**0.64

RUC Recommendation: 1.80 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA

First Identified: September 2007 **2019 est Medicare Utilization:** 390

2007 Work RVU: 2.66 **2020 Work RVU:** 2.66
2007 NF PE RVU: 5.16 **2020 NF PE RVU:** 3.91
2007 Fac PE RVU 0.89 **2020 Fac PE RVU:**1.66

RUC Recommendation: Remove 99238

Referred to CPT **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Q&A May 2010

62284 **Injection procedure for myelography and/or computed tomography, lumbar**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012 **2019 est Medicare Utilization:** 16,213

2007 Work RVU: 1.54 **2020 Work RVU:** 1.54
2007 NF PE RVU: 4.62 **2020 NF PE RVU:** 3.94
2007 Fac PE RVU 0.67 **2020 Fac PE RVU:**0.78

RUC Recommendation: 1.54

Referred to CPT October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

62287 **Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar**

Global: 090 **Issue:** Percutaneous Diskectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA

First Identified: September 2007 **2019 est Medicare Utilization:** 166

2007 Work RVU: 8.88 **2020 Work RVU:** 9.03
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.18 **2020 Fac PE RVU:**6.58

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62290 **Injection procedure for discography, each level; lumbar**

Global: 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,115

2007 Work RVU: 3.00 **2020 Work RVU:** 3.00
2007 NF PE RVU: 6.43 **2020 NF PE RVU:** 6.80
2007 Fac PE RVU 1.31 **2020 Fac PE RVU:**1.51

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

Result: Maintain

62302 **Myelography via lumbar injection, including radiological supervision and interpretation; cervical**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,191

2007 Work RVU: **2020 Work RVU:** 2.29
2007 NF PE RVU: **2020 NF PE RVU:** 4.89
2007 Fac PE RVU **2020 Fac PE RVU:**1.02

RUC Recommendation: 2.29

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62303 **Myelography via lumbar injection, including radiological supervision and interpretation; thoracic**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 411

2007 Work RVU: **2020 Work RVU:** 2.29
2007 NF PE RVU: **2020 NF PE RVU:** 5.03
2007 Fac PE RVU **2020 Fac PE RVU:**1.02

RUC Recommendation: 2.29

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62304 **Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,417

2007 Work RVU: **2020 Work RVU:** 2.25
2007 NF PE RVU: **2020 NF PE RVU:** 4.83
2007 Fac PE RVU **2020 Fac PE RVU:** 1.01

RUC Recommendation: 2.25 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62305 **Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 6,616

2007 Work RVU: **2020 Work RVU:** 2.35
2007 NF PE RVU: **2020 NF PE RVU:** 5.37
2007 Fac PE RVU **2020 Fac PE RVU:** 1.05

RUC Recommendation: 2.35 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62310 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 1.91 **2020 Work RVU:**
2007 NF PE RVU: 4.35 **2020 NF PE RVU:**
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62311 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.54 **2020 Work RVU:**
2007 NF PE RVU: 4.35 **2020 NF PE RVU:**
2007 Fac PE RVU 0.58 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62318 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 2.04 **2020 Work RVU:**
2007 NF PE RVU: 5.09 **2020 NF PE RVU:**
2007 Fac PE RVU 0.61 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62319 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 1.87 **2020 Work RVU:**
2007 NF PE RVU: 4.45 **2020 NF PE RVU:**
2007 Fac PE RVU 0.58 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62320 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 5,631

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 2.69
2007 Fac PE RVU **2020 Fac PE RVU:** 0.88

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62321 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 217,240

2007 Work RVU: **2020 Work RVU:** 1.95
2007 NF PE RVU: **2020 NF PE RVU:** 5.24
2007 Fac PE RVU **2020 Fac PE RVU:** 0.96

RUC Recommendation: 1.95 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62322 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 42,693

2007 Work RVU: **2020 Work RVU:** 1.55
2007 NF PE RVU: **2020 NF PE RVU:** 2.57
2007 Fac PE RVU **2020 Fac PE RVU:** 0.73

RUC Recommendation: 1.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62323 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 699,990

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 5.31
2007 Fac PE RVU **2020 Fac PE RVU:** 0.88

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62324 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 19,559

2007 Work RVU: **2020 Work RVU:** 1.89
2007 NF PE RVU: **2020 NF PE RVU:** 2.02
2007 Fac PE RVU **2020 Fac PE RVU:** 0.54

RUC Recommendation: 1.89 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62325 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,225

2007 Work RVU: **2020 Work RVU:** 2.20
2007 NF PE RVU: **2020 NF PE RVU:** 4.55
2007 Fac PE RVU **2020 Fac PE RVU:** 0.74

RUC Recommendation: 2.20 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62326 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 4,644

2007 Work RVU: **2020 Work RVU:** 1.78
2007 NF PE RVU: **2020 NF PE RVU:** 2.25
2007 Fac PE RVU **2020 Fac PE RVU:** 0.59

RUC Recommendation: 1.78 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62327 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS

First Identified: May 2015 **2019 est Medicare Utilization:** 1,995

2007 Work RVU: **2020 Work RVU:** 1.90
2007 NF PE RVU: **2020 NF PE RVU:** 4.99
2007 Fac PE RVU **2020 Fac PE RVU:** 0.81

RUC Recommendation: 1.90

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62328 **Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 09 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.73
2007 NF PE RVU: **2020 NF PE RVU:** 5.43
2007 Fac PE RVU **2020 Fac PE RVU:** 0.62

RUC Recommendation: 1.95

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

62329 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 09 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.03
2007 NF PE RVU: **2020 NF PE RVU:** 6.73
2007 Fac PE RVU **2020 Fac PE RVU:** 0.80

RUC Recommendation: 2.25

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,884

2007 Work RVU: 8.04 **2020 Work RVU:** 6.05
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4 **2020 Fac PE RVU:** 4.28

RUC Recommendation: 6.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62355 **Removal of previously implanted intrathecal or epidural catheter**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,056

2007 Work RVU: 6.60 **2020 Work RVU:** 3.55
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.27 **2020 Fac PE RVU:** 3.46

RUC Recommendation: 4.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 242

2007 Work RVU: 3.68 **2020 Work RVU:** 4.33
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.87 **2020 Fac PE RVU:** 3.80

RUC Recommendation: 4.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2007 Work RVU: 6.59 **2020 Work RVU:** 5.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.94 **2020 Fac PE RVU:**5.47

RUC Recommendation: 5.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,146

2007 Work RVU: 8.58 **2020 Work RVU:** 5.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.46 **2020 Fac PE RVU:**4.26

RUC Recommendation: 6.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,266

2007 Work RVU: 6.57 **2020 Work RVU:** 3.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.65 **2020 Fac PE RVU:**3.65

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62367 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 10,982

2007 Work RVU: 0.48 **2020 Work RVU:** 0.48
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.38
2007 Fac PE RVU 0.1 **2020 Fac PE RVU:**0.19

RUC Recommendation: New PE inputs. 0.48 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

62368 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 43,410

2007 Work RVU: 0.75 **2020 Work RVU:** 0.67
2007 NF PE RVU: 0.67 **2020 NF PE RVU:** 0.53
2007 Fac PE RVU 0.17 **2020 Fac PE RVU:**0.27

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62369 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 31,581

2007 Work RVU: **2020 Work RVU:** 0.67
2007 NF PE RVU: **2020 NF PE RVU:** 1.97
2007 Fac PE RVU **2020 Fac PE RVU:**0.27

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62370 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 101,707

2007 Work RVU: **2020 Work RVU:** 0.90
2007 NF PE RVU: **2020 NF PE RVU:** 1.84
2007 Fac PE RVU **2020 Fac PE RVU:** 0.35

RUC Recommendation: New PE inputs. 1.10 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63030 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis / Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,404

2007 Work RVU: 13.03 **2020 Work RVU:** 13.18
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.5 **2020 Fac PE RVU:** 11.01

RUC Recommendation: Review action plan. Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63042 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,851

2007 Work RVU: 18.61 **2020 Work RVU:** 18.76
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.2 **2020 Fac PE RVU:** 13.57

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63045 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 16 **Specialty Developing Recommendation:**

First Identified: November 2013 **2019 est Medicare Utilization:** 10,977

RUC Recommendation: 17.95

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 17.82 **2020 Work RVU:** 17.95
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.4 **2020 Fac PE RVU:** 13.41
Result: Maintain

63046 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 16 **Specialty Developing Recommendation:**

First Identified: November 2013 **2019 est Medicare Utilization:** 4,057

RUC Recommendation: 17.25

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 17.12 **2020 Work RVU:** 17.25
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.13 **2020 Fac PE RVU:** 12.98
Result: Maintain

63047 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar**

Global: 090 **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 24 **Specialty Developing Recommendation:** NASS, AANS

First Identified: September 2011 **2019 est Medicare Utilization:** 101,838

RUC Recommendation: 15.37

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 15.22 **2020 Work RVU:** 15.37
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.79 **2020 Fac PE RVU:** 12.02
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

63048 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 24 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** January 2012 **2019 est Medicare Utilization:** 128,927

2007 Work RVU: 3.47 **2020 Work RVU:** 3.47
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.58 **2020 Fac PE RVU:** 1.66

RUC Recommendation: 3.47 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,048

2007 Work RVU: 21.73 **2020 Work RVU:** 21.86
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.31 **2020 Fac PE RVU:** 14.71

RUC Recommendation: Review action plan at RAW Oct 2015. Maintain **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 428

2007 Work RVU: 19.47 **2020 Work RVU:** 19.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.87 **2020 Fac PE RVU:** 13.77

RUC Recommendation: 19.60 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 313

2007 Work RVU: 4.04 **2020 Work RVU:** 4.04
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.93 **2020 Fac PE RVU:** 1.93

RUC Recommendation: 4.04 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63090 **Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** AAOS, AANS **First Identified:** January 2015 **2019 est Medicare Utilization:** 719

2007 Work RVU: 30.78 **2020 Work RVU:** 30.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.58 **2020 Fac PE RVU:** 18.33

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 492

2007 Work RVU: **2020 Work RVU:** 15.60
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 11.01

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 160

2007 Work RVU: **2020 Work RVU:** 4.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 1.84

RUC Recommendation: 4.00

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63650 **Percutaneous implantation of neurostimulator electrode array, epidural**

Global: 010 **Issue:** Percutaneous implantation of neurostimulator **Screen:** Site of Service Anomaly / CMS Fastest Growing / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS

First Identified: September 2007

2019 est Medicare Utilization: 92,083

2007 Work RVU: 7.57 **2020 Work RVU:** 7.15
2007 NF PE RVU: NA **2020 NF PE RVU:** 46.26
2007 Fac PE RVU 3.11 **2020 Fac PE RVU:** 4.01

RUC Recommendation: 7.20. New PE Inputs

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** NASS, AANS

First Identified: October 2008

2019 est Medicare Utilization: 8,801

2007 Work RVU: 11.43 **2020 Work RVU:** 10.92
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.15 **2020 Fac PE RVU:** 9.64

RUC Recommendation: 11.43

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63660 **Deleted from CPT**

Global: **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 6.87 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 3.54 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 3,832

2007 Work RVU: **2020 Work RVU:** 5.08
2007 NF PE RVU: **2020 NF PE RVU:** 12.39
2007 Fac PE RVU **2020 Fac PE RVU:** 3.40

RUC Recommendation: 5.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 2,414

2007 Work RVU: **2020 Work RVU:** 11.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 9.79

RUC Recommendation: 10.87 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 1,584

2007 Work RVU: **2020 Work RVU:** 7.75
2007 NF PE RVU: **2020 NF PE RVU:** 15.59
2007 Fac PE RVU **2020 Fac PE RVU:** 4.21

RUC Recommendation: 70 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 692

2007 Work RVU: **2020 Work RVU:** 11.52
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 10.04

RUC Recommendation: 11.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 29,921

2007 Work RVU: 7.87 **2020 Work RVU:** 5.19
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.03 **2020 Fac PE RVU:** 4.15

RUC Recommendation: Review action plan. 6.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,593

2007 Work RVU: 6.10 **2020 Work RVU:** 5.30
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.56 **2020 Fac PE RVU:**4.28

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64405 **Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve**

Global: 000 **Issue:** Injection - Greater Occipital Nerve **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 17 **Specialty Developing Recommendation:** AAN, AAPM, AAPMR, ASA **First Identified:** July 2016 **2019 est Medicare Utilization:** 134,871

2007 Work RVU: 1.32 **2020 Work RVU:** 0.94
2007 NF PE RVU: 1.39 **2020 NF PE RVU:** 0.92
2007 Fac PE RVU 0.47 **2020 Fac PE RVU:**0.40

RUC Recommendation: 0.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64412 **Injection, anesthetic agent; spinal accessory nerve**

Global: **Issue:** Anesthetic Injection – Spinal Nerve **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 36 **Specialty Developing Recommendation:** AAN, ASA, AAPMR, ISIS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 1.18 **2020 Work RVU:**
2007 NF PE RVU: 2.5 **2020 NF PE RVU:**
2007 Fac PE RVU 0.46 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** FAQ Sept 2015

Status Report: CMS Requests and Relativity Assessment Issues

64415 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,150

2007 Work RVU: 1.48 **2020 Work RVU:** 1.35
2007 NF PE RVU: 2.47 **2020 NF PE RVU:** 1.76
2007 Fac PE RVU 0.43 **2020 Fac PE RVU:**0.37

RUC Recommendation: Refer to CPT for bundling. 1.48 **Referred to CPT** February 2021 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64416 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 17,912

2007 Work RVU: 3.85 **2020 Work RVU:** 1.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.74 **2020 Fac PE RVU:**0.26

RUC Recommendation: Refer to CPT for bundling. Remove from screen. 1.81 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64417 **Injection(s), anesthetic agent(s) and/or steroid; axillary nerve** **Global:** 000 **Issue:** Somatic Nerve Injection **Screen:** part of New/Revised Review **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 15,765

2007 Work RVU: 1.44 **2020 Work RVU:** 1.27
2007 NF PE RVU: 2.65 **2020 NF PE RVU:** 2.51
2007 Fac PE RVU 0.46 **2020 Fac PE RVU:**0.37

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64418 **Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve** **Global:** 000 **Issue:** Injection, Anesthetic Agent **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 28 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA **First Identified:** October 2015 **2019 est Medicare Utilization:** 31,818

2007 Work RVU: 1.32 **2020 Work RVU:** 1.10
2007 NF PE RVU: 2.43 **2020 NF PE RVU:** 1.20
2007 Fac PE RVU 0.46 **2020 Fac PE RVU:**0.42

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64445 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve** **Global:** 000 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 130,719

2007 Work RVU: 1.48 **2020 Work RVU:** 1.00
2007 NF PE RVU: 2.42 **2020 NF PE RVU:** 2.48
2007 Fac PE RVU 0.51 **2020 Fac PE RVU:**0.46

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64446 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,880

2007 Work RVU: 3.61 **2020 Work RVU:** 1.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.9 **2020 Fac PE RVU:**0.24

RUC Recommendation: Refer to CPT for bundling. 1.81 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64447 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 282,703

2007 Work RVU: 1.50 **2020 Work RVU:** 1.10
2007 NF PE RVU: NA **2020 NF PE RVU:** 1.34
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**0.34

RUC Recommendation: Refer to CPT for bundling. 1.50 **Referred to CPT** February 2021 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

Status Report: CMS Requests and Relativity Assessment Issues

64448 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,188

2007 Work RVU: 3.36 **2020 Work RVU:** 1.41
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.73 **2020 Fac PE RVU:** 0.25

RUC Recommendation: Refer to CPT for Bundling. Remove from screen. 1.63

Referred to CPT February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64449 **Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,957

2007 Work RVU: 3.24 **2020 Work RVU:** 1.27
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.84 **2020 Fac PE RVU:** 0.40

RUC Recommendation: 1.81

Referred to CPT February 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64450 **Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch**

Global: 000 **Issue:** Somatic Nerve Injection **Screen:** Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 09 **Specialty Developing Recommendation:** ASA, AAPM, APMA, ASIPP **First Identified:** October 2009 **2019 est Medicare Utilization:** 467,316

2007 Work RVU: 1.27 **2020 Work RVU:** 0.75
2007 NF PE RVU: 1.25 **2020 NF PE RVU:** 1.34
2007 Fac PE RVU 0.49 **2020 Fac PE RVU:** 0.39

RUC Recommendation: 0.75

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2013

Status Report: CMS Requests and Relativity Assessment Issues

64455 **Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)**

Global: 000 **Issue:** Injection – Digital Nerves **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2016 **2019 est Medicare Utilization:** 74,450

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 0.57
2007 Fac PE RVU **2020 Fac PE RVU:** 0.19

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64461 **Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,096

2007 Work RVU: **2020 Work RVU:** 1.75
2007 NF PE RVU: **2020 NF PE RVU:** 1.87
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64462 **Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,483

2007 Work RVU: **2020 Work RVU:** 1.10
2007 NF PE RVU: **2020 NF PE RVU:** 0.92
2007 Fac PE RVU **2020 Fac PE RVU:** 0.23

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64463 **Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)** **Global:** 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,514

2007 Work RVU: **2020 Work RVU:** 1.90
2007 NF PE RVU: **2020 NF PE RVU:** 3.65
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64470 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.85 **2020 Work RVU:**
2007 NF PE RVU: 6.37 **2020 NF PE RVU:**
2007 Fac PE RVU 0.71 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64472 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.29 **2020 Work RVU:**
2007 NF PE RVU: 2.05 **2020 NF PE RVU:**
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64475 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.41 **2020 Work RVU:**
2007 NF PE RVU: 6.07 **2020 NF PE RVU:**
2007 Fac PE RVU 0.62 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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64476 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.98 **2020 Work RVU:**
2007 NF PE RVU: 1.86 **2020 NF PE RVU:**
2007 Fac PE RVU 0.24 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 44,367

2007 Work RVU: 2.20 **2020 Work RVU:** 2.29
2007 NF PE RVU: 6.55 **2020 NF PE RVU:** 4.75
2007 Fac PE RVU 0.87 **2020 Fac PE RVU:**1.26

RUC Recommendation: 2.29 **Referred to CPT** June 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

64480 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 19,219

2007 Work RVU: 1.54 **2020 Work RVU:** 1.20
2007 NF PE RVU: 2.5 **2020 NF PE RVU:** 2.29
2007 Fac PE RVU 0.45 **2020 Fac PE RVU:**0.48

RUC Recommendation: 1.20 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,044,547

2007 Work RVU: 1.90 **2020 Work RVU:** 1.90
2007 NF PE RVU: 6.86 **2020 NF PE RVU:** 4.65
2007 Fac PE RVU 0.81 **2020 Fac PE RVU:**1.13

RUC Recommendation: 1.90 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64484 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 431,178

2007 Work RVU: 1.33 **2020 Work RVU:** 1.00
2007 NF PE RVU: 2.86 **2020 NF PE RVU:** 1.87
2007 Fac PE RVU 0.36 **2020 Fac PE RVU:**0.41

RUC Recommendation: 1.00 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 265,103

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 3.42
2007 Fac PE RVU **2020 Fac PE RVU:**1.04

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 239,462

2007 Work RVU: **2020 Work RVU:** 1.16
2007 NF PE RVU: **2020 NF PE RVU:** 1.45
2007 Fac PE RVU **2020 Fac PE RVU:**0.46

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 156,746

2007 Work RVU: **2020 Work RVU:** 1.16
2007 NF PE RVU: **2020 NF PE RVU:** 1.47
2007 Fac PE RVU **2020 Fac PE RVU:** 0.48

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 901,171

2007 Work RVU: **2020 Work RVU:** 1.52
2007 NF PE RVU: **2020 NF PE RVU:** 3.28
2007 Fac PE RVU **2020 Fac PE RVU:** 0.93

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 809,666

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.44
2007 Fac PE RVU **2020 Fac PE RVU:** 0.40

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 456,363

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.44
2007 Fac PE RVU **2020 Fac PE RVU:** 0.42

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 6,436

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 3.06 **2020 NF PE RVU:** 2.62
2007 Fac PE RVU 0.49 **2020 Fac PE RVU:** 0.83

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 18,919

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35
2007 NF PE RVU: 4.5 **2020 NF PE RVU:** 4.61
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:** 0.90

RUC Recommendation: PE Review - no change **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64550 **Application of surface (transcutaneous) neurostimulator (eg, TENS unit)** **Global:** **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** AANS, CNS, AOTA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 0.18 **2020 Work RVU:**
2007 NF PE RVU: 0.26 **2020 NF PE RVU:**
2007 Fac PE RVU 0.05 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64553 **Percutaneous implantation of neurostimulator electrode array; cranial nerve** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** July 2014 **2019 est Medicare Utilization:** 484

2007 Work RVU: 2.33 **2020 Work RVU:** 6.13
2007 NF PE RVU: 2.75 **2020 NF PE RVU:** 50.47
2007 Fac PE RVU 1.73 **2020 Fac PE RVU:**3.26

RUC Recommendation: 6.13 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

64555 **Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** High Volume Growth1 / CMS Fastest Growing / Final Rule for 2015 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,342

2007 Work RVU: 2.29 **2020 Work RVU:** 5.76
2007 NF PE RVU: 2.96 **2020 NF PE RVU:** 46.70
2007 Fac PE RVU 1.23 **2020 Fac PE RVU:**3.32

RUC Recommendation: 5.76. Article published Jan2016 and addressed issues. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64561 **Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed**

Global: 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** CMS Fastest Growing / High Volume Growth2 / High Level E/M in Global Period / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,987

2007 Work RVU: 7.07 **2020 Work RVU:** 5.44
2007 NF PE RVU: 27.51 **2020 NF PE RVU:** 15.26
2007 Fac PE RVU 3.05 **2020 Fac PE RVU:** 2.67

RUC Recommendation: 5.44. 99214 visit appropriate. Remove from screen.

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

64565 **Percutaneous implantation of neurostimulator electrode array; neuromuscular**

Global: **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 15 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 1.78 **2020 Work RVU:**
2007 NF PE RVU: 3.08 **2020 NF PE RVU:**
2007 Fac PE RVU 1.27 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

64566 **Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming**

Global: 000 **Issue:** Posterior Tibial Neurostimulation **Screen:** CMS Request - Final Rule for 2014 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 201,680

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** 2.90
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

64568 **Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator**

Global: 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 1,002

2007 Work RVU: **2020 Work RVU:** 9.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 6.73

RUC Recommendation: 11.19 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64573 **Deleted from CPT**

Global: **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 8.15 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.31 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64581 **Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 10,284

2007 Work RVU: 14.15 **2020 Work RVU:** 12.20
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.73 **2020 Fac PE RVU:** 5.40

RUC Recommendation: 12.20. 99214 visit appropriate. Remove from screen. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64590 **Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** RAW

Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 12,197

2007 Work RVU: 2.42 **2020 Work RVU:** 2.45
2007 NF PE RVU: 6.95 **2020 NF PE RVU:** 4.79
2007 Fac PE RVU 2.33 **2020 Fac PE RVU:** 1.84

RUC Recommendation:

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

64615 **Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)**

Global: 010 **Issue:**

Screen: High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, NANS **First Identified:** October 2019 **2019 est Medicare Utilization:** 143,888

2007 Work RVU: **2020 Work RVU:** 1.85
2007 NF PE RVU: **2020 NF PE RVU:** 1.89
2007 Fac PE RVU **2020 Fac PE RVU:** 1.12

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level**

Global: **Issue:** Fluroscopy

Screen: CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 3.02 **2020 Work RVU:**
2007 NF PE RVU: 6.82 **2020 NF PE RVU:**
2007 Fac PE RVU 1.34 **2020 Fac PE RVU:**

RUC Recommendation: PE Review - no change

Referred to CPT June 2008 and Feb 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.99 **2020 Work RVU:**
2007 NF PE RVU: 2.62 **2020 NF PE RVU:**
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 3.82 **2020 Work RVU:**
2007 NF PE RVU: 6.99 **2020 NF PE RVU:**
2007 Fac PE RVU 1.93 **2020 Fac PE RVU:**

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1/ CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.16 **2020 Work RVU:**
2007 NF PE RVU: 3.98 **2020 NF PE RVU:**
2007 Fac PE RVU 0.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64633 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 86,013

2007 Work RVU: **2020 Work RVU:** 3.84
2007 NF PE RVU: **2020 NF PE RVU:** 7.73
2007 Fac PE RVU **2020 Fac PE RVU:** 2.25

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64634 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 135,589

2007 Work RVU: **2020 Work RVU:** 1.32
2007 NF PE RVU: **2020 NF PE RVU:** 3.90
2007 Fac PE RVU **2020 Fac PE RVU:** 0.52

RUC Recommendation: 1.32 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64635 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 358,450

2007 Work RVU: **2020 Work RVU:** 3.78
2007 NF PE RVU: **2020 NF PE RVU:** 7.68
2007 Fac PE RVU **2020 Fac PE RVU:** 2.24

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

Status Report: CMS Requests and Relativity Assessment Issues

64636 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 539,040

2007 Work RVU: **2020 Work RVU:** 1.16
2007 NF PE RVU: **2020 NF PE RVU:** 3.60
2007 Fac PE RVU **2020 Fac PE RVU:** 0.45

RUC Recommendation: 1.16 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2015

64640 **Destruction by neurolytic agent; other peripheral nerve or branch**

Global: 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 25 **Specialty Developing Recommendation:** ASAM AAPM, APMA, ASIPP **First Identified:** September 2007 **2019 est Medicare Utilization:** 184,562

2007 Work RVU: 2.78 **2020 Work RVU:** 1.98
2007 NF PE RVU: 3.75 **2020 NF PE RVU:** 4.89
2007 Fac PE RVU 1.75 **2020 Fac PE RVU:** 1.22

RUC Recommendation: 1.23. Remove 99238. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64708 **Neuroplasty, major peripheral nerve, arm or leg, open; other than specified**

Global: 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,356

2007 Work RVU: 6.22 **2020 Work RVU:** 6.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.73 **2020 Fac PE RVU:** 6.96

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64712 **Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 705

2007 Work RVU: 7.98 **2020 Work RVU:** 8.07
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 4.86 **2020 Fac PE RVU:**7.30

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64831 **Suture of digital nerve, hand or foot; 1 nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 878

2007 Work RVU: 10.23 **2020 Work RVU:** 9.16
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7 **2020 Fac PE RVU:**9.07

RUC Recommendation: 9.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 835

2007 Work RVU: 9.70 **2020 Work RVU:** 9.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.13 **2020 Fac PE RVU:**14.87

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

65205 **Removal of foreign body, external eye; conjunctival superficial** **Global:** 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 26,275

2007 Work RVU: 0.71 **2020 Work RVU:** 0.49
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 0.55
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:**0.32

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65210 **Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating**

Global: 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,202

2007 Work RVU: 0.84 **2020 Work RVU:** 0.61
2007 NF PE RVU: 0.79 **2020 NF PE RVU:** 0.66
2007 Fac PE RVU 0.39 **2020 Fac PE RVU:** 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65222 **Removal of foreign body, external eye; corneal, with slit lamp**

Global: 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 26 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,544

2007 Work RVU: 0.93 **2020 Work RVU:** 0.84
2007 NF PE RVU: 0.87 **2020 NF PE RVU:** 1.04
2007 Fac PE RVU 0.4 **2020 Fac PE RVU:** 0.57

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

Global: 090 **Issue:** Repair of Eye Wound **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 8 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 704

2007 Work RVU: 14.43 **2020 Work RVU:** 15.36
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.12 **2020 Fac PE RVU:** 14.92

RUC Recommendation: 16.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65780 **Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

Global: 090 **Issue:** Ocular Reconstruction Transplant **Screen:** CMS Fastest Growing / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 31 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,974

2007 Work RVU: 10.43 **2020 Work RVU:** 7.81
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.04 **2020 Fac PE RVU:** 10.46

RUC Recommendation: 8.80 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

65800 **Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 21 **Specialty Developing Recommendation:** AAO **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,137

2007 Work RVU: 1.91 **2020 Work RVU:** 1.53
2007 NF PE RVU: 1.71 **2020 NF PE RVU:** 1.75
2007 Fac PE RVU 1.16 **2020 Fac PE RVU:** 0.94

RUC Recommendation: 1.53 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 **Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous**

Global: **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 21 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.91 **2020 Work RVU:**
2007 NF PE RVU: 2.07 **2020 NF PE RVU:**
2007 Fac PE RVU 1.16 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65855 **Trabeculoplasty by laser surgery** **Global:** 010 **Issue:** Trabeculoplasty by Laser Surgery **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 143,167

2007 Work RVU: 3.90 **2020 Work RVU:** 3.00
2007 NF PE RVU: 4.14 **2020 NF PE RVU:** 3.76
2007 Fac PE RVU 3.01 **2020 Fac PE RVU:**2.64

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66170 **Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery** **Global:** 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 32 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,957

2007 Work RVU: 14.57 **2020 Work RVU:** 13.94
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.17 **2020 Fac PE RVU:**15.97

RUC Recommendation: 13.94 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66172 **Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)** **Global:** 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 32 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,104

2007 Work RVU: 18.26 **2020 Work RVU:** 14.84
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 15.21 **2020 Fac PE RVU:**17.77

RUC Recommendation: 14.81 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66174 **Transluminal dilation of aqueous outflow canal; without retention of device or stent**

Global: 090 **Issue:** Open Angle Glaucoma Procedures **Screen:** New Technology/ New Service **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO **First Identified:** April 2010 **2019 est Medicare Utilization:** 10,214

2007 Work RVU: **2020 Work RVU:** 12.85
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 12.97
Result:

RUC Recommendation: Refer to CPT **Referred to CPT** October 2020
Referred to CPT Asst ☐ **Published in CPT Asst:**

66179 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 802

2007 Work RVU: **2020 Work RVU:** 14.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 15.49
Result: Decrease

RUC Recommendation: 14.00 **Referred to CPT** October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

66180 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 10,715

2007 Work RVU: 16.02 **2020 Work RVU:** 15.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 10.62 **2020 Fac PE RVU:** 16.11
Result: Decrease

RUC Recommendation: Maintain. 15.00 **Referred to CPT** October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66183 **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,674

2007 Work RVU: **2020 Work RVU:** 13.20
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 14.95

RUC Recommendation: Maintain. 13.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

66184 **Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 594

2007 Work RVU: **2020 Work RVU:** 9.58
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 11.97

RUC Recommendation: 9.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66185 **Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,600

2007 Work RVU: 9.35 **2020 Work RVU:** 10.58
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.37 **2020 Fac PE RVU:** 12.59

RUC Recommendation: Maintain. 10.58 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66711 **Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:** AAO

First Identified: October 2017 **2019 est Medicare Utilization:** 7,616

2007 Work RVU: 7.70 **2020 Work RVU:** 5.62
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.49 **2020 Fac PE RVU:** 8.19

RUC Recommendation: 6.36

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)**

Global: 010 **Issue:** Iridotomy **Screen:** High IWPUT / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAO

First Identified: February 2008 **2019 est Medicare Utilization:** 67,836

2007 Work RVU: 4.87 **2020 Work RVU:** 3.00
2007 NF PE RVU: 5.49 **2020 NF PE RVU:** 5.26
2007 Fac PE RVU 4.32 **2020 Fac PE RVU:** 3.45

RUC Recommendation: Maintain. 3.00

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66821 **Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)**

Global: 090 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** AAO

First Identified: October 2010 **2019 est Medicare Utilization:** 685,933

2007 Work RVU: 3.32 **2020 Work RVU:** 3.42
2007 NF PE RVU: 4.05 **2020 NF PE RVU:** 5.72
2007 Fac PE RVU 3.6 **2020 Fac PE RVU:** 5.13

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

66982 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 159,924

2007 Work RVU: 14.83 **2020 Work RVU:** 10.25
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.75 **2020 Fac PE RVU:** 10.19

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

66983 **Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 93

2007 Work RVU: 10.20 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 6.18 **2020 Fac PE RVU:** 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,694,951

2007 Work RVU: 10.36 **2020 Work RVU:** 7.35
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.24 **2020 Fac PE RVU:** 7.57

RUC Recommendation: 7.35 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66987 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 13.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66988 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 11 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 10.25

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

669X1

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:**

First Identified: January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation:

Referred to CPT October 2020
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

669X2

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)**

Global: 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 14 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,868,836

2007 Work RVU: 2.52 **2020 Work RVU:** 1.44
2007 NF PE RVU: 2.59 **2020 NF PE RVU:** 1.31
2007 Fac PE RVU 1.42 **2020 Fac PE RVU:** 1.24

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67036 **Vitrectomy, mechanical, pars plana approach;**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,016

2007 Work RVU: 13.09 **2020 Work RVU:** 12.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 8.96 **2020 Fac PE RVU:** 12.41

RUC Recommendation: 12.13 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67038 **Deleted from CPT**

Global: **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:**

2007 Work RVU: 23.30 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 15.16 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2007
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 3,357

2007 Work RVU: 16.39 **2020 Work RVU:** 13.20
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.94 **2020 Fac PE RVU:**13.07

RUC Recommendation: 13.20

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 8,666

2007 Work RVU: 19.23 **2020 Work RVU:** 14.50
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 13.41 **2020 Fac PE RVU:**13.87

RUC Recommendation: 14.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67041 **Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,146

2007 Work RVU: **2020 Work RVU:** 16.33
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 14.99
Result: Decrease

RUC Recommendation: 16.33

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67042 **Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 26,972

2007 Work RVU: **2020 Work RVU:** 16.33
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 14.98
Result: Decrease

RUC Recommendation: 16.33

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67043 **Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 373

2007 Work RVU: **2020 Work RVU:** 17.40
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 15.65
Result: Decrease

RUC Recommendation: 17.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67101 **Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 343

2007 Work RVU: 8.60 **2020 Work RVU:** 3.50
2007 NF PE RVU: 9.04 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU 6.51 **2020 Fac PE RVU:** 4.28

RUC Recommendation: 3.50 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67105 **Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,778

2007 Work RVU: 8.35 **2020 Work RVU:** 3.39
2007 NF PE RVU: 7.99 **2020 NF PE RVU:** 4.75
2007 Fac PE RVU 6.13 **2020 Fac PE RVU:** 4.12

RUC Recommendation: 3.84 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67107 **Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 623

2007 Work RVU: 16.35 **2020 Work RVU:** 16.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 11.19 **2020 Fac PE RVU:** 14.79

RUC Recommendation: 16.00. Reduce 99238 to 0.5 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67108 **Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 16,523

2007 Work RVU: 22.49 **2020 Work RVU:** 17.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 14.22 **2020 Fac PE RVU:** 15.48

RUC Recommendation: 17.13

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 2,305

2007 Work RVU: 10.02 **2020 Work RVU:** 10.25
2007 NF PE RVU: 9.99 **2020 NF PE RVU:** 14.09
2007 Fac PE RVU 7.37 **2020 Fac PE RVU:** 11.97

RUC Recommendation: 10.25. Remove 99238

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67112 **Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques**

Global: **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 12 **Specialty Developing Recommendation:** AAO

First Identified: April 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 18.45 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 11.71 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

67113 **Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,384

2007 Work RVU: **2020 Work RVU:** 19.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 17.43

RUC Recommendation: 19.00 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67141 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2020 **2019 est Medicare Utilization:** 1,395

2007 Work RVU: 6.00 **2020 Work RVU:** 6.15
2007 NF PE RVU: 5.8 **2020 NF PE RVU:** 8.24
2007 Fac PE RVU 4.86 **2020 Fac PE RVU:** 7.14

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67145 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 31,865

2007 Work RVU: 6.17 **2020 Work RVU:** 6.32
2007 NF PE RVU: 5.68 **2020 NF PE RVU:** 8.15
2007 Fac PE RVU 4.93 **2020 Fac PE RVU:** 7.25

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 56,884

2007 Work RVU: 9.35 **2020 Work RVU:** 6.36
2007 NF PE RVU: 6.48 **2020 NF PE RVU:** 7.81
2007 Fac PE RVU 5.84 **2020 Fac PE RVU:**7.28

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,636

2007 Work RVU: 14.19 **2020 Work RVU:** 6.36
2007 NF PE RVU: 10.23 **2020 NF PE RVU:** 8.25
2007 Fac PE RVU 8.9 **2020 Fac PE RVU:**7.28

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 168

2007 Work RVU: 0.47 **2020 Work RVU:** 0.47
2007 NF PE RVU: 0.25 **2020 NF PE RVU:** 0.33
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**0.29

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 **Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation**

Global: 010 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 62,152

2007 Work RVU: 13.67 **2020 Work RVU:** 4.39
2007 NF PE RVU: 11.2 **2020 NF PE RVU:** 4.96
2007 Fac PE RVU 8.43 **2020 Fac PE RVU:**3.93

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67255 **Scleral reinforcement (separate procedure); with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 833

RUC Recommendation: 10.17 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 9.97 **2020 Work RVU:** 8.38
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 9.61 **2020 Fac PE RVU:** 10.35
Result: Maintain

67311 **Strabismus surgery, recession or resection procedure; 1 horizontal muscle** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 4,955

RUC Recommendation: 5.93 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 7.59 **2020 Work RVU:** 7.77
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 5.95 **2020 Fac PE RVU:** 8.55
Result: Decrease

67312 **Strabismus surgery, recession or resection procedure; 2 horizontal muscles** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 1,514

RUC Recommendation: 9.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 9.48 **2020 Work RVU:** 9.66
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.69 **2020 Fac PE RVU:** 9.92
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67314 **Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 2,533

2007 Work RVU: 8.59 **2020 Work RVU:** 8.79
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.52 **2020 Fac PE RVU:** 9.75
Result: Decrease

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67316 **Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 168

2007 Work RVU: 10.73 **2020 Work RVU:** 10.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 7.44 **2020 Fac PE RVU:** 11.04
Result: Decrease

RUC Recommendation: 10.31

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67318 **Strabismus surgery, any procedure, superior oblique muscle**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 205

2007 Work RVU: 8.92 **2020 Work RVU:** 9.12
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 6.91 **2020 Fac PE RVU:** 10.25
Result: Decrease

RUC Recommendation: 9.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67320 **Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 362

2007 Work RVU: 5.40 **2020 Work RVU:** 5.40
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.98 **2020 Fac PE RVU:** 3.29
Result: Decrease

RUC Recommendation: 3.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67331 **Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 902

2007 Work RVU: 5.13 **2020 Work RVU:** 5.13
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.86 **2020 Fac PE RVU:**3.13

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67332 **Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,753

2007 Work RVU: 5.56 **2020 Work RVU:** 5.56
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.05 **2020 Fac PE RVU:**3.39

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67334 **Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 128

2007 Work RVU: 5.05 **2020 Work RVU:** 5.05
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.82 **2020 Fac PE RVU:**3.09

RUC Recommendation: 2.06 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67335 **Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,681

2007 Work RVU: 2.49 **2020 Work RVU:** 2.49
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.08 **2020 Fac PE RVU:** 1.50

RUC Recommendation: 3.23 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

67340 **Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 88

2007 Work RVU: 6.00 **2020 Work RVU:** 6.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.22 **2020 Fac PE RVU:** 3.68

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67500 **Retrobulbar injection; medication (separate procedure, does not include supply of medication)**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 7,903

2007 Work RVU: 1.44 **2020 Work RVU:** 1.18
2007 NF PE RVU: 0.66 **2020 NF PE RVU:** 0.80
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:** 0.47

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67505 **Retrobulbar injection; alcohol**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 140

2007 Work RVU: 1.27 **2020 Work RVU:** 1.18
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 1.08
2007 Fac PE RVU 0.34 **2020 Fac PE RVU:**0.71

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67515 **Injection of medication or other substance into Tenon's capsule**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** July 2016 **2019 est Medicare Utilization:** 24,360

2007 Work RVU: 1.40 **2020 Work RVU:** 0.75
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 1.00
2007 Fac PE RVU 0.45 **2020 Fac PE RVU:**0.86

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67820 **Correction of trichiasis; epilation, by forceps only**

Global: 000 **Issue:** Correction of Trichiasis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 29 **Specialty Developing Recommendation:** AOA, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 222,157

2007 Work RVU: 0.71 **2020 Work RVU:** 0.32
2007 NF PE RVU: 0.57 **2020 NF PE RVU:** 0.41
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:**0.46

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67914 **Repair of ectropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 1,601

RUC Recommendation: 3.75

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 3.70 **2020 Work RVU:** 3.75
2007 NF PE RVU: 5.98 **2020 NF PE RVU:** 9.60
2007 Fac PE RVU 2.99 **2020 Fac PE RVU:**5.19
Result: Maintain

67915 **Repair of ectropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 332

RUC Recommendation: 2.03

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 3.21 **2020 Work RVU:** 2.03
2007 NF PE RVU: 5.62 **2020 NF PE RVU:** 6.48
2007 Fac PE RVU 2.75 **2020 Fac PE RVU:**3.38
Result: Decrease

67916 **Repair of ectropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 1,895

RUC Recommendation: 5.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 5.37 **2020 Work RVU:** 5.48
2007 NF PE RVU: 7.68 **2020 NF PE RVU:** 11.24
2007 Fac PE RVU 4.65 **2020 Fac PE RVU:**6.23
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

67917 **Repair of ectropion; extensive (eg, tarsal strip operations)** **Global:** 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 24,678

RUC Recommendation: 5.93

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 6.08 **2020 Work RVU:** 5.93
2007 NF PE RVU: 8.08 **2020 NF PE RVU:** 11.09
2007 Fac PE RVU 4.95 **2020 Fac PE RVU:**6.52
Result: Decrease

67921 **Repair of entropion; suture** **Global:** 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 3,614

RUC Recommendation: 3.47

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 3.42 **2020 Work RVU:** 3.47
2007 NF PE RVU: 5.83 **2020 NF PE RVU:** 9.64
2007 Fac PE RVU 2.84 **2020 Fac PE RVU:**5.02
Result: Maintain

67922 **Repair of entropion; thermocauterization** **Global:** 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 100

RUC Recommendation: 2.03

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 3.09 **2020 Work RVU:** 2.03
2007 NF PE RVU: 5.55 **2020 NF PE RVU:** 6.26
2007 Fac PE RVU 2.7 **2020 Fac PE RVU:**3.36
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67923 **Repair of entropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 1,300

2007 Work RVU: 5.94 **2020 Work RVU:** 5.48
2007 NF PE RVU: 7.76 **2020 NF PE RVU:** 11.25
2007 Fac PE RVU 4.86 **2020 Fac PE RVU:** 6.26

RUC Recommendation: 5.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67924 **Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 11,149

2007 Work RVU: 5.84 **2020 Work RVU:** 5.93
2007 NF PE RVU: 8.48 **2020 NF PE RVU:** 11.87
2007 Fac PE RVU 4.57 **2020 Fac PE RVU:** 6.53

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO

First Identified: February 2008 **2019 est Medicare Utilization:** 6,702

2007 Work RVU: 0.85 **2020 Work RVU:** 0.85
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.88
2007 Fac PE RVU 0.42 **2020 Fac PE RVU:** 0.50

RUC Recommendation: Revised parenthetical

Referred to CPT February 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

68200 **Subconjunctival injection**

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** AAO

First Identified: April 2011 **2019 est Medicare Utilization:** 8,059

2007 Work RVU: 0.49 **2020 Work RVU:** 0.49
2007 NF PE RVU: 0.52 **2020 NF PE RVU:** 0.65
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.45

RUC Recommendation: 0.49

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

68801 **Dilation of lacrimal punctum, with or without irrigation**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: January 2014 **2019 est Medicare Utilization:** 27,980

2007 Work RVU: 0.96 **2020 Work RVU:** 0.82
2007 NF PE RVU: 1.91 **2020 NF PE RVU:** 1.73
2007 Fac PE RVU 1.48 **2020 Fac PE RVU:**1.31

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

68810 **Probing of nasolacrimal duct, with or without irrigation;**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** Site of Service Anomaly / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2007 **2019 est Medicare Utilization:** 28,019

2007 Work RVU: 2.63 **2020 Work RVU:** 1.54
2007 NF PE RVU: 3.62 **2020 NF PE RVU:** 2.86
2007 Fac PE RVU 2.7 **2020 Fac PE RVU:**1.95

RUC Recommendation: 1.54

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

68811 **Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2014 **2019 est Medicare Utilization:** 451

2007 Work RVU: 2.39 **2020 Work RVU:** 1.74
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 2.36 **2020 Fac PE RVU:** 1.95

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

68815 **Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** January 2014 **2019 est Medicare Utilization:** 8,129

2007 Work RVU: 3.24 **2020 Work RVU:** 2.70
2007 NF PE RVU: 7.82 **2020 NF PE RVU:** 8.12
2007 Fac PE RVU 2.74 **2020 Fac PE RVU:** 3.35

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

68816 **Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2014 **2019 est Medicare Utilization:** 248

2007 Work RVU: **2020 Work RVU:** 2.10
2007 NF PE RVU: **2020 NF PE RVU:** 20.00
2007 Fac PE RVU **2020 Fac PE RVU:** 2.19

RUC Recommendation: 2.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 **Biopsy external ear**

Global: 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 28 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 164,973

2007 Work RVU: 0.81 **2020 Work RVU:** 0.81
2007 NF PE RVU: 1.75 **2020 NF PE RVU:** 1.89
2007 Fac PE RVU 0.4 **2020 Fac PE RVU:** 0.47

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69200 **Removal foreign body from external auditory canal; without general anesthesia** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2019 est Medicare Utilization:** 59,479

2007 Work RVU: 0.77 **2020 Work RVU:** 0.77
2007 NF PE RVU: 2.29 **2020 NF PE RVU:** 1.43
2007 Fac PE RVU 0.56 **2020 Fac PE RVU:**0.47

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69210 **Removal impacted cerumen requiring instrumentation, unilateral** **Global:** 000 **Issue:** Removal of Cerumen **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 29 **Specialty Developing Recommendation:** AAFP, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,589,620

2007 Work RVU: 0.61 **2020 Work RVU:** 0.61
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.66
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.26

RUC Recommendation: 0.58. **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69400 **Eustachian tube inflation, transnasal; with catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.83 **2020 Work RVU:**
2007 NF PE RVU: 2.27 **2020 NF PE RVU:**
2007 Fac PE RVU 0.66 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69401 **Eustachian tube inflation, transnasal; without catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.63 **2020 Work RVU:**
2007 NF PE RVU: 1.3 **2020 NF PE RVU:**
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69405 **Eustachian tube catheterization, transtympanic**

Global: **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 2.65 **2020 Work RVU:**
2007 NF PE RVU: 3.48 **2020 NF PE RVU:**
2007 Fac PE RVU 2.19 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69433 **Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia**

Global: 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 30 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2019 est Medicare Utilization:** 48,248

2007 Work RVU: 1.54 **2020 Work RVU:** 1.57
2007 NF PE RVU: 3.09 **2020 NF PE RVU:** 3.83
2007 Fac PE RVU 1.6 **2020 Fac PE RVU:**1.93

RUC Recommendation: 1.57 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69801 **Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal**

Global: 000 **Issue:** Labyrinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 24,321

2007 Work RVU: 8.61 **2020 Work RVU:** 2.06
2007 NF PE RVU: NA **2020 NF PE RVU:** 3.71
2007 Fac PE RVU 9.31 **2020 Fac PE RVU:**1.21

RUC Recommendation: Review action plan at RAW Oct 2015. 2.06 **Referred to CPT** Feb 2010 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

Status Report: CMS Requests and Relativity Assessment Issues

69802 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy** **Global:** **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 13.39 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 11.91 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** Feburary 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69930 **Cochlear device implantation, with or without mastoidectomy** **Global:** 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** M **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,267

2007 Work RVU: 17.60 **2020 Work RVU:** 17.73
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 14.06 **2020 Fac PE RVU:**14.60

RUC Recommendation: 17.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70030 **Radiologic examination, eye, for detection of foreign body** **Global:** XXX **Issue:** X-Ray of Eye **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 28 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,756

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70100 **Radiologic examination, mandible; partial, less than 4 views** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,165

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.59 **2020 NF PE RVU:** 0.83
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

70210 **Radiologic examination, sinuses, paranasal, less than 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 31,748

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.20

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

70220 **Radiologic examination, sinuses, paranasal, complete, minimum of 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 59,212

2007 Work RVU: 0.25 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.82 **2020 NF PE RVU:** 0.79
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.22

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

70250 **Radiologic examination, skull; less than 4 views** **Global:** XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 45,019

2007 Work RVU: 0.24 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.7 **2020 NF PE RVU:** 0.80
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70260 **Radiologic examination, skull; complete, minimum of 4 views** **Global:** XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 9,622

2007 Work RVU: 0.34 **2020 Work RVU:** 0.28
2007 NF PE RVU: 0.96 **2020 NF PE RVU:** 0.94
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70310 **Radiologic examination, teeth; partial examination, less than full mouth** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,217

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.58 **2020 NF PE RVU:** 0.92
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70360 **Radiologic examination; neck, soft tissue** **Global:** XXX **Issue:** X-Ray Exam – Neck **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 26 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 64,675

2007 Work RVU: 0.17 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.5 **2020 NF PE RVU:** 0.66
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

70371 **Complex dynamic pharyngeal and speech evaluation by cine or video recording** **Global:** XXX **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,976

2007 Work RVU: 0.84 **2020 Work RVU:** 0.84
2007 NF PE RVU: 2.14 **2020 NF PE RVU:** 2.12
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: CPT Assistant article published, addressed issues identified. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

70373 **Laryngography, contrast, radiological supervision and interpretation** **Global:** **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.44 **2020 Work RVU:**
2007 NF PE RVU: 1.83 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

70450 **Computed tomography, head or brain; without contrast material**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,711,912

2007 Work RVU: 0.85 **2020 Work RVU:** 0.85
2007 NF PE RVU: 4.91 **2020 NF PE RVU:** 2.34
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.85

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

70460 **Computed tomography, head or brain; with contrast material(s)**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 28,050

2007 Work RVU: 1.13 **2020 Work RVU:** 1.13
2007 NF PE RVU: 6.06 **2020 NF PE RVU:** 3.40
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

70470 **Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,135

2007 Work RVU: 1.27 **2020 Work RVU:** 1.27
2007 NF PE RVU: 7.49 **2020 NF PE RVU:** 4.04
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.27

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70480 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material** **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 54,791

2007 Work RVU: 1.28 **2020 Work RVU:** 1.28
2007 NF PE RVU: 5.86 **2020 NF PE RVU:** 4.29
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70481 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)** **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 10,929

2007 Work RVU: 1.38 **2020 Work RVU:** 1.13
2007 NF PE RVU: 6.95 **2020 NF PE RVU:** 5.10
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

70482 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,917

2007 Work RVU: 1.45 **2020 Work RVU:** 1.27
2007 NF PE RVU: 8.36 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70486 **Computed tomography, maxillofacial area; without contrast material** **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 532,110

2007 Work RVU: 1.14 **2020 Work RVU:** 0.85
2007 NF PE RVU: 5.42 **2020 NF PE RVU:** 3.01
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

70487 **Computed tomography, maxillofacial area; with contrast material(s)** **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 30,559

2007 Work RVU: 1.30 **2020 Work RVU:** 1.13
2007 NF PE RVU: 6.55 **2020 NF PE RVU:** 3.51
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

70488 **Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,505

2007 Work RVU: 1.42 **2020 Work RVU:** 1.27
2007 NF PE RVU: 8.11 **2020 NF PE RVU:** 4.39
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

70490 **Computed tomography, soft tissue neck; without contrast material** **Global:** XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,230

2007 Work RVU: 1.28 **2020 Work RVU:** 1.28
2007 NF PE RVU: 5.39 **2020 NF PE RVU:** 3.28
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70491 **Computed tomography, soft tissue neck; with contrast material(s)**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 279,888

2007 Work RVU: 1.38 **2020 Work RVU:** 1.38
2007 NF PE RVU: 6.48 **2020 NF PE RVU:** 4.25
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70492 **Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 25,867

2007 Work RVU: 1.45 **2020 Work RVU:** 1.62
2007 NF PE RVU: 8.04 **2020 NF PE RVU:** 5.17
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 525,192

2007 Work RVU: 1.75 **2020 Work RVU:** 1.75
2007 NF PE RVU: 12.43 **2020 NF PE RVU:** 6.49
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 546,880

2007 Work RVU: 1.75 **2020 Work RVU:** 1.75
2007 NF PE RVU: 12.45 **2020 NF PE RVU:** 6.48
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70540 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 10,325

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35
2007 NF PE RVU: 12.11 **2020 NF PE RVU:** 5.91
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70542 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 993

2007 Work RVU: 1.62 **2020 Work RVU:** 1.62
2007 NF PE RVU: 14.09 **2020 NF PE RVU:** 6.99
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70543 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,843

2007 Work RVU: 2.15 **2020 Work RVU:** 2.15
2007 NF PE RVU: 23.65 **2020 NF PE RVU:** 8.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70544 **Magnetic resonance angiography, head; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 247,119

2007 Work RVU: 1.20 **2020 Work RVU:** 1.20
2007 NF PE RVU: 12.46 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

70545 **Magnetic resonance angiography, head; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 3,638

2007 Work RVU: 1.20 **2020 Work RVU:** 1.20
2007 NF PE RVU: 12.44 **2020 NF PE RVU:** 5.93
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70546 **Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 18,220

2007 Work RVU: 1.80 **2020 Work RVU:** 1.48
2007 NF PE RVU: 22.97 **2020 NF PE RVU:** 8.87
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70547 **Magnetic resonance angiography, neck; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 78,876

2007 Work RVU: 1.20 **2020 Work RVU:** 1.20
2007 NF PE RVU: 12.45 **2020 NF PE RVU:** 5.65
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70548 **Magnetic resonance angiography, neck; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,524

2007 Work RVU: 1.20 **2020 Work RVU:** 1.50
2007 NF PE RVU: 12.65 **2020 NF PE RVU:** 6.14
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70549 **Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 58,959

2007 Work RVU: 1.80 **2020 Work RVU:** 1.80
2007 NF PE RVU: 22.96 **2020 NF PE RVU:** 9.05
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

70551 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,166,152

2007 Work RVU: 1.48 **2020 Work RVU:** 1.48
2007 NF PE RVU: 12.2 **2020 NF PE RVU:** 4.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

70552 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,951

2007 Work RVU: 1.78 **2020 Work RVU:** 1.78
2007 NF PE RVU: 14.22 **2020 NF PE RVU:** 6.80
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.78

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70553 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,005,264

2007 Work RVU: 2.36 **2020 Work RVU:** 2.29
2007 NF PE RVU: 23.53 **2020 NF PE RVU:** 7.85
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 2.36 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71010 **Radiologic examination, chest; single view, frontal**

Global: **Issue:** Chest X-Rays **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.18 **2020 Work RVU:**
2007 NF PE RVU: 0.5 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71015 **Radiologic examination, chest; stereo, frontal**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.21 **2020 Work RVU:**
2007 NF PE RVU: 0.58 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71020 **Radiologic examination, chest, 2 views, frontal and lateral;**

Global: **Issue:** Chest X-Rays **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.22 **2020 Work RVU:**
2007 NF PE RVU: 0.66 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71021 **Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.27 **2020 Work RVU:**
2007 NF PE RVU: 0.79 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71022 **Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.31 **2020 Work RVU:**
2007 NF PE RVU: 0.84 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71023 **Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy** **Global:** **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.38 **2020 Work RVU:**
2007 NF PE RVU: 1.06 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71030 **Radiologic examination, chest, complete, minimum of 4 views;** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.31 **2020 Work RVU:**
2007 NF PE RVU: 0.88 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71034 **Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.46 **2020 Work RVU:**
2007 NF PE RVU: 1.69 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71035 **Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.18 **2020 Work RVU:**
2007 NF PE RVU: 0.62 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71045 **Radiologic examination, chest; single view**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,582,853

RUC Recommendation: 0.18

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.18

2007 NF PE RVU: **2020 NF PE RVU:** 0.52

2007 Fac PE RVU **2020 Fac PE RVU:** NA

Result: Decrease

71046 **Radiologic examination, chest; 2 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,465,557

RUC Recommendation: 0.22

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.22

2007 NF PE RVU: **2020 NF PE RVU:** 0.68

2007 Fac PE RVU **2020 Fac PE RVU:** NA

Result: Decrease

71047 **Radiologic examination, chest; 3 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,324

RUC Recommendation: 0.27

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.27

2007 NF PE RVU: **2020 NF PE RVU:** 0.87

2007 Fac PE RVU **2020 Fac PE RVU:** NA

Result: Decrease

71048 **Radiologic examination, chest; 4 or more views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,897

RUC Recommendation: 0.31

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.31

2007 NF PE RVU: **2020 NF PE RVU:** 0.93

2007 Fac PE RVU **2020 Fac PE RVU:** NA

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: **Issue:** Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

71100 **Radiologic examination, ribs, unilateral; 2 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 30 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 174,554

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 0.76
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71101 **Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 30 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 301,474

2007 Work RVU: 0.27 **2020 Work RVU:** 0.27
2007 NF PE RVU: 0.75 **2020 NF PE RVU:** 0.86
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71110 **Radiologic examination, ribs, bilateral; 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 24,795

2007 Work RVU: 0.27 **2020 Work RVU:** 0.29
2007 NF PE RVU: 0.84 **2020 NF PE RVU:** 0.90
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

71111 **Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 30,595

2007 Work RVU: 0.32 **2020 Work RVU:** 0.32
2007 NF PE RVU: 1 **2020 NF PE RVU:** 1.10
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.32

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

71250 **Computed tomography, thorax, diagnostic; without contrast material**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 2,320,224

2007 Work RVU: 1.16 **2020 Work RVU:** 1.16
2007 NF PE RVU: 6.24 **2020 NF PE RVU:** 3.23
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

71260 **Computed tomography, thorax, diagnostic; with contrast material(s)**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,835,534

2007 Work RVU: 1.24 **2020 Work RVU:** 1.24
2007 NF PE RVU: 7.5 **2020 NF PE RVU:** 4.21
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71270 **Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 70,977

2007 Work RVU: 1.38 **2020 Work RVU:** 1.38
2007 NF PE RVU: 9.36 **2020 NF PE RVU:** 5.08
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71271 **Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)**

Global: **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 07 **Specialty Developing Recommendation:** **First Identified:** May 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71275 **Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography-Chest **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 27 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,282,747

2007 Work RVU: 1.92 **2020 Work RVU:** 1.82
2007 NF PE RVU: 12.53 **2020 NF PE RVU:** 6.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

72020 **Radiologic examination, spine, single view, specify level**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 145,820

2007 Work RVU: 0.15 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.46 **2020 NF PE RVU:** 0.50
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

72040 **Radiologic examination, spine, cervical; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 641,468

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.83
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.22 **Referred to CPT** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72050 **Radiologic examination, spine, cervical; 4 or 5 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 378,821

RUC Recommendation: 0.27 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 0.31 **2020 Work RVU:** 0.27
2007 NF PE RVU: 1 **2020 NF PE RVU:** 1.13
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Decrease

72052 **Radiologic examination, spine, cervical; 6 or more views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 80,862

RUC Recommendation: 0.30 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 0.36 **2020 Work RVU:** 0.30
2007 NF PE RVU: 1.27 **2020 NF PE RVU:** 1.35
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Decrease

72070 **Radiologic examination, spine; thoracic, 2 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 300,255

RUC Recommendation: 0.20 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 0.22 **2020 Work RVU:** 0.20
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

72072 **Radiologic examination, spine; thoracic, 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 184,802

2007 Work RVU: 0.22 **2020 Work RVU:** 0.23
2007 NF PE RVU: 0.78 **2020 NF PE RVU:** 0.83
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.23 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

72074 **Radiologic examination, spine; thoracic, minimum of 4 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 12,934

2007 Work RVU: 0.22 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.96 **2020 NF PE RVU:** 0.94
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

72080 **Radiologic examination, spine; thoracolumbar junction, minimum of 2 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 46,745

2007 Work RVU: 0.22 **2020 Work RVU:** 0.21
2007 NF PE RVU: 0.72 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72100 **Radiologic examination, spine, lumbosacral; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,818,987

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.75 **2020 NF PE RVU:** 0.83
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72110 **Radiologic examination, spine, lumbosacral; minimum of 4 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 821,121

2007 Work RVU: 0.31 **2020 Work RVU:** 0.26
2007 NF PE RVU: 1.03 **2020 NF PE RVU:** 1.08
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.26 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

72114 **Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 96,261

2007 Work RVU: 0.36 **2020 Work RVU:** 0.30
2007 NF PE RVU: 1.36 **2020 NF PE RVU:** 1.35
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72120 **Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,798

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.98 **2020 NF PE RVU:** 0.87
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.22 **Referred to CPT** October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,308,607

2007 Work RVU: 1.16 **2020 Work RVU:** 1.00
2007 NF PE RVU: 6.24 **2020 NF PE RVU:** 3.32
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.07 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 20,553

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2020 NF PE RVU:** 4.21
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.22 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,798

2007 Work RVU: 1.27 **2020 Work RVU:** 1.27
2007 NF PE RVU: 9.3 **2020 NF PE RVU:** 5.14
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.27 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128 **Computed tomography, thoracic spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,533

2007 Work RVU: 1.16 **2020 Work RVU:** 1.00
2007 NF PE RVU: 6.24 **2020 NF PE RVU:** 3.32
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72129 **Computed tomography, thoracic spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 26,437

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2020 NF PE RVU:** 4.25
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.22

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,318

2007 Work RVU: 1.27 **2020 Work RVU:** 1.27
2007 NF PE RVU: 9.29 **2020 NF PE RVU:** 5.15
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.27

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72131 **Computed tomography, lumbar spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 519,043

2007 Work RVU: 1.16 **2020 Work RVU:** 1.00
2007 NF PE RVU: 6.24 **2020 NF PE RVU:** 3.30
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72132 **Computed tomography, lumbar spine; with contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,654

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2020 NF PE RVU:** 4.22
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,078

2007 Work RVU: 1.27 **2020 Work RVU:** 1.27
2007 NF PE RVU: 9.34 **2020 NF PE RVU:** 5.11
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** September 2011 **2019 est Medicare Utilization:** 600,156

2007 Work RVU: 1.60 **2020 Work RVU:** 1.48
2007 NF PE RVU: 11.76 **2020 NF PE RVU:** 4.54
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72142 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,391

2007 Work RVU: 1.92 **2020 Work RVU:** 1.78
2007 NF PE RVU: 14.26 **2020 NF PE RVU:** 6.99
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.78

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72146 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 223,500

2007 Work RVU: 1.60 **2020 Work RVU:** 1.48
2007 NF PE RVU: 12.69 **2020 NF PE RVU:** 4.54
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72147 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,124

2007 Work RVU: 1.92 **2020 Work RVU:** 1.78
2007 NF PE RVU: 13.76 **2020 NF PE RVU:** 6.93
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.78

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72148 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** AAOS, AUR, ACR, NASS, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,346,832

2007 Work RVU: 1.48 **2020 Work RVU:** 1.48
2007 NF PE RVU: 12.66 **2020 NF PE RVU:** 4.55
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.48 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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72149 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,622

2007 Work RVU: 1.78 **2020 Work RVU:** 1.78
2007 NF PE RVU: 14.23 **2020 NF PE RVU:** 6.85
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.78 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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72156 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 120,879

2007 Work RVU: 2.57 **2020 Work RVU:** 2.29
2007 NF PE RVU: 23.52 **2020 NF PE RVU:** 7.93
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.29 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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Status Report: CMS Requests and Relativity Assessment Issues

72157 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:**

First Identified: April 2013 **2019 est Medicare Utilization:** 98,889

2007 Work RVU: 2.57 **2020 Work RVU:** 2.29
2007 NF PE RVU: 23.12 **2020 NF PE RVU:** 7.95
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72158 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 25 **Specialty Developing Recommendation:**

First Identified: April 2013 **2019 est Medicare Utilization:** 244,364

2007 Work RVU: 2.36 **2020 Work RVU:** 2.29
2007 NF PE RVU: 23.45 **2020 NF PE RVU:** 7.91
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72170 **Radiologic examination, pelvis; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** Low Value-High Volume / Codes Reported Together 75% or More-Part2 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 28 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 792,294

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.61
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72190 **Radiologic examination, pelvis; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 28 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 56,338

2007 Work RVU: 0.21 **2020 Work RVU:** 0.25

2007 NF PE RVU: 0.76 **2020 NF PE RVU:** 0.87

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified: February 2008 **2019 est Medicare Utilization:** 2,441

2007 Work RVU: 1.81 **2020 Work RVU:** 1.81

2007 NF PE RVU: 12.15 **2020 NF PE RVU:** 7.16

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.81

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

72192 **Computed tomography, pelvis; without contrast material**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 183,953

2007 Work RVU: 1.09 **2020 Work RVU:** 1.09

2007 NF PE RVU: 6.12 **2020 NF PE RVU:** 2.94

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.09

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72193 **Computed tomography, pelvis; with contrast material(s)**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,206

2007 Work RVU: 1.16 **2020 Work RVU:** 1.16
2007 NF PE RVU: 7.2 **2020 NF PE RVU:** 5.59
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.16 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 44 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,552

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 9.06 **2020 NF PE RVU:** 6.36
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.22 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72195 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 85,947

2007 Work RVU: 1.46 **2020 Work RVU:** 1.46
2007 NF PE RVU: 12.19 **2020 NF PE RVU:** 5.93
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72196 **Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)** **Global:** XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,606

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 14.18 **2020 NF PE RVU:** 6.90
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.73 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

72197 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences** **Global:** XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,192

2007 Work RVU: 2.26 **2020 Work RVU:** 2.20
2007 NF PE RVU: 23.71 **2020 NF PE RVU:** 8.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 2.20 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

72200 **Radiologic examination, sacroiliac joints; less than 3 views** **Global:** XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 14,605

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.58 **2020 NF PE RVU:** 0.71
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Increase

RUC Recommendation: 0.20 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

72202 **Radiologic examination, sacroiliac joints; 3 or more views** **Global:** XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 39,418

2007 Work RVU: 0.19 **2020 Work RVU:** 0.23
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.82
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Increase

RUC Recommendation: 0.26 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72220 **Radiologic examination, sacrum and coccyx, minimum of 2 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2016 **2019 est Medicare Utilization:** 116,528

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.69
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Increase

RUC Recommendation: 0.20

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

72240 **Myelography, cervical, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 647

2007 Work RVU: 0.91 **2020 Work RVU:** 0.91
2007 NF PE RVU: 4.37 **2020 NF PE RVU:** 2.17
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

72255 **Myelography, thoracic, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2013 **2019 est Medicare Utilization:** 125

2007 Work RVU: 0.91 **2020 Work RVU:** 0.91
2007 NF PE RVU: 3.98 **2020 NF PE RVU:** 2.19
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72265 **Myelography, lumbosacral, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,681

2007 Work RVU: 0.83 **2020 Work RVU:** 0.83
2007 NF PE RVU: 3.83 **2020 NF PE RVU:** 2.01
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.83 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72270 **Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,087

2007 Work RVU: 1.33 **2020 Work RVU:** 1.33
2007 NF PE RVU: 5.81 **2020 NF PE RVU:** 2.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.33 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72275 **Epidurography, radiological supervision and interpretation**

Global: XXX **Issue:** Epidurography **Screen:** Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 66,516

2007 Work RVU: 0.76 **2020 Work RVU:** 0.76
2007 NF PE RVU: 2.15 **2020 NF PE RVU:** 2.87
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009 and Q&A - May 2010

Status Report: CMS Requests and Relativity Assessment Issues

72291 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

72292 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

73000 **Radiologic examination; clavicle, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 100,682

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73010 **Radiologic examination; scapula, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,052

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.58 **2020 NF PE RVU:** 0.59
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73020 **Radiologic examination, shoulder; 1 view**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 119,144

2007 Work RVU: 0.15 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.5 **2020 NF PE RVU:** 0.43
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73030 **Radiologic examination, shoulder; complete, minimum of 2 views**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** Low Value-High Volume / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,765,924

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73050 **Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 8,123

2007 Work RVU: 0.20 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.73 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73060 **Radiologic examination; humerus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 341,436

2007 Work RVU: 0.17 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73070 **Radiologic examination, elbow; 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 219,794

2007 Work RVU: 0.15 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.62
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73080 **Radiologic examination, elbow; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 404,093

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.66 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73090 **Radiologic examination; forearm, 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 230,897

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.63
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73100 **Radiologic examination, wrist; 2 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 32 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 274,134

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.55 **2020 NF PE RVU:** 0.74
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73110 **Radiologic examination, wrist; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 32 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,064,258

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 0.90
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

73120 **Radiologic examination, hand; 2 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 33 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:** 278,753

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.54 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

73130 **Radiologic examination, hand; minimum of 3 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 33 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,282,863

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.6 **2020 NF PE RVU:** 0.79
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73140 **Radiologic examination, finger(s), minimum of 2 views** **Global:** XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 33 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 388,288

2007 Work RVU: 0.13 **2020 Work RVU:** 0.13
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.85
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73200 **Computed tomography, upper extremity; without contrast material** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 23 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 126,320

2007 Work RVU: 1.09 **2020 Work RVU:** 1.00
2007 NF PE RVU: 5.5 **2020 NF PE RVU:** 3.97
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.09 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73201 **Computed tomography, upper extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,360

2007 Work RVU: 1.16 **2020 Work RVU:** 1.16
2007 NF PE RVU: 6.58 **2020 NF PE RVU:** 5.04
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 8.38 **2020 NF PE RVU:** 6.52
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73206 **Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** May 2013 **2019 est Medicare Utilization:** 6,543

2007 Work RVU: 1.81 **2020 Work RVU:** 1.81
2007 NF PE RVU: 11.22 **2020 NF PE RVU:** 7.31
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Survey with all CTA codes for October 2013.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 33,624

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35
2007 NF PE RVU: 12.24 **2020 NF PE RVU:** 8.50
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2011

Result: Maintain

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 475,051

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35
2007 NF PE RVU: 11.98 **2020 NF PE RVU:** 5.02
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73500 **Radiologic examination, hip, unilateral; 1 view**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.52 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73501 **Radiologic examination, hip, unilateral, with pelvis when performed; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 285,022

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.69
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73502 **Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,694,536

2007 Work RVU: **2020 Work RVU:** 0.22
2007 NF PE RVU: **2020 NF PE RVU:** 1.03
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73503 **Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,804

2007 Work RVU: **2020 Work RVU:** 0.27
2007 NF PE RVU: **2020 NF PE RVU:** 1.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.27 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73510 **Radiologic examination, hip, unilateral; complete, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.21 **2020 Work RVU:**
2007 NF PE RVU: 0.67 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73520 **Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 0.76 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73521 **Radiologic examination, hips, bilateral, with pelvis when performed; 2 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 158,149

2007 Work RVU: **2020 Work RVU:** 0.22
2007 NF PE RVU: **2020 NF PE RVU:** 0.88
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73522 **Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 188,143

2007 Work RVU: **2020 Work RVU:** 0.29
2007 NF PE RVU: **2020 NF PE RVU:** 1.15
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.29 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73523 **Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 107,476

2007 Work RVU: **2020 Work RVU:** 0.31
2007 NF PE RVU: **2020 NF PE RVU:** 1.33
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.31 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73540 **Radiologic examination, pelvis and hips, infant or child, minimum of 2 views** **Global:** **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.20 **2020 Work RVU:**
2007 NF PE RVU: 0.68 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73542 **Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation** **Global:** **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.59 **2020 Work RVU:**
2007 NF PE RVU: 1.98 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT

73550 **Radiologic examination, femur, 2 views** **Global:** **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.61 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73551 **Radiologic examination, femur; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 37,871

2007 Work RVU: **2020 Work RVU:** 0.16
2007 NF PE RVU: **2020 NF PE RVU:** 0.64
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.16

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

73552 **Radiologic examination, femur; minimum 2 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 548,327

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.77
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.18

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

73560 **Radiologic examination, knee; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,784,814

2007 Work RVU: 0.17 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.58 **2020 NF PE RVU:** 0.76
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

73562 **Radiologic examination, knee; 3 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 2,516,006

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 0.90
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73564 **Radiologic examination, knee; complete, 4 or more views** **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,648,754

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 0.73 **2020 NF PE RVU:** 0.99
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73565 **Radiologic examination, knee; both knees, standing, anteroposterior** **Global:** XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 207,121

2007 Work RVU: 0.17 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.57 **2020 NF PE RVU:** 0.91
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 30,453

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 2.67 **2020 NF PE RVU:** 3.24
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT. **Referred to CPT** February 2021 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

Status Report: CMS Requests and Relativity Assessment Issues

73590 **Radiologic examination; tibia and fibula, 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 500,593

2007 Work RVU: 0.17 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.57 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73600 **Radiologic examination, ankle; 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 240,693

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.54 **2020 NF PE RVU:** 0.71
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73610 **Radiologic examination, ankle; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,281,503

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.79
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73620 **Radiologic examination, foot; 2 views**

Global: XXX **Issue:** X-Ray Exam of Foot **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 27 **Specialty Developing Recommendation:** ACR, AAOS, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 574,129

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.54 **2020 NF PE RVU:** 0.60
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73630 **Radiologic examination, foot; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,820,181

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.6 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73650 **Radiologic examination; calcaneus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Heel **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 31 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 81,836

2007 Work RVU: 0.16 **2020 Work RVU:** 0.16
2007 NF PE RVU: 0.53 **2020 NF PE RVU:** 0.61
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73660 **Radiologic examination; toe(s), minimum of 2 views**

Global: XXX **Issue:** X-Ray Toe **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 32 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 120,091

2007 Work RVU: 0.13 **2020 Work RVU:** 0.13
2007 NF PE RVU: 0.5 **2020 NF PE RVU:** 0.64
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73700 **Computed tomography, lower extremity; without contrast material**

Global: XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 338,278

2007 Work RVU: 1.09 **2020 Work RVU:** 1.00
2007 NF PE RVU: 5.5 **2020 NF PE RVU:** 3.30
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73701 **Computed tomography, lower extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 47,637

2007 Work RVU: 1.16 **2020 Work RVU:** 1.16
2007 NF PE RVU: 6.6 **2020 NF PE RVU:** 4.23
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,842

2007 Work RVU: 1.22 **2020 Work RVU:** 1.22
2007 NF PE RVU: 8.4 **2020 NF PE RVU:** 5.27
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Global:** XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 16,508

2007 Work RVU: 1.90 **2020 Work RVU:** 1.90
2007 NF PE RVU: 11.61 **2020 NF PE RVU:** 7.98
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Survey for October 2013. Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73718 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 148,143

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35
2007 NF PE RVU: 12.14 **2020 NF PE RVU:** 5.82
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73719 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,344

2007 Work RVU: 1.62 **2020 Work RVU:** 1.62
2007 NF PE RVU: 14.12 **2020 NF PE RVU:** 6.85
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73720 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 64,864

2007 Work RVU: 2.15 **2020 Work RVU:** 2.15
2007 NF PE RVU: 23.7 **2020 NF PE RVU:** 8.72
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73721 **Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material**

Global: XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 670,662

RUC Recommendation: 1.35

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 1.35 **2020 Work RVU:** 1.35

2007 NF PE RVU: 12.05 **2020 NF PE RVU:** 5.01

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

Result: Maintain

74000 **Radiologic examination, abdomen; single anteroposterior view**

Global: **Issue:** Abdominal X-Ray **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 0.18 **2020 Work RVU:**

2007 NF PE RVU: 0.55 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

Result: Deleted from CPT

74010 **Radiologic examination, abdomen; anteroposterior and additional oblique and cone views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 0.23 **2020 Work RVU:**

2007 NF PE RVU: 0.68 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

74018 **Radiologic examination, abdomen; 1 view**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 2,153,087

2007 Work RVU: **2020 Work RVU:** 0.18

2007 NF PE RVU: **2020 NF PE RVU:** 0.62

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.18

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

74019 **Radiologic examination, abdomen; 2 views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 429,437

2007 Work RVU: **2020 Work RVU:** 0.23

2007 NF PE RVU: **2020 NF PE RVU:** 0.76

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.23

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

74020 **Radiologic examination, abdomen; complete, including decubitus and/or erect views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.27 **2020 Work RVU:**

2007 NF PE RVU: 0.72 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

74021 **Radiologic examination, abdomen; 3 or more views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 58,811

2007 Work RVU: **2020 Work RVU:** 0.27

2007 NF PE RVU: **2020 NF PE RVU:** 0.88

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.27

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

74022 **Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:** 283,318

2007 Work RVU: 0.32 **2020 Work RVU:** 0.32
2007 NF PE RVU: 0.85 **2020 NF PE RVU:** 1.02
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.32

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74150 **Computed tomography, abdomen; without contrast material**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACR

First Identified: February 2008 **2019 est Medicare Utilization:** 77,343

2007 Work RVU: 1.19 **2020 Work RVU:** 1.19
2007 NF PE RVU: 5.97 **2020 NF PE RVU:** 2.94
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74160 **Computed tomography, abdomen; with contrast material(s)**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / MPC List / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 44 **Specialty Developing Recommendation:** ACR

First Identified: February 2008 **2019 est Medicare Utilization:** 105,409

2007 Work RVU: 1.27 **2020 Work RVU:** 1.27
2007 NF PE RVU: 7.53 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.42

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen

Screen: Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2012

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 34

Specialty Developing Recommendation: ACR

First Identified: February 2008

2019 est Medicare Utilization: 107,476

2007 Work RVU: 1.40 **2020 Work RVU:** 1.40

2007 NF PE RVU: 9.6 **2020 NF PE RVU:** 6.35

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.40

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography

Screen: Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 12

Specialty Developing Recommendation: ACR, SIR

First Identified:

2019 est Medicare Utilization: 294,980

2007 Work RVU: **2020 Work RVU:** 2.20

2007 NF PE RVU: **2020 NF PE RVU:** 9.06

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.20

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography

Screen: CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 12

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2008

2019 est Medicare Utilization: 37,638

2007 Work RVU: 1.90 **2020 Work RVU:** 1.82

2007 NF PE RVU: 12.39 **2020 NF PE RVU:** 7.17

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.82

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

74176 **Computed tomography, abdomen and pelvis; without contrast material** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,284,436

2007 Work RVU: **2020 Work RVU:** 1.74
2007 NF PE RVU: **2020 NF PE RVU:** 3.79
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 **Computed tomography, abdomen and pelvis; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen and Pelvis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 44 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,361,910

2007 Work RVU: **2020 Work RVU:** 1.82
2007 NF PE RVU: **2020 NF PE RVU:** 7.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.82 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74178 **Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 534,971

2007 Work RVU: **2020 Work RVU:** 2.01
2007 NF PE RVU: **2020 NF PE RVU:** 8.23
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.01 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74181 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 117,420

2007 Work RVU: 1.46 **2020 Work RVU:** 1.46
2007 NF PE RVU: 11.71 **2020 NF PE RVU:** 4.79
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.46

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

74182 **Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 4,286

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 14.63 **2020 NF PE RVU:** 8.06
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 1.73

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

74183 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 354,840

2007 Work RVU: 2.26 **2020 Work RVU:** 2.20
2007 NF PE RVU: 23.72 **2020 NF PE RVU:** 8.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 2.20

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74210 **Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 1,577

2007 Work RVU: 0.36 **2020 Work RVU:** 0.59
2007 NF PE RVU: 1.4 **2020 NF PE RVU:** 2.03
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74220 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR **First Identified:** April 2016 **2019 est Medicare Utilization:** 196,573

2007 Work RVU: 0.46 **2020 Work RVU:** 0.60
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 2.07
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74221 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.70
2007 NF PE RVU: **2020 NF PE RVU:** 2.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74230 **Radiologic examination, swallowing function, with cineradiography/videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Esophagus **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: April 2013 **2019 est Medicare Utilization:** 370,056

2007 Work RVU: 0.53 **2020 Work RVU:** 0.53
2007 NF PE RVU: 1.57 **2020 NF PE RVU:** 3.08
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.53

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74240 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 53,309

2007 Work RVU: 0.69 **2020 Work RVU:** 0.80
2007 NF PE RVU: 1.8 **2020 NF PE RVU:** 2.53
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74241 **Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 25,415

2007 Work RVU: 0.69 **2020 Work RVU:**
2007 NF PE RVU: 1.89 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

74245 **Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 12,946

2007 Work RVU: 0.91 **2020 Work RVU:**
2007 NF PE RVU: 2.94 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

74246 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 34,438

2007 Work RVU: 0.69 **2020 Work RVU:** 0.90
2007 NF PE RVU: 2.06 **2020 NF PE RVU:** 2.94
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.90

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74247 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: April 2011 **2019 est Medicare Utilization:** 21,591

2007 Work RVU: 0.69 **2020 Work RVU:**
2007 NF PE RVU: 2.18 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

74248 **Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)**

Global: ZZZ **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.70
2007 NF PE RVU: **2020 NF PE RVU:** 1.59
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70

Referred to CPT February 2019-EC **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74249 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 13,972

2007 Work RVU: 0.91 **2020 Work RVU:**
2007 NF PE RVU: 3.17 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74250 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 52,021

2007 Work RVU: 0.47 **2020 Work RVU:** 0.81
2007 NF PE RVU: 1.68 **2020 NF PE RVU:** 2.54
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.81

Referred to CPT May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74251 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 206

2007 Work RVU: 0.69 **2020 Work RVU:** 1.17
2007 NF PE RVU: 3.52 **2020 NF PE RVU:** 10.07
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.17

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74260 **Duodenography, hypotonic**

Global: **Issue:** X-Ray Exam – Small Intestine/Colon **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 24

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 3.21 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

74270 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 28,934

2007 Work RVU: 0.69 **2020 Work RVU:** 1.04
2007 NF PE RVU: 2.29 **2020 NF PE RVU:** 3.24
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.04

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

74280 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,205

2007 Work RVU: 0.99 **2020 Work RVU:** 1.26
2007 NF PE RVU: 3.07 **2020 NF PE RVU:** 4.91
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.26 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74300 **Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 29,648

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74301 **Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 19 **Specialty Developing Recommendation:** ACR, ACS, SAGES, SIR **First Identified:** October 2018 **2019 est Medicare Utilization:** 63

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74305 **Deleted from CPT**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2019 est Medicare Utilization:

2007 Work RVU: 0.00

2020 Work RVU:

2007 NF PE RVU: NA

2020 NF PE RVU:

2007 Fac PE RVU NA

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74320 **Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2019 est Medicare Utilization:

2007 Work RVU: 0.54

2020 Work RVU:

2007 NF PE RVU: 3

2020 NF PE RVU:

2007 Fac PE RVU NA

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74327 **Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation**

Global:

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: February 2015

2019 est Medicare Utilization:

2007 Work RVU: 0.70

2020 Work RVU:

2007 NF PE RVU: 2.19

2020 NF PE RVU:

2007 Fac PE RVU NA

2020 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74328 **Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 64,506

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74329 **Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 2,990

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74330 **Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 13,859

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74400 **Urography (pyelography), intravenous, with or without KUB, with or without tomography**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,180

2007 Work RVU: 0.49 **2020 Work RVU:** 0.49
2007 NF PE RVU: 2 **2020 NF PE RVU:** 3.08
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74420 **Urography, retrograde, with or without KUB**

Global: XXX **Issue:** X-Ray Urinary Tract **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 26 **Specialty Developing Recommendation:** ACR, AUA

First Identified: April 2016 **2019 est Medicare Utilization:** 166,220

2007 Work RVU: 0.00 **2020 Work RVU:** 0.52

2007 NF PE RVU: NA **2020 NF PE RVU:** 1.53

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.52

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74425 **Urography, antegrade, radiological supervision and interpretation**

Global: XXX **Issue:** Urography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, AUA, SIR

First Identified: October 2012 **2019 est Medicare Utilization:** 3,703

2007 Work RVU: 0.00 **2020 Work RVU:** 0.51

2007 NF PE RVU: NA **2020 NF PE RVU:** 3.12

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.51, editorially revised

Referred to CPT September 2019

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74475 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.54 **2020 Work RVU:**

2007 NF PE RVU: 3.69 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

74480 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.54 **2020 Work RVU:**
2007 NF PE RVU: 3.69 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

74485 **Dilation of ureter(s) or urethra, radiological supervision and interpretation**

Global: XXX **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,628

2007 Work RVU: 0.54 **2020 Work RVU:** 0.83
2007 NF PE RVU: 3.03 **2020 NF PE RVU:** 2.32
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.83 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Increase

75561 **Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.60
2007 NF PE RVU: **2020 NF PE RVU:** 9.11
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result:

Status Report: CMS Requests and Relativity Assessment Issues

75572 **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.75
2007 NF PE RVU: **2020 NF PE RVU:** 5.16
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.40
2007 NF PE RVU: **2020 NF PE RVU:** 7.61
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, ACC **First Identified:** May 2013 **2019 est Medicare Utilization:** 86,531

2007 Work RVU: **2020 Work RVU:** 2.40
2007 NF PE RVU: **2020 NF PE RVU:** 7.61
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Survey with all CTA codes for October 2013. **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75625 **Aortography, abdominal, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 96,916

2007 Work RVU: 1.14 **2020 Work RVU:** 1.44
2007 NF PE RVU: 10.55 **2020 NF PE RVU:** 2.29
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75630 **Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 27,465

2007 Work RVU: 1.79 **2020 Work RVU:** 2.00
2007 NF PE RVU: 11.24 **2020 NF PE RVU:** 2.61
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography of Abdominal Arteries **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 114,472

2007 Work RVU: 2.40 **2020 Work RVU:** 2.40
2007 NF PE RVU: 15.56 **2020 NF PE RVU:** 9.95
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.40 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75650 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.49 **2020 Work RVU:**
2007 NF PE RVU: 10.66 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75671 **Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.66 **2020 Work RVU:**
2007 NF PE RVU: 11.08 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75680 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.66 **2020 Work RVU:**
2007 NF PE RVU: 10.96 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75710 **Angiography, extremity, unilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,614

2007 Work RVU: 1.14 **2020 Work RVU:** 1.75
2007 NF PE RVU: 10.72 **2020 NF PE RVU:** 2.65
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.75 and review utilization in October 2020 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75716 **Angiography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 74,926

2007 Work RVU: 1.31 **2020 Work RVU:** 1.97
2007 NF PE RVU: 10.96 **2020 NF PE RVU:** 2.76
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75722 **Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.14 **2020 Work RVU:**
2007 NF PE RVU: 10.7 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75724 **Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation**

Global: **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.49 **2020 Work RVU:**
2007 NF PE RVU: 11.15 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

75726 **Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 41,396

2007 Work RVU: 1.14 **2020 Work RVU:** 2.05
2007 NF PE RVU: 10.61 **2020 NF PE RVU:** 3.02
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.05 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Increase

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75774 **Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 77,363

2007 Work RVU: 0.36 **2020 Work RVU:** 1.01
2007 NF PE RVU: 10.15 **2020 NF PE RVU:** 1.93
2007 Fac PE RVU 10.15 **2020 Fac PE RVU:**NA

RUC Recommendation: 1.01 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Increase

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Status Report: CMS Requests and Relativity Assessment Issues

75790 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.84 **2020 Work RVU:**
2007 NF PE RVU: 2.2 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

75791 **Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

75820 **Venography, extremity, unilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 29 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,689

2007 Work RVU: 0.70 **2020 Work RVU:** 0.70
2007 NF PE RVU: 1.62 **2020 NF PE RVU:** 2.27
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.05 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Increase

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Status Report: CMS Requests and Relativity Assessment Issues

75822 **Venography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 29 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 10,692

2007 Work RVU: 1.06 **2020 Work RVU:** 1.06
2007 NF PE RVU: 2.12 **2020 NF PE RVU:** 2.40
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation** **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 348

2007 Work RVU: 1.44 **2020 Work RVU:** 1.44
2007 NF PE RVU: 10.54 **2020 NF PE RVU:** 2.67
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation** **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 525

2007 Work RVU: 1.44 **2020 Work RVU:** 1.44
2007 NF PE RVU: 10.6 **2020 NF PE RVU:** 2.70
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75894 **Transcatheter therapy, embolization, any method, radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,539

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan **Referred to CPT** RAW will assess Oct 2018 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

75896 **Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation**

Global: **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 09 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 February 2015 May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75898 **Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis**

Global: XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,637

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT Assistant **Referred to CPT** February 2014 February 2015 **Result:** Contractor Price
Referred to CPT Asst ☑ **Published in CPT Asst:** September 2019

Status Report: CMS Requests and Relativity Assessment Issues

75940 **Percutaneous placement of IVC filter, radiological supervision and interpretation**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75945 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75946 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75952 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75953 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75954 **Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75960 **Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**

Global: **Issue:** RAW **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 27 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75961 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 4.24 **2020 Work RVU:**
2007 NF PE RVU: 9.99 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75962 **Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.54 **2020 Work RVU:**
2007 NF PE RVU: 12.8 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75964 **Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.36 **2020 Work RVU:**
2007 NF PE RVU: 6.96 **2020 NF PE RVU:**
2007 Fac PE RVU 6.96 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75966 **Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.31 **2020 Work RVU:**
2007 NF PE RVU: 13.18 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75968 **Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.36 **2020 Work RVU:**
2007 NF PE RVU: 6.99 **2020 NF PE RVU:**
2007 Fac PE RVU 6.99 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75978 **Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.54 **2020 Work RVU:**
2007 NF PE RVU: 12.72 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75980 **Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75982 **Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75984 **Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation**

Global: XXX **Issue:** Introduction of Catheter or Stent **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 17 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,664

2007 Work RVU: 0.72 **2020 Work RVU:** 0.72
2007 NF PE RVU: 2.18 **2020 NF PE RVU:** 2.01
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.83 **Referred to CPT** RAW will assess Oct 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75992 **Deleted from CPT**

Global: **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75993 **Deleted from CPT**

Global: **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75994 **Revised to Category III**

Global: **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75995 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75996 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76000 **Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time** **Global:** XXX **Issue:** Fluoroscopy **Screen:** Low Value-Billed in Multiple Units / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 27 **Specialty Developing Recommendation:** ACR, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 118,492

2007 Work RVU: 0.17 **2020 Work RVU:** 0.30
2007 NF PE RVU: 1.68 **2020 NF PE RVU:** 0.84
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76001 **Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)**

Global: **Issue:** Fluoroscopy **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 27 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76098 **Radiological examination, surgical specimen**

Global: XXX **Issue:** X-Ray Exam Specimen **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 68,182

2007 Work RVU: 0.16 **2020 Work RVU:** 0.31
2007 NF PE RVU: 0.43 **2020 NF PE RVU:** 0.87
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.31 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography**

Global: XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 5,269

2007 Work RVU: 0.58 **2020 Work RVU:** 0.58
2007 NF PE RVU: 1.93 **2020 NF PE RVU:** 2.11
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral**

Global: XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2

2007 Work RVU: 0.58 **2020 Work RVU:** 0.58
2007 NF PE RVU: 2.5 **2020 NF PE RVU:** 2.06
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral**

Global: XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2,408

2007 Work RVU: 0.58 **2020 Work RVU:** 0.58
2007 NF PE RVU: 3.35 **2020 NF PE RVU:** 4.33
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76376 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 23 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2017 **2019 est Medicare Utilization:** 276,317

2007 Work RVU: 0.20 **2020 Work RVU:** 0.20
2007 NF PE RVU: 2.95 **2020 NF PE RVU:** 0.43
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76377 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering with Interpretation and Report **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 30 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** July 2019 **2019 est Medicare Utilization:** 190,343

2007 Work RVU: 0.79 **2020 Work RVU:** 0.79
2007 NF PE RVU: 3.09 **2020 NF PE RVU:** 1.18
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

76510 **Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 14,435

2007 Work RVU: 1.55 **2020 Work RVU:** 0.70
2007 NF PE RVU: 2.73 **2020 NF PE RVU:** 1.84
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

76511 **Ophthalmic ultrasound, diagnostic; quantitative A-scan only**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,208

2007 Work RVU: 0.94 **2020 Work RVU:** 0.64
2007 NF PE RVU: 2.17 **2020 NF PE RVU:** 1.09
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76512 **Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)** **Global:** XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 220,526

2007 Work RVU: 0.94 **2020 Work RVU:** 0.56
2007 NF PE RVU: 1.97 **2020 NF PE RVU:** 0.91
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral** **Global:** XXX **Issue:** Ophthalmic Ultrasound Anterior Segment **Screen:** High Volume Growth1 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 17 **Specialty Developing Recommendation:** AAO, AOA (optometric), ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 26,263

2007 Work RVU: 0.66 **2020 Work RVU:** 0.66
2007 NF PE RVU: 1.75 **2020 NF PE RVU:** 2.13
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.60 and CPT Assistant article published **Referred to CPT** September 2019 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2013

76514 **Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)** **Global:** XXX **Issue:** Echo Exam of Eye Thickness **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 12 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2017 **2019 est Medicare Utilization:** 488,963

2007 Work RVU: 0.17 **2020 Work RVU:** 0.14
2007 NF PE RVU: 0.15 **2020 NF PE RVU:** 0.18
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76516 **Ophthalmic biometry by ultrasound echography, A-scan;** **Global:** XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,403

2007 Work RVU: 0.54 **2020 Work RVU:** 0.40
2007 NF PE RVU: 1.39 **2020 NF PE RVU:** 0.94
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

76519 **Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation** **Global:** XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 187,253

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.49 **2020 NF PE RVU:** 1.32
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation** **Global:** XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2019 est Medicare Utilization:** 945,181

2007 Work RVU: 0.56 **2020 Work RVU:** 0.56
2007 NF PE RVU: 1.83 **2020 NF PE RVU:** 2.67
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76604 **Ultrasound, chest (includes mediastinum), real time with image documentation** **Global:** XXX **Issue:** Ultrasound Exam - Chest **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 24 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 106,091

2007 Work RVU: 0.55 **2020 Work RVU:** 0.59
2007 NF PE RVU: 1.54 **2020 NF PE RVU:** 1.60
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76641 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete**

Global: XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 647,984

2007 Work RVU: **2020 Work RVU:** 0.73
2007 NF PE RVU: **2020 NF PE RVU:** 2.25
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.73 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76642 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited**

Global: XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 769,119

2007 Work RVU: **2020 Work RVU:** 0.68
2007 NF PE RVU: **2020 NF PE RVU:** 1.75
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.68 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76645 **Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation**

Global: **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.54 **2020 Work RVU:**
2007 NF PE RVU: 1.41 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76700 **Ultrasound, abdominal, real time with image documentation; complete**

Global: XXX **Issue:** Ultrasound **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 908,859

2007 Work RVU: 0.81 **2020 Work RVU:** 0.81
2007 NF PE RVU: 2.39 **2020 NF PE RVU:** 2.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76705 **Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,100,059

2007 Work RVU: 0.59 **2020 Work RVU:** 0.59
2007 NF PE RVU: 1.77 **2020 NF PE RVU:** 1.94
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76706 **Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)**

Global: XXX **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** May 2015 **2019 est Medicare Utilization:** 159,273

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2020 Work RVU: 0.55
2020 NF PE RVU: 2.62
2020 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

76770 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,345,427

2007 Work RVU: 0.74 **2020 Work RVU:** 0.74
2007 NF PE RVU: 2.36 **2020 NF PE RVU:** 2.41
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76775 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 522,183

2007 Work RVU: 0.58 **2020 Work RVU:** 0.58
2007 NF PE RVU: 1.81 **2020 NF PE RVU:** 1.04
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.58 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76819 **Fetal biophysical profile; without non-stress testing**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified: April 2013 **2019 est Medicare Utilization:** 12,225

2007 Work RVU: 0.77 **2020 Work RVU:** 0.77
2007 NF PE RVU: 1.81 **2020 NF PE RVU:** 1.64
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

76830 **Ultrasound, transvaginal**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA

First Identified: September 2011 **2019 est Medicare Utilization:** 442,342

2007 Work RVU: 0.69 **2020 Work RVU:** 0.69
2007 NF PE RVU: 1.97 **2020 NF PE RVU:** 2.74
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

76856 **Ultrasound, pelvic (nonobstetric), real time with image documentation; complete**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR

First Identified: April 2011 **2019 est Medicare Utilization:** 429,962

2007 Work RVU: 0.69 **2020 Work RVU:** 0.69
2007 NF PE RVU: 1.99 **2020 NF PE RVU:** 2.36
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

76857 **Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 13 **Specialty Developing Recommendation:** ACR

First Identified: April 2013 **2019 est Medicare Utilization:** 205,984

2007 Work RVU: 0.38 **2020 Work RVU:** 0.50
2007 NF PE RVU: 1.99 **2020 NF PE RVU:** 0.84
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

76870 **Ultrasound, scrotum and contents**

Global: XXX **Issue:** Ultrasound Exam - Scrotum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 28 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 147,467

2007 Work RVU: 0.64 **2020 Work RVU:** 0.64
2007 NF PE RVU: 1.97 **2020 NF PE RVU:** 2.28
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76872 **Ultrasound, transrectal;**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 212,765

2007 Work RVU: 0.69 **2020 Work RVU:** 0.69
2007 NF PE RVU: 2.52 **2020 NF PE RVU:** 3.71
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76880 **Deleted from CPT**

Global: **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.59 **2020 Work RVU:**
2007 NF PE RVU: 1.97 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76881 **Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 196,753

2007 Work RVU: **2020 Work RVU:** 0.63
2007 NF PE RVU: **2020 NF PE RVU:** 1.53
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Revised PE. RAW review in Oct 2021 **Referred to CPT** June 2017 **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Winter 2011; Apr 2016

Status Report: CMS Requests and Relativity Assessment Issues

76882 **Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 288,120

2007 Work RVU: **2020 Work RVU:** 0.49
2007 NF PE RVU: **2020 NF PE RVU:** 1.09
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Revised PE. RAW review in Oct 2021 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Summer and Winter 2011; Apr 2016

76930 **Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 04 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 2,662

2007 Work RVU: 0.67 **2020 Work RVU:**
2007 NF PE RVU: 1.85 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76932 **Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 34 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,241

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76936 **Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)**

Global: XXX **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified: July 2013

2019 est Medicare Utilization: 810

2007 Work RVU: 1.99 **2020 Work RVU:** 1.99
2007 NF PE RVU: 6.67 **2020 NF PE RVU:** 5.40
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Maintain

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

76937 **Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:**

First Identified: January 2018

2019 est Medicare Utilization: 637,782

2007 Work RVU: 0.30 **2020 Work RVU:** 0.30
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.71
2007 Fac PE RVU 0.51 **2020 Fac PE RVU:**NA

RUC Recommendation: Review in 2 years (Oct 2021)

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

76940 **Ultrasound guidance for, and monitoring of, parenchymal tissue ablation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 29 **Specialty Developing Recommendation:** ACS, ACR, SIR

First Identified: July 2013

2019 est Medicare Utilization: 1,403

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

76942 **Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**

Global: XXX **Issue:** Ultrasound Guidance for Needle Placement **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: April 2014 **Tab** 35 **Specialty Developing Recommendation:** AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR

First Identified: April 2011 **2019 est Medicare Utilization:** 1,178,266

2007 Work RVU: 0.67 **2020 Work RVU:** 0.67
2007 NF PE RVU: 3.43 **2020 NF PE RVU:** 0.91
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT. 0.67

Referred to CPT May 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

76948 **Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation**

Global: XXX **Issue:** Echo Guidance for Ova Aspiration **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 25 **Specialty Developing Recommendation:** ACOG

First Identified: July 2013 **2019 est Medicare Utilization:** 3

2007 Work RVU: 0.38 **2020 Work RVU:** 0.67
2007 NF PE RVU: 1.34 **2020 NF PE RVU:** 1.45
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.85

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

76950 **Ultrasonic guidance for placement of radiation therapy fields**

Global: **Issue:** Ultrasound Guidance **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 34 **Specialty Developing Recommendation:**

First Identified: February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.58 **2020 Work RVU:**
2007 NF PE RVU: 1.43 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

76965 **Ultrasonic guidance for interstitial radioelement application**

Global: XXX **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** NO INTERESET **First Identified:** July 2013 **2019 est Medicare Utilization:** 6,316

2007 Work RVU: 1.34 **2020 Work RVU:** 1.34
2007 NF PE RVU: 4.8 **2020 NF PE RVU:** 1.24
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76970 **Ultrasound study follow-up (specify)**

Global: XXX **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth1 / CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2019 est Medicare Utilization:** 25,085

2007 Work RVU: 0.40 **2020 Work RVU:** 0.40
2007 NF PE RVU: 1.41 **2020 NF PE RVU:** 2.07
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76998 **Ultrasonic guidance, intraoperative**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS **First Identified:** January 2019 **2019 est Medicare Utilization:** 29,381

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77001 **Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 09 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 310,854

2007 Work RVU: 0.38 **2020 Work RVU:** 0.38
2007 NF PE RVU: 1.73 **2020 NF PE RVU:** 2.29
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.38 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77002 **Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2015 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 528,759

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.4 **2020 NF PE RVU:** 2.47
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.54 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77003 **Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS

First Identified: October 2010 **2019 est Medicare Utilization:** 77,998

2007 Work RVU: 0.60 **2020 Work RVU:** 0.60
2007 NF PE RVU: 1.28 **2020 NF PE RVU:** 2.21
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.60

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77011 **Computed tomography guidance for stereotactic localization**

Global: XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 15 **Specialty Developing Recommendation:** ASTRO, ACRO

First Identified: **2019 est Medicare Utilization:** 4,582

2007 Work RVU: 1.21 **2020 Work RVU:** 1.21
2007 NF PE RVU: 11.38 **2020 NF PE RVU:** 5.26
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

77012 **Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation**

Global: XXX **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 05 **Specialty Developing Recommendation:** ACR, SIR

First Identified: April 2016 **2019 est Medicare Utilization:** 210,656

2007 Work RVU: 1.16 **2020 Work RVU:** 1.50
2007 NF PE RVU: 7.02 **2020 NF PE RVU:** 2.66
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Bundled 32405 and 77012. 1.50

Referred to CPT February 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,401,373

2007 Work RVU: 0.85 **2020 Work RVU:** 0.85
2007 NF PE RVU: 3.53 **2020 NF PE RVU:** 2.56
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Referred to CPT, but CMS has not addressed. RAW review action plan (Oct 2021).

Referred to CPT
Result:
Referred to CPT Asst ☐ **Published in CPT Asst:**

77031 **Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 1.59 **2020 Work RVU:**
2007 NF PE RVU: 6.19 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Result: Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77032 **Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.56 **2020 Work RVU:**
2007 NF PE RVU: 1.26 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Result: Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77046 **Magnetic resonance imaging, breast, without contrast material; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017 **2019 est Medicare Utilization:** 367

2007 Work RVU: **2020 Work RVU:** 1.45
2007 NF PE RVU: **2020 NF PE RVU:** 5.36
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.45

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77047 **Magnetic resonance imaging, breast, without contrast material; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017 **2019 est Medicare Utilization:** 4,029

2007 Work RVU: **2020 Work RVU:** 1.60
2007 NF PE RVU: **2020 NF PE RVU:** 5.39
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.60

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77048 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017 **2019 est Medicare Utilization:** 1,164

2007 Work RVU: **2020 Work RVU:** 2.10
2007 NF PE RVU: **2020 NF PE RVU:** 8.72
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.10

Referred to CPT June 2017 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77049 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017 **2019 est Medicare Utilization:** 87,710

2007 Work RVU: **2020 Work RVU:** 2.30
2007 NF PE RVU: **2020 NF PE RVU:** 8.76
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.30 **Referred to CPT** June 2017 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

77051 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: **2019 est Medicare Utilization:**

2007 Work RVU: 0.06 **2020 Work RVU:**
2007 NF PE RVU: 0.38 **2020 NF PE RVU:**
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77052 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.06 **2020 Work RVU:**
2007 NF PE RVU: 0.38 **2020 NF PE RVU:**
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77055 **Mammography; unilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.70 **2020 Work RVU:**
2007 NF PE RVU: 1.34 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77056 **Mammography; bilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.87 **2020 Work RVU:**
2007 NF PE RVU: 1.68 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77057 **Screening mammography, bilateral (2-view study of each breast)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.70 **2020 Work RVU:**
2007 NF PE RVU: 1.43 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77058 **Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral** **Global:** **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.63 **2020 Work RVU:**
2007 NF PE RVU: 18.76 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77059 **Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral** **Global:** **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.63 **2020 Work RVU:**
2007 NF PE RVU: 23.46 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77065 **Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral** **Global:** XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 765,901

2007 Work RVU: **2020 Work RVU:** 0.81
2007 NF PE RVU: **2020 NF PE RVU:** 2.91
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 0.81 **Referred to CPT** October 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

77066 **Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral** **Global:** XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 612,243

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 3.70
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 1.00 **Referred to CPT** October 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77067 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,106,768

2007 Work RVU: **2020 Work RVU:** 0.76
2007 NF PE RVU: **2020 NF PE RVU:** 3.04
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.76 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77073 **Bone length studies (orthoroentgenogram, scanogram)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 57,827

2007 Work RVU: 0.27 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.81 **2020 NF PE RVU:** 0.95
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77074 **Radiologic examination, osseous survey; limited (eg, for metastases)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,891

2007 Work RVU: 0.45 **2020 Work RVU:** 0.44
2007 NF PE RVU: 1.2 **2020 NF PE RVU:** 1.31
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77075 **Radiologic examination, osseous survey; complete (axial and appendicular skeleton)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 44,120

2007 Work RVU: 0.54 **2020 Work RVU:** 0.55
2007 NF PE RVU: 1.76 **2020 NF PE RVU:** 2.09
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77076 **Radiologic examination, osseous survey, infant**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 50

2007 Work RVU: 0.70 **2020 Work RVU:** 0.70

2007 NF PE RVU: 1.2 **2020 NF PE RVU:** 2.16

2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77077 **Joint survey, single view, 2 or more joints (specify)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 39,322

2007 Work RVU: 0.31 **2020 Work RVU:** 0.33

2007 NF PE RVU: 1.07 **2020 NF PE RVU:** 0.93

2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.33

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

77079 **Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACR, AAFP, ACP

First Identified: October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.22 **2020 Work RVU:**

2007 NF PE RVU: 2.45 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

77080 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,624,321

2007 Work RVU: 0.20 **2020 Work RVU:** 0.20
2007 NF PE RVU: 2.59 **2020 NF PE RVU:** 0.89
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.20 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77081 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: XXX **Issue:** Dual-energy X-Ray Absorptiometry (DXA) **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 42,987

2007 Work RVU: 0.22 **2020 Work RVU:** 0.20
2007 NF PE RVU: 0.8 **2020 NF PE RVU:** 0.69
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77082 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment**

Global: **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.71 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77083 **Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites**

Global: **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACR, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.20 **2020 Work RVU:**
2007 NF PE RVU: 0.71 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

77085 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 110,730

2007 Work RVU: **2020 Work RVU:** 0.30
2007 NF PE RVU: **2020 NF PE RVU:** 1.18
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.30 **Referred to CPT** May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

77086 **Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 1,925

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.78
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17 **Referred to CPT** May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

77261 **Therapeutic radiology treatment planning; simple**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 9,135

2007 Work RVU: 1.39 **2020 Work RVU:** 1.30
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.65
2007 Fac PE RVU 0.51 **2020 Fac PE RVU:**0.65

RUC Recommendation: 1.30

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77262 **Therapeutic radiology treatment planning; intermediate**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 3,526

2007 Work RVU: 2.11 **2020 Work RVU:** 2.00
2007 NF PE RVU: 0.74 **2020 NF PE RVU:** 0.96
2007 Fac PE RVU 0.74 **2020 Fac PE RVU:**0.96

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77263 **Therapeutic radiology treatment planning; complex**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 297,484

2007 Work RVU: 3.14 **2020 Work RVU:** 3.14
2007 NF PE RVU: 1.1 **2020 NF PE RVU:** 1.46
2007 Fac PE RVU 1.1 **2020 Fac PE RVU:**1.46

RUC Recommendation: 3.14

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

77280 **Therapeutic radiology simulation-aided field setting; simple**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO

First Identified: April 2011 **2019 est Medicare Utilization:** 370,105

2007 Work RVU: 0.70 **2020 Work RVU:** 0.70
2007 NF PE RVU: 3.89 **2020 NF PE RVU:** 7.11
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77285 **Therapeutic radiology simulation-aided field setting; intermediate**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO

First Identified: September 2011 **2019 est Medicare Utilization:** 4,612

2007 Work RVU: 1.05 **2020 Work RVU:** 1.05
2007 NF PE RVU: 6.45 **2020 NF PE RVU:** 12.03
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.05

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77290 **Therapeutic radiology simulation-aided field setting; complex**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2010 **2019 est Medicare Utilization:** 210,211

2007 Work RVU: 1.56 **2020 Work RVU:** 1.56
2007 NF PE RVU: 8.63 **2020 NF PE RVU:** 12.44
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.56

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

77293 **Respiratory motion management simulation (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:** 31,536

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 10.65
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77295 **3-dimensional radiotherapy plan, including dose-volume histograms** **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 142,124

2007 Work RVU: 4.56 **2020 Work RVU:** 4.29
2007 NF PE RVU: 23.92 **2020 NF PE RVU:** 9.30
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 4.29 **Referred to CPT** October 2012, October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77300 **Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician** **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** MPC List / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,349,820

2007 Work RVU: 0.62 **2020 Work RVU:** 0.62
2007 NF PE RVU: 1.45 **2020 NF PE RVU:** 1.23
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.62 **Referred to CPT** February 2014, October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications**

Global: XXX **Issue:** IMRT - PE Only **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes1 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:** 143,270

2007 Work RVU: 7.99 **2020 Work RVU:** 7.99
2007 NF PE RVU: 37.25 **2020 NF PE RVU:** 45.46
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs. 7.99. CPT Assistant article published.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009

77305 **Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.70 **2020 Work RVU:**
2007 NF PE RVU: 1.79 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77306 **Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,027

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 2.76
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.40

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77307 **Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 40,701

2007 Work RVU: **2020 Work RVU:** 2.90
2007 NF PE RVU: **2020 NF PE RVU:** 5.14
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77310 **Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.05 **2020 Work RVU:**
2007 NF PE RVU: 2.32 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77315 **Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.56 **2020 Work RVU:**
2007 NF PE RVU: 2.9 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77316 **Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 4,610

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 4.67
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77317 **Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 3,179

2007 Work RVU: **2020 Work RVU:** 1.83
2007 NF PE RVU: **2020 NF PE RVU:** 6.13
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.83

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77318 **Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 / RUC Request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 5,949

2007 Work RVU: **2020 Work RVU:** 2.90
2007 NF PE RVU: **2020 NF PE RVU:** 8.48
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.90

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

77326 **Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.93 **2020 Work RVU:**
2007 NF PE RVU: 2.75 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77327 **Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.39 **2020 Work RVU:**
2007 NF PE RVU: 3.97 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77328 **Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 2.09 **2020 Work RVU:**
2007 NF PE RVU: 5.54 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

77332 **Treatment devices, design and construction; simple (simple block, simple bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 75,801

2007 Work RVU: 0.54 **2020 Work RVU:** 0.45
2007 NF PE RVU: 1.53 **2020 NF PE RVU:** 0.86
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77333 **Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 12,128

2007 Work RVU: 0.84 **2020 Work RVU:** 0.75
2007 NF PE RVU: 1.75 **2020 NF PE RVU:** 2.62
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77334 **Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)**

Global: XXX **Issue:** **Screen:** MPC List / RUC request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 845,243

2007 Work RVU: 1.24 **2020 Work RVU:** 1.15
2007 NF PE RVU: 3.43 **2020 NF PE RVU:** 2.40
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77336 **Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy**

Global: XXX **Issue:** Continuing Medical Physics Consultation-PE Only **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 31 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 412,038

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 2.52 **2020 NF PE RVU:** 2.19
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: PE Only

RUC Recommendation: New PE Inputs
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77338 **Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan**

Global: XXX **Issue:** IMRT - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 28 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 165,179

2007 Work RVU: **2020 Work RVU:** 4.29
2007 NF PE RVU: **2020 NF PE RVU:** 9.26
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: PE Only

RUC Recommendation: New PE Inputs
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77371 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based**

Global: XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** NA **2019 est Medicare Utilization:** 100

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 30.25 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.00
Result: PE Only

RUC Recommendation: New PE inputs
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77372 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:** 818

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 22.93 **2020 NF PE RVU:** 29.48
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77373 **Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASTRO, ACRO **First Identified:** July 2012 **2019 est Medicare Utilization:** 33,144

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 42.87 **2020 NF PE RVU:** 33.91
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77385 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00
Result: PE Only

RUC Recommendation: PE Only, revised introductory guidelines

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77386 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77387 **Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 0.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77401 **Radiation treatment delivery, superficial and/or ortho voltage, per day**

Global: XXX **Issue:** Radiation Treatement Delivery (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 31 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 221,049

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.45 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** May 2019 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77402 **Radiation treatment delivery, >=1 MeV; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 2.37 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 and Feburary 2014 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77403 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 2.27 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77404 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 2.38 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77406 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 2.38 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77407 **Radiation treatment delivery, >=1 MeV; intermediate**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 2.93 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77408 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 2.87 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77409 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 3.02 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77411 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 3.01 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77412 **Radiation treatment delivery, >=1 MeV; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 3.46 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77413 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 3.46 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77414 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 3.68 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77416 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 3.68 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 16.8 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009 and Q&A - Mar 2010

77421 **Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.39 **2020 Work RVU:**
2007 NF PE RVU: 3.11 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77422 **High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking**

Global: **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 4.58 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77423 **High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)**

Global: XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 3.84 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77427 **Radiation treatment management, 5 treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,043,579

2007 Work RVU: 3.70 **2020 Work RVU:** 3.37
2007 NF PE RVU: 1.15 **2020 NF PE RVU:** 1.82
2007 Fac PE RVU 1.15 **2020 Fac PE RVU:** 1.82

RUC Recommendation: 3.45. Remove from high E/M screen. **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77435 **Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 38,142

2007 Work RVU: 13.00 **2020 Work RVU:** 11.87
2007 NF PE RVU: 4.63 **2020 NF PE RVU:** 5.64
2007 Fac PE RVU NA **2020 Fac PE RVU:** 5.64

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77470 **Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)** **Global:** XXX **Issue:** Special Radiation Treatment **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 41 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 91,885

2007 Work RVU: 2.09 **2020 Work RVU:** 2.03
2007 NF PE RVU: 9.35 **2020 NF PE RVU:** 1.66
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77520 **Proton treatment delivery; simple, without compensation** **Global:** XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 256

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77522 **Proton treatment delivery; simple, with compensation** **Global:** XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** January 2018 **2019 est Medicare Utilization:** 15,881

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77523 **Proton treatment delivery; intermediate**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** High Volume Growth4 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2016 **2019 est Medicare Utilization:** 47,302

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77525 **Proton treatment delivery; complex**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 20,144

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77600 **Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)**

Global: XXX **Issue:** Hyperthermia - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,464

2007 Work RVU: 1.56 **2020 Work RVU:** 1.31
2007 NF PE RVU: 5.09 **2020 NF PE RVU:** 11.75
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77767 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 5,362

2007 Work RVU: **2020 Work RVU:** 1.05
2007 NF PE RVU: **2020 NF PE RVU:** 5.63
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.05 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77768 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 7,665

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 8.65
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.40 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77770 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,117

2007 Work RVU: **2020 Work RVU:** 1.95
2007 NF PE RVU: **2020 NF PE RVU:** 7.43
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.95 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77771 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,697

2007 Work RVU: **2020 Work RVU:** 3.80
2007 NF PE RVU: **2020 NF PE RVU:** 12.95
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77772 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,164

2007 Work RVU: **2020 Work RVU:** 5.40
2007 NF PE RVU: **2020 NF PE RVU:** 19.84
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 5.40 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77776 **Interstitial radiation source application; simple**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 4.67 **2020 Work RVU:**
2007 NF PE RVU: 4.23 **2020 NF PE RVU:**
2007 Fac PE RVU 4.23 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77777 **Interstitial radiation source application; intermediate**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 7.49 **2020 Work RVU:**
2007 NF PE RVU: 6.92 **2020 NF PE RVU:**
2007 Fac PE RVU 6.92 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77778 **Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed**

Global: 000 **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,806

2007 Work RVU: 11.23 **2020 Work RVU:** 8.78
2007 NF PE RVU: 9.38 **2020 NF PE RVU:** 15.33
2007 Fac PE RVU 9.38 **2020 Fac PE RVU:** NA

RUC Recommendation: 8.78 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77781 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.21 **2020 Work RVU:**
2007 NF PE RVU: 16.73 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77782 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 2.04 **2020 Work RVU:**
2007 NF PE RVU: 18.94 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 5.15 **2020 Work RVU:**
2007 NF PE RVU: 28.04 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77790 **Supervision, handling, loading of radiation source**

Global: XXX **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** ACR, ASTRO, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 145

2007 Work RVU: 1.05 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1 **2020 NF PE RVU:** 0.42
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.00 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78000 **Thyroid uptake; single determination**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.19 **2020 Work RVU:**
2007 NF PE RVU: 1.21 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78001 **Thyroid uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 1.59 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78003 **Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.33 **2020 Work RVU:**
2007 NF PE RVU: 1.26 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78006 **Thyroid imaging, with uptake; single determination**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.49 **2020 Work RVU:**
2007 NF PE RVU: 3.38 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78007 **Thyroid imaging, with uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 2.76 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78010 **Thyroid imaging; only**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.39 **2020 Work RVU:**
2007 NF PE RVU: 2.45 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78011 **Thyroid imaging; with vascular flow**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.45 **2020 Work RVU:**
2007 NF PE RVU: 2.99 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,653

2007 Work RVU: **2020 Work RVU:** 0.19
2007 NF PE RVU: **2020 NF PE RVU:** 2.10
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.19 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78013 **Thyroid imaging (including vascular flow, when performed);**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,711

2007 Work RVU: **2020 Work RVU:** 0.37
2007 NF PE RVU: **2020 NF PE RVU:** 5.08
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.37 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78014 **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 18,954

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 6.29
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78070 **Parathyroid planar imaging (including subtraction, when performed);**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 13,220

2007 Work RVU: 0.82 **2020 Work RVU:** 0.80
2007 NF PE RVU: 4.21 **2020 NF PE RVU:** 7.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

Status Report: CMS Requests and Relativity Assessment Issues

78071 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,974

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 8.82
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78072 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 12,267

2007 Work RVU: **2020 Work RVU:** 1.60
2007 NF PE RVU: **2020 NF PE RVU:** 11.05
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78223 **Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function**

Global: **Issue:** Hepatobiliary Ductal System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.84 **2020 Work RVU:**
2007 NF PE RVU: 4.95 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78226 **Hepatobiliary system imaging, including gallbladder when present;**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 61,197

2007 Work RVU: **2020 Work RVU:** 0.74
2007 NF PE RVU: **2020 NF PE RVU:** 8.56
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78227 **Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 64,389

2007 Work RVU: **2020 Work RVU:** 0.90
2007 NF PE RVU: **2020 NF PE RVU:** 11.66
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78265 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,303

2007 Work RVU: **2020 Work RVU:** 0.98
2007 NF PE RVU: **2020 NF PE RVU:** 10.17
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

78266 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 313

2007 Work RVU: **2020 Work RVU:** 1.08
2007 NF PE RVU: **2020 NF PE RVU:** 11.14
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

Status Report: CMS Requests and Relativity Assessment Issues

78278 **Acute gastrointestinal blood loss imaging**

Global: XXX **Issue:** Acute GI Blood Loss Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 34 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 26,257

2007 Work RVU: 0.99 **2020 Work RVU:** 0.99
2007 NF PE RVU: 5.92 **2020 NF PE RVU:** 8.88
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.99 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78300 **Bone and/or joint imaging; limited area**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 6,808

2007 Work RVU: 0.62 **2020 Work RVU:** 0.62
2007 NF PE RVU: 3 **2020 NF PE RVU:** 5.88
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78305 **Bone and/or joint imaging; multiple areas**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,645

2007 Work RVU: 0.83 **2020 Work RVU:** 0.83
2007 NF PE RVU: 4.24 **2020 NF PE RVU:** 7.04
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78306 **Bone and/or joint imaging; whole body**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 262,283

2007 Work RVU: 0.86 **2020 Work RVU:** 0.86
2007 NF PE RVU: 4.84 **2020 NF PE RVU:** 7.66
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78429 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78430 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.67 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78431 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78432 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.07 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78433 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.26 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78434 **Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.63 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78451 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 35,912

2007 Work RVU: **2020 Work RVU:** 1.38
2007 NF PE RVU: **2020 NF PE RVU:** 8.15
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.40 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78452 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,787,846

2007 Work RVU: **2020 Work RVU:** 1.62
2007 NF PE RVU: **2020 NF PE RVU:** 11.67
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,518

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 7.56
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 10,009

2007 Work RVU: **2020 Work RVU:** 1.34
2007 NF PE RVU: **2020 NF PE RVU:** 10.96
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78459 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 3,214

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78460 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.86 **2020 Work RVU:**
2007 NF PE RVU: 3.1 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78461 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 1.23 **2020 Work RVU:**
2007 NF PE RVU: 4.81 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78464 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 1.09 **2020 Work RVU:**
2007 NF PE RVU: 7.03 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78465 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.46 **2020 Work RVU:**
2007 NF PE RVU: 12.08 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78472 **Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

Global: XXX **Issue:** Cardiac Blood Pool Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 35 **Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 18,051

2007 Work RVU: 0.98 **2020 Work RVU:** 0.98
2007 NF PE RVU: 5.87 **2020 NF PE RVU:** 5.45
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.98 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

78478 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 1.54 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78480 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.30 **2020 Work RVU:**
2007 NF PE RVU: 1.51 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78491 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 1,809

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78492 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** October 2016 **2019 est Medicare Utilization:** 179,360

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 1.80 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78579 **Pulmonary ventilation imaging (eg, aerosol or gas)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 360

2007 Work RVU: **2020 Work RVU:** 0.49
2007 NF PE RVU: **2020 NF PE RVU:** 4.82
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.49 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78580 **Pulmonary perfusion imaging (eg, particulate)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,224

2007 Work RVU: 0.74 **2020 Work RVU:** 0.74
2007 NF PE RVU: 3.97 **2020 NF PE RVU:** 5.97
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.74 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

78582 **Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 165,031

2007 Work RVU: **2020 Work RVU:** 1.07
2007 NF PE RVU: **2020 NF PE RVU:** 8.37
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.07 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78584 **Pulmonary perfusion imaging, particulate, with ventilation; single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.99 **2020 Work RVU:**
2007 NF PE RVU: 3.34 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78585 **Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 1.09 **2020 Work RVU:**
2007 NF PE RVU: 6.53 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78586 **Pulmonary ventilation imaging, aerosol; single projection**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.40 **2020 Work RVU:**
2007 NF PE RVU: 3.02 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78587 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.49 **2020 Work RVU:**
2007 NF PE RVU: 3.51 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.09 **2020 Work RVU:**
2007 NF PE RVU: 4.7 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78591 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.40 **2020 Work RVU:**
2007 NF PE RVU: 3.21 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78593 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.49 **2020 Work RVU:**
2007 NF PE RVU: 3.84 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78594 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.53 **2020 Work RVU:**
2007 NF PE RVU: 5.12 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 1.27 **2020 Work RVU:**
2007 NF PE RVU: 7.7 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78597 **Quantitative differential pulmonary perfusion, including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,640

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 4.94
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.75 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78598 **Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,383

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 7.77
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.85 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78803 **Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging**

Global: XXX **Issue:** RAW **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 14 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** January 2016 **2019 est Medicare Utilization:** 11,736

2007 Work RVU: 1.09 **2020 Work RVU:** 1.09
2007 NF PE RVU: 8.73 **2020 NF PE RVU:** 9.93
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78815 **Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2010 **2019 est Medicare Utilization:** 604,627

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: Reaffirmed RUC recommendation **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

79101 **Radiopharmaceutical therapy, by intravenous administration** **Global:** XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 12,142

2007 Work RVU: 1.96 **2020 Work RVU:** 1.96
2007 NF PE RVU: 2.98 **2020 NF PE RVU:** 2.17
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Article published Feb 2012 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2012

80500 **Clinical pathology consultation; limited, without review of patient's history and medical records** **Global:** XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** CAP **First Identified:** January 2019 **2019 est Medicare Utilization:** 21,998

2007 Work RVU: 0.37 **2020 Work RVU:** 0.37
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.25
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**0.17

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

80502 **Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records** **Global:** XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: 1.33 **2020 Work RVU:** 1.33
2007 NF PE RVU: 0.48 **2020 NF PE RVU:** 0.70
2007 Fac PE RVU 0.47 **2020 Fac PE RVU:**0.61

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX0 **Global:** **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80XX1 **Global:** **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX2 **Global:** **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX3 **Global:** **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** January 2021 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** October 2020 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

85060 **Blood smear, peripheral, interpretation by physician with written report** **Global:** XXX **Issue:** Blood Smear Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 30 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 185,409

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.17 **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.17 **2020 Fac PE RVU:** 0.22

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

85097 **Bone marrow, smear interpretation**

Global: XXX **Issue:** Bone Marrow Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 31 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 140,727

2007 Work RVU: 0.94 **2020 Work RVU:** 0.94
2007 NF PE RVU: 1.76 **2020 NF PE RVU:** 0.99
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**0.43

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

85390 **Fibrinolysins or coagulopathy screen, interpretation and report**

Global: XXX **Issue:** Fibrinolysins Screen **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 26 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 34,588

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

88104 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 65,152

2007 Work RVU: 0.56 **2020 Work RVU:** 0.56
2007 NF PE RVU: 0.93 **2020 NF PE RVU:** 1.35
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88106 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,360

2007 Work RVU: 0.56 **2020 Work RVU:** 0.37
2007 NF PE RVU: 1.39 **2020 NF PE RVU:** 1.44
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs. 0.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88107 **Deleted from CPT**

Global: **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.76 **2020 Work RVU:**
2007 NF PE RVU: 1.66 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

88108 **Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 229,625

2007 Work RVU: 0.56 **2020 Work RVU:** 0.44
2007 NF PE RVU: 1.27 **2020 NF PE RVU:** 1.29
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs. 0.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88112 **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 886,295

2007 Work RVU: 1.18 **2020 Work RVU:** 0.56
2007 NF PE RVU: 1.85 **2020 NF PE RVU:** 1.32
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Decrease

RUC Recommendation: New PE Inputs. 0.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88120 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 49,876

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 15.09
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: Utilization shift is appropriate.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88121 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 28,769

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 11.45
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: Utilization shift is appropriate.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88141 **Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 55,857

2007 Work RVU: 0.42 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.46

RUC Recommendation: 0.42

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88160 **Cytopathology, smears, any other source; screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:**

First Identified: April 2015 **2019 est Medicare Utilization:** 8,020

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.85 **2020 NF PE RVU:** 1.49
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

88161 **Cytopathology, smears, any other source; preparation, screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:**

First Identified: April 2015 **2019 est Medicare Utilization:** 4,156

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.99 **2020 NF PE RVU:** 1.41
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

88162 **Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,306

2007 Work RVU: 0.76 **2020 Work RVU:** 0.76
2007 NF PE RVU: 1.05 **2020 NF PE RVU:** 2.01
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88184 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker**

Global: XXX **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 104,681

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.6 **2020 NF PE RVU:** 1.87
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued. **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88185 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)**

Global: ZZZ **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,918,080

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.85 **2020 NF PE RVU:** 0.62
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued. **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88187 **Flow cytometry, interpretation; 2 to 8 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015 **2019 est Medicare Utilization:** 42,225

2007 Work RVU: 1.36 **2020 Work RVU:** 0.74
2007 NF PE RVU: 0.44 **2020 NF PE RVU:** 0.30
2007 Fac PE RVU 0.44 **2020 Fac PE RVU:**0.30

RUC Recommendation: 0.74

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88188 **Flow cytometry, interpretation; 9 to 15 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015 **2019 est Medicare Utilization:** 38,197

2007 Work RVU: 1.69 **2020 Work RVU:** 1.20
2007 NF PE RVU: 0.54 **2020 NF PE RVU:** 0.57
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:**0.57

RUC Recommendation: 1.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88189 **Flow cytometry, interpretation; 16 or more markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015 **2019 est Medicare Utilization:** 222,162

2007 Work RVU: 2.23 **2020 Work RVU:** 1.70
2007 NF PE RVU: 0.68 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU 0.68 **2020 Fac PE RVU:**0.67

RUC Recommendation: 1.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88300 **Level I - Surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 207,562

2007 Work RVU: 0.08 **2020 Work RVU:** 0.08
2007 NF PE RVU: 0.49 **2020 NF PE RVU:** 0.34
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.08 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88302 **Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 75,443

2007 Work RVU: 0.13 **2020 Work RVU:** 0.13
2007 NF PE RVU: 1.1 **2020 NF PE RVU:** 0.72
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.13 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88304 **Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 967,907

2007 Work RVU: 0.22 **2020 Work RVU:** 0.22
2007 NF PE RVU: 1.37 **2020 NF PE RVU:** 0.92
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.22 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88305 **Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,561,979

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 1.97 **2020 NF PE RVU:** 1.21
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.75 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88307 **Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 983,152

2007 Work RVU: 1.59 **2020 Work RVU:** 1.59
2007 NF PE RVU: 3.48 **2020 NF PE RVU:** 6.15
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.59 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88309 **Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 150,124

2007 Work RVU: 2.80 **2020 Work RVU:** 2.80
2007 NF PE RVU: 4.86 **2020 NF PE RVU:** 8.97
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 2.80 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88312 **Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,383,233

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.76 **2020 NF PE RVU:** 2.41
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.54 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 **Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,362,216

2007 Work RVU: 0.24 **2020 Work RVU:** 0.24
2007 NF PE RVU: 1.42 **2020 NF PE RVU:** 1.88
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.24 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 **Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,474

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 2.04 **2020 NF PE RVU:** 2.26
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.45 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318 **Deleted from CPT**

Global: **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 22 **Specialty Developing Recommendation:** CAP, AAD **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.42 **2020 Work RVU:**
2007 NF PE RVU: 1.98 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

88319 **Special stain including interpretation and report; Group III, for enzyme constituents**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 33 **Specialty Developing Recommendation:** CAP **First Identified:** **2019 est Medicare Utilization:** 17,807

2007 Work RVU: 0.53 **2020 Work RVU:** 0.53
2007 NF PE RVU: 3.36 **2020 NF PE RVU:** 2.60
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.53 **Referred to CPT** June 2010
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

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88321 **Consultation and report on referred slides prepared elsewhere**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 182,148

2007 Work RVU: 1.63 **2020 Work RVU:** 1.63
2007 NF PE RVU: 0.78 **2020 NF PE RVU:** 1.12
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:**0.72

RUC Recommendation: 1.63 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

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88323 **Consultation and report on referred material requiring preparation of slides**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 35,000

2007 Work RVU: 1.83 **2020 Work RVU:** 1.83
2007 NF PE RVU: 1.88 **2020 NF PE RVU:** 1.40
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.83 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

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Status Report: CMS Requests and Relativity Assessment Issues

88325 **Consultation, comprehensive, with review of records and specimens, with report on referred material**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 11,656

2007 Work RVU: 2.50 **2020 Work RVU:** 2.85
2007 NF PE RVU: 2.76 **2020 NF PE RVU:** 1.99
2007 Fac PE RVU 0.87 **2020 Fac PE RVU:**1.21

RUC Recommendation: 2.85 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

88329 **Pathology consultation during surgery;**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 27,870

2007 Work RVU: 0.67 **2020 Work RVU:** 0.67
2007 NF PE RVU: 0.66 **2020 NF PE RVU:** 0.79
2007 Fac PE RVU 0.27 **2020 Fac PE RVU:**0.33

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88331 **Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 448,638

2007 Work RVU: 1.19 **2020 Work RVU:** 1.19
2007 NF PE RVU: 1.14 **2020 NF PE RVU:** 1.56
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88332 **Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 163,257

2007 Work RVU: 0.59 **2020 Work RVU:** 0.59
2007 NF PE RVU: 0.46 **2020 NF PE RVU:** 0.93
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88333 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 69,359

2007 Work RVU: 1.20 **2020 Work RVU:** 1.20
2007 NF PE RVU: 1.15 **2020 NF PE RVU:** 1.32
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88334 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,996

2007 Work RVU: 0.73 **2020 Work RVU:** 0.73
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 0.86
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.73 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88341 **Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 3,097,983

2007 Work RVU: **2020 Work RVU:** 0.56
2007 NF PE RVU: **2020 NF PE RVU:** 2.04
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88342 **Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,040,539

2007 Work RVU: 0.85 **2020 Work RVU:** 0.70
2007 NF PE RVU: 1.6 **2020 NF PE RVU:** 2.25
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88343 **Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)**

Global: **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88344 **Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 132,224

2007 Work RVU: **2020 Work RVU:** 0.77
2007 NF PE RVU: **2020 NF PE RVU:** 4.07
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88346 **Immunofluorescence, per specimen; initial single antibody stain procedure** **Global:** XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,000

2007 Work RVU: 0.86 **2020 Work RVU:** 0.74
2007 NF PE RVU: 1.67 **2020 NF PE RVU:** 2.80
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.74 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88347 **Immunofluorescent study, each antibody; indirect method** **Global:** **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.86 **2020 Work RVU:**
2007 NF PE RVU: 1.28 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88348 **Electron microscopy, diagnostic** **Global:** XXX **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:** 17,170

2007 Work RVU: 1.51 **2020 Work RVU:** 1.51
2007 NF PE RVU: 11.48 **2020 NF PE RVU:** 9.33
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88349 **Electron microscopy; scanning**

Global: **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 14 **Specialty Developing Recommendation:** CAP

First Identified: October 2012 **2019 est Medicare Utilization:**

2007 Work RVU: 0.76 **2020 Work RVU:**
2007 NF PE RVU: 4.88 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT Oct 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

88350 **Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 17 **Specialty Developing Recommendation:** CAP, ASC

First Identified: October 2014 **2019 est Medicare Utilization:** 260,841

2007 Work RVU: **2020 Work RVU:** 0.59
2007 NF PE RVU: **2020 NF PE RVU:** 2.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88356 **Morphometric analysis; nerve**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 37 **Specialty Developing Recommendation:** ASCP, CAP

First Identified: April 2013 **2019 est Medicare Utilization:** 15,440

2007 Work RVU: 3.02 **2020 Work RVU:** 2.80
2007 NF PE RVU: 4.79 **2020 NF PE RVU:** 3.76
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 2.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88360 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 506,136

2007 Work RVU: 1.10 **2020 Work RVU:** 0.85
2007 NF PE RVU: 1.87 **2020 NF PE RVU:** 2.66
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88361 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 169,281

2007 Work RVU: 1.18 **2020 Work RVU:** 0.95
2007 NF PE RVU: 2.94 **2020 NF PE RVU:** 2.61
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88364 **In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 28,908

2007 Work RVU: **2020 Work RVU:** 0.70
2007 NF PE RVU: **2020 NF PE RVU:** 3.17
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88365 **In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 48,038

2007 Work RVU: 1.20 **2020 Work RVU:** 0.88
2007 NF PE RVU: 2.32 **2020 NF PE RVU:** 4.18
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88366 **In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 2,322

2007 Work RVU: **2020 Work RVU:** 1.24
2007 NF PE RVU: **2020 NF PE RVU:** 6.52
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.24 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88367 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,914

2007 Work RVU: 1.30 **2020 Work RVU:** 0.73
2007 NF PE RVU: 4.31 **2020 NF PE RVU:** 2.44
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.86 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

Status Report: CMS Requests and Relativity Assessment Issues

88368 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,780

2007 Work RVU: 1.40 **2020 Work RVU:** 0.88
2007 NF PE RVU: 2.96 **2020 NF PE RVU:** 2.80
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88373 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 6,229

2007 Work RVU: **2020 Work RVU:** 0.58
2007 NF PE RVU: **2020 NF PE RVU:** 1.49
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

88374 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** **2019 est Medicare Utilization:** 113,039

2007 Work RVU: **2020 Work RVU:** 0.93
2007 NF PE RVU: **2020 NF PE RVU:** 8.70
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.04 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88377 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 24 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 152,595

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 9.97
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.40 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

90465 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.35 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90467 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.17 **2020 NF PE RVU:**
2007 Fac PE RVU 0.09 **2020 Fac PE RVU:**

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2019 est Medicare Utilization:** 282,357

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.35 **2020 NF PE RVU:** 0.22
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2019 est Medicare Utilization:** 22,524

2007 Work RVU: 0.15 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.13 **2020 NF PE RVU:** 0.20
2007 Fac PE RVU 0.11 **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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90473 **Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:** 3

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.18 **2020 NF PE RVU:** 0.22
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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Status Report: CMS Requests and Relativity Assessment Issues

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:** 1

2007 Work RVU: 0.15 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.09 **2020 NF PE RVU:** 0.20
2007 Fac PE RVU 0.05 **2020 Fac PE RVU:** NA
Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90785 **Interactive complexity (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 408,566

2007 Work RVU: **2020 Work RVU:** 0.33
2007 NF PE RVU: **2020 NF PE RVU:** 0.09
2007 Fac PE RVU **2020 Fac PE RVU:** 0.05
Result: Increase

RUC Recommendation: Refer to CPT Review in 3 years (Oct 2023). 0.33

Referred to CPT October 2020
Referred to CPT Asst ☐ **Published in CPT Asst:**

90791 **Psychiatric diagnostic evaluation**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 917,143

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.92
2007 Fac PE RVU **2020 Fac PE RVU:** 0.43
Result: Increase

RUC Recommendation: 3.00

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90792 **Psychiatric diagnostic evaluation with medical services**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

First Identified: April 2013 **2019 est Medicare Utilization:** 586,327

2007 Work RVU: **2020 Work RVU:** 3.25

2007 NF PE RVU: **2020 NF PE RVU:** 1.10

2007 Fac PE RVU **2020 Fac PE RVU:** 0.60

RUC Recommendation: 3.25

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

90801 **Psychiatric diagnostic interview examination**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.80 **2020 Work RVU:**

2007 NF PE RVU: 1.25 **2020 NF PE RVU:**

2007 Fac PE RVU 0.85 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

90805 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.37 **2020 Work RVU:**

2007 NF PE RVU: 0.53 **2020 NF PE RVU:**

2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

90806 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.86 **2020 Work RVU:**
2007 NF PE RVU: 0.66 **2020 NF PE RVU:**
2007 Fac PE RVU 0.53 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

90808 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 2.79 **2020 Work RVU:**
2007 NF PE RVU: 0.94 **2020 NF PE RVU:**
2007 Fac PE RVU 0.8 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

90818 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.89 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0.63 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

90832 **Psychotherapy, 30 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,306,870

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.41
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90833 **Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,401,042

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.46
2007 Fac PE RVU **2020 Fac PE RVU:** 0.28

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90834 **Psychotherapy, 45 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 4,939,452

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.54
2007 Fac PE RVU **2020 Fac PE RVU:** 0.28

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90836 **Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 510,888

2007 Work RVU: **2020 Work RVU:** 1.90
2007 NF PE RVU: **2020 NF PE RVU:** 0.58
2007 Fac PE RVU **2020 Fac PE RVU:** 0.35

RUC Recommendation: 1.90 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90837 **Psychotherapy, 60 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,027,217

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.81
2007 Fac PE RVU **2020 Fac PE RVU:** 0.42

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90838 **Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 100,884

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.77
2007 Fac PE RVU **2020 Fac PE RVU:** 0.47

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90839 **Psychotherapy for crisis; first 60 minutes**

Global: XXX **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 23,040

2007 Work RVU: **2020 Work RVU:** 3.13
2007 NF PE RVU: **2020 NF PE RVU:** 0.85
2007 Fac PE RVU **2020 Fac PE RVU:** 0.45

RUC Recommendation: 3.13 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90840 **Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,284

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.40
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90845 **Psychoanalysis**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2011 **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,591

2007 Work RVU: 1.79 **2020 Work RVU:** 2.10
2007 NF PE RVU: 0.53 **2020 NF PE RVU:** 0.59
2007 Fac PE RVU 0.49 **2020 Fac PE RVU:** 0.34

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90846 **Family psychotherapy (without the patient present), 50 minutes**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 21,975

2007 Work RVU: 1.83 **2020 Work RVU:** 2.40
2007 NF PE RVU: 0.62 **2020 NF PE RVU:** 0.38
2007 Fac PE RVU 0.6 **2020 Fac PE RVU:** 0.36

RUC Recommendation: 2.40 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90847 **Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 178,166

2007 Work RVU: 2.21 **2020 Work RVU:** 2.50
2007 NF PE RVU: 0.8 **2020 NF PE RVU:** 0.38
2007 Fac PE RVU 0.69 **2020 Fac PE RVU:**0.37

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90853 **Group psychotherapy (other than of a multiple-family group)**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 906,163

2007 Work RVU: 0.59 **2020 Work RVU:** 0.59
2007 NF PE RVU: 0.26 **2020 NF PE RVU:** 0.17
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:**0.09

RUC Recommendation: 0.59 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

90862 **Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.95 **2020 Work RVU:**
2007 NF PE RVU: 0.46 **2020 NF PE RVU:**
2007 Fac PE RVU 0.31 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90863 **Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global: XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 40 **Specialty Developing Recommendation:** APA (HCPAC)

First Identified: April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.48
2007 NF PE RVU: **2020 NF PE RVU:** 0.23
2007 Fac PE RVU **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90868 **Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session**

Global: 000 **Issue:** **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: January 2018 **2019 est Medicare Utilization:** 238,754

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Review in 2 years (Oct 2020) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

90870 **Electroconvulsive therapy (includes necessary monitoring)**

Global: 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 41 **Specialty Developing Recommendation:** APA

First Identified: October 2009 **2019 est Medicare Utilization:** 126,401

2007 Work RVU: 1.88 **2020 Work RVU:** 2.50
2007 NF PE RVU: 1.93 **2020 NF PE RVU:** 2.40
2007 Fac PE RVU 0.54 **2020 Fac PE RVU:** 0.52

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90911 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry**

Global: **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** April 2017 **2019 est Medicare Utilization:** 28,865

2007 Work RVU: 0.89 **2020 Work RVU:**
2007 NF PE RVU: 1.51 **2020 NF PE RVU:**
2007 Fac PE RVU 0.31 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90912 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient**

Global: 000 **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.90
2007 NF PE RVU: **2020 NF PE RVU:** 1.32
2007 Fac PE RVU **2020 Fac PE RVU:** 0.31

RUC Recommendation: 0.90 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90913 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.39
2007 Fac PE RVU **2020 Fac PE RVU:** 0.17

RUC Recommendation: 0.50 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90935 **Hemodialysis procedure with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA

First Identified: October 2008

2019 est Medicare Utilization: 1,098,691

2007 Work RVU: 1.22 **2020 Work RVU:** 1.48

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 0.64 **2020 Fac PE RVU:**0.51

RUC Recommendation: 1.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA

First Identified: February 2009

2019 est Medicare Utilization: 51,752

2007 Work RVU: 2.11 **2020 Work RVU:** 2.11

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 0.93 **2020 Fac PE RVU:**0.74

RUC Recommendation: 2.11

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA

First Identified: February 2009

2019 est Medicare Utilization: 165,382

2007 Work RVU: 1.28 **2020 Work RVU:** 1.56

2007 NF PE RVU: NA **2020 NF PE RVU:** NA

2007 Fac PE RVU 0.66 **2020 Fac PE RVU:**0.79

RUC Recommendation: 1.56

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 11,769

2007 Work RVU: 2.16 **2020 Work RVU:** 2.52
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.94 **2020 Fac PE RVU:** 0.87

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90951 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 17

2007 Work RVU: **2020 Work RVU:** 18.46
2007 NF PE RVU: **2020 NF PE RVU:** 6.96
2007 Fac PE RVU **2020 Fac PE RVU:** 6.96

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90952 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 4

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90953 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90954 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 571

2007 Work RVU: **2020 Work RVU:** 15.98
2007 NF PE RVU: **2020 NF PE RVU:** 6.10
2007 Fac PE RVU **2020 Fac PE RVU:** 6.10

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90955 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 57

2007 Work RVU: **2020 Work RVU:** 8.79
2007 NF PE RVU: **2020 NF PE RVU:** 3.69
2007 Fac PE RVU **2020 Fac PE RVU:** 3.69

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90956 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 124

2007 Work RVU: **2020 Work RVU:** 5.95
2007 NF PE RVU: **2020 NF PE RVU:** 2.73
2007 Fac PE RVU **2020 Fac PE RVU:** 2.73

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90957 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,539

2007 Work RVU: **2020 Work RVU:** 12.52
2007 NF PE RVU: **2020 NF PE RVU:** 5.00
2007 Fac PE RVU **2020 Fac PE RVU:** 5.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90958 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 393

2007 Work RVU: **2020 Work RVU:** 8.34
2007 NF PE RVU: **2020 NF PE RVU:** 3.58
2007 Fac PE RVU **2020 Fac PE RVU:** 3.58

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90959 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 292

2007 Work RVU: **2020 Work RVU:** 5.50
2007 NF PE RVU: **2020 NF PE RVU:** 2.57
2007 Fac PE RVU **2020 Fac PE RVU:** 2.57

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90960 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,218,361

2007 Work RVU: **2020 Work RVU:** 5.18
2007 NF PE RVU: **2020 NF PE RVU:** 2.58
2007 Fac PE RVU **2020 Fac PE RVU:** 2.58

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90961 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 719,245

2007 Work RVU: **2020 Work RVU:** 4.26
2007 NF PE RVU: **2020 NF PE RVU:** 2.26
2007 Fac PE RVU **2020 Fac PE RVU:** 2.26

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90962 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 213,048

2007 Work RVU: **2020 Work RVU:** 3.15
2007 NF PE RVU: **2020 NF PE RVU:** 1.89
2007 Fac PE RVU **2020 Fac PE RVU:** 1.89

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90963 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 229

2007 Work RVU: **2020 Work RVU:** 10.56
2007 NF PE RVU: **2020 NF PE RVU:** 4.26
2007 Fac PE RVU **2020 Fac PE RVU:** 4.26

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90964 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 934

2007 Work RVU: **2020 Work RVU:** 9.14
2007 NF PE RVU: **2020 NF PE RVU:** 3.82
2007 Fac PE RVU **2020 Fac PE RVU:** 3.82

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90965 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,343

2007 Work RVU: **2020 Work RVU:** 8.69
2007 NF PE RVU: **2020 NF PE RVU:** 3.70
2007 Fac PE RVU **2020 Fac PE RVU:** 3.70

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90966 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,733

2007 Work RVU: **2020 Work RVU:** 4.26
2007 NF PE RVU: **2020 NF PE RVU:** 2.25
2007 Fac PE RVU **2020 Fac PE RVU:** 2.25

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

91038 **Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)**

Global: 000 **Issue:** Gastroenterological Tests **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 23 **Specialty Developing Recommendation:** AGA, ASGE **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,829

2007 Work RVU: 1.10 **2020 Work RVU:** 1.10
2007 NF PE RVU: 2.36 **2020 NF PE RVU:** 11.29
2007 Fac PE RVU 2.36 **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

91110 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 53,131

2007 Work RVU: 3.64 **2020 Work RVU:** 2.49
2007 NF PE RVU: 21.77 **2020 NF PE RVU:** 21.78
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.49 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

91111 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 146

2007 Work RVU: 1.00 **2020 Work RVU:** 1.00
2007 NF PE RVU: 18.65 **2020 NF PE RVU:** 23.42
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

91132 **Electrogastrography, diagnostic, transcutaneous;**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 114

2007 Work RVU: 0.00 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0 **2020 NF PE RVU:** 8.61
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

91133 **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 14

2007 Work RVU: 0.00 **2020 Work RVU:** 0.66
2007 NF PE RVU: 0 **2020 NF PE RVU:** 9.13
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92065 **Orthoptic and/or pleoptic training, with continuing medical direction and evaluation**

Global: XXX **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 09 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 32,858

2007 Work RVU: 0.37 **2020 Work RVU:** 0.37
2007 NF PE RVU: 0.62 **2020 NF PE RVU:** 1.10
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT

Referred to CPT February 2021 May 2020-Tab 37
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

92081 **Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,708

2007 Work RVU: 0.36 **2020 Work RVU:** 0.30
2007 NF PE RVU: 0.95 **2020 NF PE RVU:** 0.63
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.30

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92082 **Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 122,984

2007 Work RVU: 0.44 **2020 Work RVU:** 0.40
2007 NF PE RVU: 1.26 **2020 NF PE RVU:** 0.92
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92083 **Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)**

Global: XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 46 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,969,637

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 1.46 **2020 NF PE RVU:** 1.26
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92100 **Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)**

Global: XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 31,551

2007 Work RVU: 0.92 **2020 Work RVU:** 0.61
2007 NF PE RVU: 1.33 **2020 NF PE RVU:** 1.70
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.31

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,814,680

2007 Work RVU: **2020 Work RVU:** 0.40
2007 NF PE RVU: **2020 NF PE RVU:** 0.63
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye)

First Identified: October 2008 **2019 est Medicare Utilization:** 7,509,080

2007 Work RVU: **2020 Work RVU:** 0.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.68
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92135 **Deleted from CPT**

Global: **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 31 **Specialty Developing Recommendation:** AAO, AOA

First Identified: October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.35 **2020 Work RVU:**
2007 NF PE RVU: 0.79 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation**

Global: XXX **Issue:** Ophthalmic Biometry **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 36 **Specialty Developing Recommendation:** AAO

First Identified: October 2008 **2019 est Medicare Utilization:** 1,688,098

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.6 **2020 NF PE RVU:** 1.20
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.54

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

92140 **Provocative tests for glaucoma, with interpretation and report, without tonography**

Global: **Issue:** Glaucoma Provacative Tests **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 41 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 0.97 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92201 **Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.40
2007 NF PE RVU: **2020 NF PE RVU:** 0.29
2007 Fac PE RVU **2020 Fac PE RVU:** 0.23

RUC Recommendation: 0.40 **Referred to CPT** February 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92202 **Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.26
2007 NF PE RVU: **2020 NF PE RVU:** 0.18
2007 Fac PE RVU **2020 Fac PE RVU:** 0.15

RUC Recommendation: 0.26 **Referred to CPT** February 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92225 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** April 2017 **2019 est Medicare Utilization:** 947,451

2007 Work RVU: 0.38 **2020 Work RVU:**
2007 NF PE RVU: 0.23 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92226 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:** 2,551,942

2007 Work RVU: 0.33 **2020 Work RVU:**
2007 NF PE RVU: 0.22 **2020 NF PE RVU:**
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92235 **Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2011 **2019 est Medicare Utilization:** 428,183

2007 Work RVU: 0.81 **2020 Work RVU:** 0.75
2007 NF PE RVU: 2.54 **2020 NF PE RVU:** 2.16
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.75 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92240 **Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2015 **2019 est Medicare Utilization:** 10,668

2007 Work RVU: 1.10 **2020 Work RVU:** 0.80
2007 NF PE RVU: 5.7 **2020 NF PE RVU:** 4.83
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92242 **Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2015 **2019 est Medicare Utilization:** 37,989

2007 Work RVU: **2020 Work RVU:** 0.95
2007 NF PE RVU: **2020 NF PE RVU:** 5.74
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.95 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92250 **Fundus photography with interpretation and report**

Global: XXX **Issue:** Fundus Photography **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 45 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** October 2010 **2019 est Medicare Utilization:** 3,490,129

2007 Work RVU: 0.44 **2020 Work RVU:** 0.40
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 0.85
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92270 **Electro-oculography with interpretation and report**

Global: XXX **Issue:** Electro-oculography **Screen:** High Volume Growth1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: February 2008 **2019 est Medicare Utilization:** 2,435

2007 Work RVU: 0.81 **2020 Work RVU:** 0.81
2007 NF PE RVU: 1.5 **2020 NF PE RVU:** 1.88
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant article published.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2008 and Q&A Jun 2009

92273 **Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 68,699

2007 Work RVU: **2020 Work RVU:** 0.69
2007 NF PE RVU: **2020 NF PE RVU:** 2.96
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan. 0.80

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92274 **Electroretinography (ERG), with interpretation and report; multifocal (mfERG)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 6,340

2007 Work RVU: **2020 Work RVU:** 0.61
2007 NF PE RVU: **2020 NF PE RVU:** 1.86
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan. 0.72

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92275 **Electroretinography with interpretation and report**

Global: **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 17 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.01 **2020 Work RVU:**
2007 NF PE RVU: 2.08 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

92284 **Dark adaptation examination with interpretation and report**

Global: XXX **Issue:** **Screen:** Harvard Valued - Utilization over 30,000-Part5 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: 0.24 **2020 Work RVU:** 0.24
2007 NF PE RVU: 1.72 **2020 NF PE RVU:** 1.41
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Review action plan **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result:

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)**

Global: XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 32 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:** 406,118

2007 Work RVU: 0.20 **2020 Work RVU:** 0.05
2007 NF PE RVU: 0.95 **2020 NF PE RVU:** 0.55
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.05 and new PE inputs **Referred to CPT** February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92286 **Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric)

First Identified: April 2011 **2019 est Medicare Utilization:** 115,474

2007 Work RVU: 0.66 **2020 Work RVU:** 0.40
2007 NF PE RVU: 2.83 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.40

Referred to CPT October 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92287 **Anterior segment imaging with interpretation and report; with fluorescein angiography**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AAO, AOA (optometric)

First Identified: **2019 est Medicare Utilization:** 7,182

2007 Work RVU: 0.81 **2020 Work RVU:** 0.81
2007 NF PE RVU: 2.28 **2020 NF PE RVU:** 3.62
2007 Fac PE RVU 0.31 **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan. CPT Assistant article published

Referred to CPT October 2011

Result: Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2013

92504 **Binocular microscopy (separate diagnostic procedure)**

Global: XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 43 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2009 **2019 est Medicare Utilization:** 239,518

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.63
2007 Fac PE RVU 0.08 **2020 Fac PE RVU:** 0.08

RUC Recommendation: 0.18

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing**

Global: **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.86 **2020 Work RVU:**
2007 NF PE RVU: 2.76 **2020 NF PE RVU:**
2007 Fac PE RVU 0.36 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth 3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2015 **2019 est Medicare Utilization:** 350,653

2007 Work RVU: 0.52 **2020 Work RVU:** 1.30
2007 NF PE RVU: 1.13 **2020 NF PE RVU:** 0.90
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 4,438

2007 Work RVU: 0.26 **2020 Work RVU:** 0.33
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.34
2007 Fac PE RVU 0.11 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92521 **Evaluation of speech fluency (eg, stuttering, cluttering)** **Global:** XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 197

2007 Work RVU: **2020 Work RVU:** 1.75
2007 NF PE RVU: **2020 NF PE RVU:** 1.38
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92522 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);** **Global:** XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 3,374

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.04
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** October 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92523 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)** **Global:** XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 19,962

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 2.39
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 3.36 **Referred to CPT** October 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92524 **Behavioral and qualitative analysis of voice and resonance**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 18,441

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.98
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 133,424

2007 Work RVU: 0.55 **2020 Work RVU:** 1.34
2007 NF PE RVU: 1.65 **2020 NF PE RVU:** 1.09
2007 Fac PE RVU 0.19 **2020 Fac PE RVU:** NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92537 **Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 68,931

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** 0.56
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92538 **Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 6,794

2007 Work RVU: **2020 Work RVU:** 0.30
2007 NF PE RVU: **2020 NF PE RVU:** 0.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.55 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 89,363

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.48
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 13,573

2007 Work RVU: 0.40 **2020 Work RVU:** 0.40
2007 NF PE RVU: 1.05 **2020 NF PE RVU:** 0.30
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.40 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 19,332

2007 Work RVU: 0.33 **2020 Work RVU:** 0.48
2007 NF PE RVU: 1.16 **2020 NF PE RVU:** 0.34
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92543 **Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording**

Global: **Issue:** Vestibular Caloric Irrigation **Screen:** Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.10 **2020 Work RVU:**
2007 NF PE RVU: 0.59 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,943

2007 Work RVU: 0.26 **2020 Work RVU:** 0.27
2007 NF PE RVU: 0.93 **2020 NF PE RVU:** 0.21
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.27 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92545 **Oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,622

2007 Work RVU: 0.23 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.85 **2020 NF PE RVU:** 0.20
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.25 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92546 **Sinusoidal vertical axis rotational testing**

Global: XXX **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 43,026

2007 Work RVU: 0.29 **2020 Work RVU:** 0.29
2007 NF PE RVU: 1.94 **2020 NF PE RVU:** 2.83
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92547 **Use of vertical electrodes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 26,526

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.09 **2020 NF PE RVU:** 0.24
2007 Fac PE RVU 0.09 **2020 Fac PE RVU:** NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92548 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 16 **Specialty Developing Recommendation:** AAA, AAN, ASHA **First Identified:** February 2014 **2019 est Medicare Utilization:** 51,157

2007 Work RVU: 0.50 **2020 Work RVU:** 0.67
2007 NF PE RVU: 2.1 **2020 NF PE RVU:** 0.71
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.76 **Referred to CPT** September 2018 / February 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92549 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 16 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.87
2007 NF PE RVU: **2020 NF PE RVU:** 0.90
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.96 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92550 **Tympanometry and reflex threshold measurements**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 231,898

2007 Work RVU: **2020 Work RVU:** 0.35
2007 NF PE RVU: **2020 NF PE RVU:** 0.26
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,255,685

2007 Work RVU: 0.00 **2020 Work RVU:** 0.60
2007 NF PE RVU: 1.21 **2020 NF PE RVU:** 0.45
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.30

RUC Recommendation: 0.60 work RVU and clinical staff time removed

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92558 **Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** February 2011 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.10
2007 Fac PE RVU **2020 Fac PE RVU:** 0.07

RUC Recommendation: 0.17

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

92567 **Tympanometry (impedance testing)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 922,916

2007 Work RVU: 0.00 **2020 Work RVU:** 0.20
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.24
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.10

RUC Recommendation: 0.20 work RVU and clinical staff time removed

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92568 **Acoustic reflex testing, threshold**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,046

2007 Work RVU: 0.00 **2020 Work RVU:** 0.29
2007 NF PE RVU: 0.32 **2020 NF PE RVU:** 0.14
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.13

RUC Recommendation: 0.29 work RVU and clinical staff time removed

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92569 **Deleted from CPT**

Global: **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0.35 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 38,849

2007 Work RVU: **2020 Work RVU:** 0.55
2007 NF PE RVU: **2020 NF PE RVU:** 0.36
2007 Fac PE RVU **2020 Fac PE RVU:** 0.27

RUC Recommendation: 0.55

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92584 **Electrocochleography**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 11,016

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 2.14 **2020 NF PE RVU:** 2.06
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

92585 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,565

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 2.02 **2020 NF PE RVU:** 3.28
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92586 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 1,425

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.74 **2020 NF PE RVU:** 2.66
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92587 **Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2008 **2019 est Medicare Utilization:** 58,068

2007 Work RVU: 0.13 **2020 Work RVU:** 0.35
2007 NF PE RVU: 1.19 **2020 NF PE RVU:** 0.26
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.45 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92588 **Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 85,077

2007 Work RVU: 0.36 **2020 Work RVU:** 0.55
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 0.39
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.60 **Referred to CPT** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 2,839

2007 Work RVU: 0.86 **2020 Work RVU:** 1.26
2007 NF PE RVU: 1.69 **2020 NF PE RVU:** 0.76
2007 Fac PE RVU 0.4 **2020 Fac PE RVU:** NA

RUC Recommendation: 1.48 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92605 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 1.75
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.82
2007 Fac PE RVU 0 **2020 Fac PE RVU:** 0.67

RUC Recommendation: 1.75 **Referred to CPT** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 1.40
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.88
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.54

RUC Recommendation: 1.40 work RVU and clinical staff time removed **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 544

2007 Work RVU: 0.00 **2020 Work RVU:** 1.85
2007 NF PE RVU: 3.38 **2020 NF PE RVU:** 1.73
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 220

2007 Work RVU: 0.00 **2020 Work RVU:** 0.70
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 0.74
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70 work RVU and clinical staff time removed **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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Status Report: CMS Requests and Relativity Assessment Issues

92609 **Therapeutic services for the use of speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 14,910

2007 Work RVU: 0.00 **2020 Work RVU:** 1.50
2007 NF PE RVU: 1.77 **2020 NF PE RVU:** 1.52
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 **Evaluation of oral and pharyngeal swallowing function**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 22,897

2007 Work RVU: 0.00 **2020 Work RVU:** 1.30
2007 NF PE RVU: 2.98 **2020 NF PE RVU:** 1.11
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.71

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 9,673

2007 Work RVU: 0.00 **2020 Work RVU:** 1.34
2007 NF PE RVU: 3.04 **2020 NF PE RVU:** 1.19
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92618 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.65
2007 NF PE RVU: **2020 NF PE RVU:** 0.26
2007 Fac PE RVU **2020 Fac PE RVU:** 0.25

RUC Recommendation: 0.65 **Referred to CPT** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 **Evaluation of central auditory function, with report; initial 60 minutes**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 818

2007 Work RVU: 0.00 **2020 Work RVU:** 1.50
2007 NF PE RVU: 1.32 **2020 NF PE RVU:** 1.11
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.77

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92621 **Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 43

2007 Work RVU: 0.00 **2020 Work RVU:** 0.35
2007 NF PE RVU: 0.29 **2020 NF PE RVU:** 0.28
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 9,371

2007 Work RVU: 0.00 **2020 Work RVU:** 1.15
2007 NF PE RVU: 1.3 **2020 NF PE RVU:** 0.80
2007 Fac PE RVU 1.3 **2020 Fac PE RVU:**0.58

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92626 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 30 **Specialty Developing Recommendation:** AAA, ASHA **First Identified:** NA **2019 est Medicare Utilization:** 29,623

2007 Work RVU: 0.00 **2020 Work RVU:** 1.40
2007 NF PE RVU: 2.11 **2020 NF PE RVU:** 1.11
2007 Fac PE RVU NA **2020 Fac PE RVU:**0.72

RUC Recommendation: 1.40 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

92627 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 7,594

2007 Work RVU: 0.00 **2020 Work RVU:** 0.33
2007 NF PE RVU: 0.52 **2020 NF PE RVU:** 0.27
2007 Fac PE RVU 0.52 **2020 Fac PE RVU:**0.17

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 11

2007 Work RVU: 0.00 **2020 Work RVU:** 1.76
2007 NF PE RVU: 1.4 **2020 NF PE RVU:** 1.42
2007 Fac PE RVU 1.4 **2020 Fac PE RVU:**0.92

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92650 **Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis** **Global:** **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 0.25 **Referred to CPT** February 2019 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92651 **Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report** **Global:** **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 1.00 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92652 **Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report** **Global:** **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92653 **Auditory evoked potentials; neurodiagnostic, with interpretation and report** **Global:** **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 06 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ACNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 1.05 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92920 **Percutaneous transluminal coronary angioplasty; single major coronary artery or branch** **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 24,084

2007 Work RVU: **2020 Work RVU:** 9.85
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.40

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92921 **Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 4.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92924 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch** **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,282

2007 Work RVU: **2020 Work RVU:** 11.74
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.04

RUC Recommendation: 11.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92925 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 5.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92928 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:** 254,826

2007 Work RVU: **2020 Work RVU:** 10.96
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.77

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92929 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 4.44 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92933 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:** 19,416

2007 Work RVU: **2020 Work RVU:** 12.29
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.22

RUC Recommendation: 12.32

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92934 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 5.50

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92937 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:** 18,930

2007 Work RVU: **2020 Work RVU:** 10.95
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.76

RUC Recommendation: 10.49

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92938 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92941 **Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 41,108

2007 Work RVU: **2020 Work RVU:** 12.31
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.24

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92943 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 9,129

2007 Work RVU: **2020 Work RVU:** 12.31
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 4.24

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92944 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92960 **Cardioversion, elective, electrical conversion of arrhythmia; external**

Global: 000 **Issue:** Cardioversion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 19 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 201,622

2007 Work RVU: 2.25 **2020 Work RVU:** 2.00
2007 NF PE RVU: 5.83 **2020 NF PE RVU:** 2.38
2007 Fac PE RVU 1.25 **2020 Fac PE RVU:** 0.99

RUC Recommendation: 2.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92973 **Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,130

2007 Work RVU: 3.28 **2020 Work RVU:** 3.28
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 1.42 **2020 Fac PE RVU:** 1.12

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92980 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 14.82 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 6.65 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92981 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 4.16 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.8 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92982 **Percutaneous transluminal coronary balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 10.96 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 4.97 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92984 **Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 2.97 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.28 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

92986 **Percutaneous balloon valvuloplasty; aortic valve**

Global: 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: October 2008 **2019 est Medicare Utilization:** 2,857

2007 Work RVU: 22.70 **2020 Work RVU:** 22.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 12.84 **2020 Fac PE RVU:**10.60

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

92992 **Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:** 76

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Deleted from CPT

Referred to CPT September 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

92993 **Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:** 1

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Deleted from CPT

Referred to CPT September 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

92995 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 12.07 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 5.45 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92996 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 3.26 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 1.41 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93000 **Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 20 **Specialty Developing Recommendation:** ACC **First Identified:** September 2011 **2019 est Medicare Utilization:** 11,883,535

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.47 **2020 NF PE RVU:** 0.29
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93005 **Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 20 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:** 460,887

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.41 **2020 NF PE RVU:** 0.23
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

93010 **Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 20 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:** 18,866,949

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.06 **2020 NF PE RVU:** 0.06
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:** 0.06

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93012 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 5.55 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93014 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.52 **2020 Work RVU:**
2007 NF PE RVU: 0.2 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93015 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 999,644

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 1.95 **2020 NF PE RVU:** 1.21
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.75. CPT Assistant published.

Referred to CPT October 2010
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

Result: Maintain

93016 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 1,047,732

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.19 **2020 NF PE RVU:** 0.16
2007 Fac PE RVU 0.19 **2020 Fac PE RVU:**0.16

RUC Recommendation: 0.45

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 96,453

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.64 **2020 NF PE RVU:** 0.94
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93018 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only**

Global: XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,241,516

2007 Work RVU: 0.30 **2020 Work RVU:** 0.30
2007 NF PE RVU: 0.12 **2020 NF PE RVU:** 0.11
2007 Fac PE RVU 0.12 **2020 Fac PE RVU:** 0.11

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93025 **Microvolt T-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 213

2007 Work RVU: 0.75 **2020 Work RVU:** 0.75
2007 NF PE RVU: 6.67 **2020 NF PE RVU:** 3.19
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93040 **Rhythm ECG, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 108,714

2007 Work RVU: 0.16 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.2 **2020 NF PE RVU:** 0.19
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93041 **Rhythm ECG, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 12,914

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.15 **2020 NF PE RVU:** 0.15
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.00 (PE only) **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93042 **Rhythm ECG, 1-3 leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 34 **Specialty Developing Recommendation:** ACC, ACEP **First Identified:** October 2008 **2019 est Medicare Utilization:** 362,235

2007 Work RVU: 0.16 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.05 **2020 NF PE RVU:** 0.04
2007 Fac PE RVU 0.05 **2020 Fac PE RVU:**0.04

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93224 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 284,557

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 3.29 **2020 NF PE RVU:** 1.93
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93225 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 110,328

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.2 **2020 NF PE RVU:** 0.71
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 154,751

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.88 **2020 NF PE RVU:** 1.01
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93227 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:** 344,162

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.21
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.21

RUC Recommendation: 0.52

Referred to CPT Feburary 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93228 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 20 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2009 **2019 est Medicare Utilization:** 186,123

2007 Work RVU: **2020 Work RVU:** 0.52
2007 NF PE RVU: **2020 NF PE RVU:** 0.19
2007 Fac PE RVU **2020 Fac PE RVU:**0.19

RUC Recommendation: 0.52

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93229 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 20 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2009 **2019 est Medicare Utilization:** 271,792

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 19.75
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

93230 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC

First Identified: NA **2019 est Medicare Utilization:**

2007 Work RVU: 0.52 **2020 Work RVU:**
2007 NF PE RVU: 3.49 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93231 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 1.37 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93232 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 1.92 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93233 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2007 Work RVU: 0.52 **2020 Work RVU:**
2007 NF PE RVU: 0.2 **2020 NF PE RVU:**
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93235 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 **Deleted from CPT**

Global: **Issue:** Cardiovascular Stress Test **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93237 **Deleted from CPT**

Global: **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2007 Work RVU: 0.45 **2020 Work RVU:**
2007 NF PE RVU: 0.18 **2020 NF PE RVU:**
2007 Fac PE RVU 0.18 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93268 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 11,689

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 7.02 **2020 NF PE RVU:** 5.08
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93270 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 39,075

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1 **2020 NF PE RVU:** 0.24
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93271 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:** 54,627

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 5.82 **2020 NF PE RVU:** 4.66
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93272 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:** 104,829

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0.2 **2020 NF PE RVU:** 0.18
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93279 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS

First Identified: July 2015 **2019 est Medicare Utilization:** 152,741

2007 Work RVU: **2020 Work RVU:** 0.65
2007 NF PE RVU: **2020 NF PE RVU:** 1.04
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.65 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93280 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 986,249

2007 Work RVU: **2020 Work RVU:** 0.77
2007 NF PE RVU: **2020 NF PE RVU:** 1.22
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.77 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93281 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 73,701

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 1.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93282 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 115,690

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 1.19
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93283 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,401

2007 Work RVU: **2020 Work RVU:** 1.15
2007 NF PE RVU: **2020 NF PE RVU:** 1.39
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.15 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93284 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 246,603

2007 Work RVU: **2020 Work RVU:** 1.25
2007 NF PE RVU: **2020 NF PE RVU:** 1.50
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.25 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93285 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 40,620

2007 Work RVU: **2020 Work RVU:** 0.52
2007 NF PE RVU: **2020 NF PE RVU:** 0.97
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.52 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93286 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 20,480

2007 Work RVU: **2020 Work RVU:** 0.30
2007 NF PE RVU: **2020 NF PE RVU:** 0.82
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.30 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93287 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,854

2007 Work RVU: **2020 Work RVU:** 0.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.88
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93288 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 242,876

2007 Work RVU: **2020 Work RVU:** 0.43
2007 NF PE RVU: **2020 NF PE RVU:** 0.94
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93289 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 97,500

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 1.08
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.75 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93290 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 118,819

2007 Work RVU: **2020 Work RVU:** 0.43
2007 NF PE RVU: **2020 NF PE RVU:** 0.88
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93291 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,111

2007 Work RVU: **2020 Work RVU:** 0.37
2007 NF PE RVU: **2020 NF PE RVU:** 0.83
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.37 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93292 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,142

2007 Work RVU: **2020 Work RVU:** 0.43
2007 NF PE RVU: **2020 NF PE RVU:** 0.81
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93293 **Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 50,828

2007 Work RVU: **2020 Work RVU:** 0.31
2007 NF PE RVU: **2020 NF PE RVU:** 1.13
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.31 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93294 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,162,316

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** 0.24
2007 Fac PE RVU **2020 Fac PE RVU:** 0.24

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93295 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS

First Identified: July 2015

2019 est Medicare Utilization: 618,312

2007 Work RVU: **2020 Work RVU:** 0.74
2007 NF PE RVU: **2020 NF PE RVU:** 0.30
2007 Fac PE RVU **2020 Fac PE RVU:** 0.30

RUC Recommendation: 0.74

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93296 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS

First Identified: July 2015

2019 est Medicare Utilization: 1,298,857

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.71
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs and Refer to CPT

Referred to CPT February 2017

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93297 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS

First Identified: July 2015

2019 est Medicare Utilization: 436,176

2007 Work RVU: **2020 Work RVU:** 0.52
2007 NF PE RVU: **2020 NF PE RVU:** 0.20
2007 Fac PE RVU **2020 Fac PE RVU:** 0.20

RUC Recommendation: 0.52

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93298 **Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 718,193

2007 Work RVU: **2020 Work RVU:** 0.52
2007 NF PE RVU: **2020 NF PE RVU:** 0.21
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93299 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 790,455

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93306 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography**

Global: XXX **Issue:** Complete Transthoracic Echocardiography (TTE) with Doppler **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 21 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 7,396,555

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 4.29
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93307 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 42 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 26,672

2007 Work RVU: 0.92 **2020 Work RVU:** 0.92
2007 NF PE RVU: 4.1 **2020 NF PE RVU:** 3.02
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.92 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93308 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 42 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 435,885

2007 Work RVU: 0.53 **2020 Work RVU:** 0.53
2007 NF PE RVU: 2.26 **2020 NF PE RVU:** 2.23
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 30 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,942

2007 Work RVU: 0.38 **2020 Work RVU:** 0.38
2007 NF PE RVU: 1.82 **2020 NF PE RVU:** 1.11
2007 Fac PE RVU 1.82 **2020 Fac PE RVU:** NA

RUC Recommendation: 0.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93321 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 30 **Specialty Developing Recommendation:** ACC

First Identified: October 2013

2019 est Medicare Utilization: 239,405

2007 Work RVU: 0.15 **2020 Work RVU:** 0.15
2007 NF PE RVU: 1.04 **2020 NF PE RVU:** 0.59
2007 Fac PE RVU 1.04 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.15

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93325 **Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 30 **Specialty Developing Recommendation:** ACC

First Identified: February 2009

2019 est Medicare Utilization: 606,488

2007 Work RVU: 0.07 **2020 Work RVU:** 0.07
2007 NF PE RVU: 2.36 **2020 NF PE RVU:** 0.63
2007 Fac PE RVU 2.36 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.07

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93350 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** Other - Identified by RUC / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: April 2008

2019 est Medicare Utilization: 95,788

2007 Work RVU: 1.48 **2020 Work RVU:** 1.46
2007 NF PE RVU: 3.03 **2020 NF PE RVU:** 3.83
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.46; CPT Assistant article published

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

Status Report: CMS Requests and Relativity Assessment Issues

93351 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 26 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 241,940

2007 Work RVU: **2020 Work RVU:** 1.75
2007 NF PE RVU: **2020 NF PE RVU:** 4.79
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93451 **Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 44,232

2007 Work RVU: **2020 Work RVU:** 2.47
2007 NF PE RVU: **2020 NF PE RVU:** 21.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from Modifier -51 exempt list. 3.02 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93452 **Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,594

2007 Work RVU: **2020 Work RVU:** 4.50
2007 NF PE RVU: **2020 NF PE RVU:** 20.57
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 4.32 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93453 **Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 2,368

2007 Work RVU: **2020 Work RVU:** 5.99
2007 NF PE RVU: **2020 NF PE RVU:** 26.26
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 5.98 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93454 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 127,375

2007 Work RVU: **2020 Work RVU:** 4.54
2007 NF PE RVU: **2020 NF PE RVU:** 20.56
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 4.95 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93455 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 27,649

2007 Work RVU: **2020 Work RVU:** 5.29
2007 NF PE RVU: **2020 NF PE RVU:** 23.21
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 6.15 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93456 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 19,829

2007 Work RVU: **2020 Work RVU:** 5.90
2007 NF PE RVU: **2020 NF PE RVU:** 25.85
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93457 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,711

2007 Work RVU: **2020 Work RVU:** 6.64
2007 NF PE RVU: **2020 NF PE RVU:** 28.47
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 7.66 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93458 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 507,961

2007 Work RVU: **2020 Work RVU:** 5.60
2007 NF PE RVU: **2020 NF PE RVU:** 23.73
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 6.51 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93459 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 90,436

2007 Work RVU: **2020 Work RVU:** 6.35
2007 NF PE RVU: **2020 NF PE RVU:** 25.53
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 7.34 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93460 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 89,701

2007 Work RVU: **2020 Work RVU:** 7.10
2007 NF PE RVU: **2020 NF PE RVU:** 28.18
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 7.88 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93461 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 14,051

2007 Work RVU: **2020 Work RVU:** 7.85
2007 NF PE RVU: **2020 NF PE RVU:** 31.66
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 9.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93462 **Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,479

2007 Work RVU: **2020 Work RVU:** 3.73
2007 NF PE RVU: **2020 NF PE RVU:** 1.56
2007 Fac PE RVU **2020 Fac PE RVU:** 1.56

RUC Recommendation: 3.73 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93463 **Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,287

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.69
2007 Fac PE RVU **2020 Fac PE RVU:** 0.69

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93464 **Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,054

2007 Work RVU: **2020 Work RVU:** 1.80
2007 NF PE RVU: **2020 NF PE RVU:** 4.99
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.80 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93501 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93503 **Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 71,386

2007 Work RVU: 0.00 **2020 Work RVU:** 2.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.37

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93508 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93510 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More/ CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93511 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93514 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93524 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93526 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93527 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93528 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93529 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93539 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93540 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93541 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93542 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93543 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93544 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93545 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93555 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93556 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93561 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 27 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 6

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93562 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 27 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 14

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93563 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 167

2007 Work RVU: **2020 Work RVU:** 1.11
2007 NF PE RVU: **2020 NF PE RVU:** 0.38
2007 Fac PE RVU **2020 Fac PE RVU:** 0.38

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6

2007 Work RVU: **2020 Work RVU:** 1.13
2007 NF PE RVU: **2020 NF PE RVU:** 0.39
2007 Fac PE RVU **2020 Fac PE RVU:** 0.39

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93565 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 80

2007 Work RVU: **2020 Work RVU:** 0.86
2007 NF PE RVU: **2020 NF PE RVU:** 0.30
2007 Fac PE RVU **2020 Fac PE RVU:** 0.30

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93566 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 388

2007 Work RVU: **2020 Work RVU:** 0.86
2007 NF PE RVU: **2020 NF PE RVU:** 3.14
2007 Fac PE RVU **2020 Fac PE RVU:** 0.30

RUC Recommendation: 0.96 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 28,640

2007 Work RVU: **2020 Work RVU:** 0.97
2007 NF PE RVU: **2020 NF PE RVU:** 2.36
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34

RUC Recommendation: 0.97 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93568 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,334

2007 Work RVU: **2020 Work RVU:** 0.88
2007 NF PE RVU: **2020 NF PE RVU:** 2.78
2007 Fac PE RVU **2020 Fac PE RVU:** 0.31

RUC Recommendation: 0.98 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93571 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2016 **2019 est Medicare Utilization:** 69,945

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93572 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,600

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** NA
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93613 **Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intracardiac 3D Mapping add-on **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 24 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 80,773

2007 Work RVU: 6.99 **2020 Work RVU:** 5.23
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 3.03 **2020 Fac PE RVU:** 2.24

RUC Recommendation: 5.23 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93620 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording**

Global: 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 8,849

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: 11.57

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93621 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Electrophysiologic Evaluation **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab** 21 **Specialty Developing Recommendation:**

First Identified: October 2019 **2019 est Medicare Utilization:** 29,892

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: 1.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93623 **Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pacing Heart Stimulation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 22 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2018 **2019 est Medicare Utilization:** 38,626

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**NA

RUC Recommendation: Referral to CPT for parenthetical. 2.04

Referred to CPT May 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

93641 **Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator**

Global: 000 **Issue:** Insertion/Removal of Pacemaker or Pacing Carioverter-Defibillator **Screen:** Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,210

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: NA **2020 NF PE RVU:** 0.00
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 2B.

Referred to CPT February 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93651 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 16.23 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 6.96 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 17.65 **2020 Work RVU:**
2007 NF PE RVU: NA **2020 NF PE RVU:**
2007 Fac PE RVU 7.58 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93653 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,821

2007 Work RVU: **2020 Work RVU:** 14.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 6.28

RUC Recommendation: 15.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93654 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 7,750

2007 Work RVU: **2020 Work RVU:** 19.75
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 8.40

RUC Recommendation: 20.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93655 **Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 /High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2011 **2019 est Medicare Utilization:** 31,147

2007 Work RVU: **2020 Work RVU:** 7.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.21

RUC Recommendation: Review action plan. 9.00

Referred to CPT October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2011 **2019 est Medicare Utilization:** 53,327

2007 Work RVU: **2020 Work RVU:** 19.77
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 8.47

RUC Recommendation: Refer to CPT

Referred to CPT October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93657 **Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2012 **Tab** 11 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2011 **2019 est Medicare Utilization:** 21,959

2007 Work RVU: **2020 Work RVU:** 7.50
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 3.20

RUC Recommendation: 10.00

Referred to CPT October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intracardiac Echocardiography **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 23 **Specialty Developing Recommendation:** ACC, HRS

First Identified: February 2008

2019 est Medicare Utilization: 63,470

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: 2.53

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93668 **Peripheral arterial disease (PAD) rehabilitation, per session**

Global: XXX **Issue:** Peripheral Artery Disease (PAD) Rehabilitation (PE Only) **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 28 **Specialty Developing Recommendation:**

First Identified: July 2017

2019 est Medicare Utilization: 814

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.4 **2020 NF PE RVU:** 0.42
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

93701 **Bioimpedance-derived physiologic cardiovascular analysis**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: October 2010

2019 est Medicare Utilization: 14,268

2007 Work RVU: 0.17 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.91 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

93731 **Deleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC

First Identified: October 2008

2019 est Medicare Utilization:

2007 Work RVU: 0.45 **2020 Work RVU:**
2007 NF PE RVU: 0.7 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93732 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.92 **2020 Work RVU:**
2007 NF PE RVU: 0.94 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93733 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.17 **2020 Work RVU:**
2007 NF PE RVU: 0.83 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93743 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.03 **2020 Work RVU:**
2007 NF PE RVU: 1.15 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93744 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 1.18 **2020 Work RVU:**
2007 NF PE RVU: 1.19 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93750 **Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report**

Global: XXX **Issue:** Ventricular Assist Device (VAD) Interrogation **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 24 **Specialty Developing Recommendation:** AATS, ACC, STS **First Identified:** October 2018 **2019 est Medicare Utilization:** 97,423

2007 Work RVU: **2020 Work RVU:** 0.92
2007 NF PE RVU: **2020 NF PE RVU:** 0.61
2007 Fac PE RVU **2020 Fac PE RVU:** 0.35

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93792 **Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,742

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.81
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Reviewe in 2 years. 0.00 PE Only **Referred to CPT** September 2016 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93793 **Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,555,390

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.14
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review in 2 years. 0.18 **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93875 **Deleted from CPT**

Global: **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.22 **2020 Work RVU:**
2007 NF PE RVU: 2.38 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** SS in process of developing draft of CPT Asst article (Aug 2011). Code was deleted

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93880 **Duplex scan of extracranial arteries; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACR, ACC, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,198,611

2007 Work RVU: 0.60 **2020 Work RVU:** 0.80
2007 NF PE RVU: 5.67 **2020 NF PE RVU:** 4.76
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Addressed in CPT Coding Changes

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93882 **Duplex scan of extracranial arteries; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,564

2007 Work RVU: 0.40 **2020 Work RVU:** 0.50
2007 NF PE RVU: 3.63 **2020 NF PE RVU:** 3.04
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Result:** Increase
Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93886 **Transcranial Doppler study of the intracranial arteries; complete study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 104,495

2007 Work RVU: 0.94 **2020 Work RVU:** 0.91
2007 NF PE RVU: 6.77 **2020 NF PE RVU:** 6.71
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.00 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93888 **Transcranial Doppler study of the intracranial arteries; limited study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,532

2007 Work RVU: 0.62 **2020 Work RVU:** 0.50
2007 NF PE RVU: 4.36 **2020 NF PE RVU:** 4.02
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93890 **Transcranial Doppler study of the intracranial arteries; vasoreactivity study** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 52,137

2007 Work RVU: 1.00 **2020 Work RVU:** 1.00
2007 NF PE RVU: 5.2 **2020 NF PE RVU:** 6.75
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93892 **Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection**

Global: XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:**

First Identified: October 2019 **2019 est Medicare Utilization:** 55,222

2007 Work RVU: 1.15 **2020 Work RVU:** 1.15
2007 NF PE RVU: 5.52 **2020 NF PE RVU:** 7.55
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from Screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

93895 **Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral**

Global: XXX **Issue:** Carotid Intima-Media Thickness Ultrasound **Screen:** New Code in CPT 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 37 **Specialty Developing Recommendation:** No Interest

First Identified: April 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Rescind April 2014 recommendation, contractor price.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Not Part of RAW

93922 **Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC

First Identified: October 2008 **2019 est Medicare Utilization:** 694,382

2007 Work RVU: 0.25 **2020 Work RVU:** 0.25
2007 NF PE RVU: 2.78 **2020 NF PE RVU:** 2.11
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.25

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

93923 **Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 440,595

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 4.18 **2020 NF PE RVU:** 3.22
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.45 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,266

2007 Work RVU: 0.50 **2020 Work RVU:** 0.50
2007 NF PE RVU: 5.05 **2020 NF PE RVU:** 4.05
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.50 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925 **Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 661,535

2007 Work RVU: 0.58 **2020 Work RVU:** 0.80
2007 NF PE RVU: 7.05 **2020 NF PE RVU:** 6.28
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93926 **Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 262,918

2007 Work RVU: 0.39 **2020 Work RVU:** 0.50
2007 NF PE RVU: 4.31 **2020 NF PE RVU:** 3.67
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93930 **Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** November 2013 **2019 est Medicare Utilization:** 23,417

2007 Work RVU: 0.46 **2020 Work RVU:** 0.80
2007 NF PE RVU: 5.54 **2020 NF PE RVU:** 4.92
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93931 **Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 47,500

2007 Work RVU: 0.31 **2020 Work RVU:** 0.50
2007 NF PE RVU: 3.64 **2020 NF PE RVU:** 3.07
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93965 **Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)**

Global: **Issue:** Non-invasive Physiologic Studies of Extremity Veins **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 47 **Specialty Developing Recommendation:** ACC, ACR, SCAI, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.35 **2020 Work RVU:**
2007 NF PE RVU: 2.83 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93970 **Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,626,806

2007 Work RVU: 0.68 **2020 Work RVU:** 0.70
2007 NF PE RVU: 5.44 **2020 NF PE RVU:** 4.73
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93971 **Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Low Value-High Volume / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,753,619

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 3.67 **2020 NF PE RVU:** 2.95
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.45

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93975 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** November 2013 **2019 est Medicare Utilization:** 218,302

2007 Work RVU: 1.80 **2020 Work RVU:** 1.16
2007 NF PE RVU: 7.78 **2020 NF PE RVU:** 6.55
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.30

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 173,269

2007 Work RVU: 1.21 **2020 Work RVU:** 0.80
2007 NF PE RVU: 4.33 **2020 NF PE RVU:** 3.77
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93978 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:**

First Identified: April 2013 **2019 est Medicare Utilization:** 287,616

2007 Work RVU: 0.65 **2020 Work RVU:** 0.80
2007 NF PE RVU: 4.85 **2020 NF PE RVU:** 4.41
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.97

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93979 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 33 **Specialty Developing Recommendation:**

First Identified: October 2013 **2019 est Medicare Utilization:** 66,512

2007 Work RVU: 0.44 **2020 Work RVU:** 0.50
2007 NF PE RVU: 3.46 **2020 NF PE RVU:** 2.84
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93982 **Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS

First Identified: January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93985 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 17 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.80
2007 NF PE RVU: **2020 NF PE RVU:** 6.61
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93986 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 17 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 3.77
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)**

Global: XXX **Issue:** Doppler Flow Testing **Screen:** CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 40 **Specialty Developing Recommendation:** ACR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:** 132,133

2007 Work RVU: 0.25 **2020 Work RVU:** 0.50
2007 NF PE RVU: 4.28 **2020 NF PE RVU:** 3.78
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94010 **Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation**

Global: XXX **Issue:** Spirometry **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,234,541

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.81
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 47

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0.77 **2020 NF PE RVU:** 1.03
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Remove from Screen

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 38

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.85
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA
Result: Remove from Screen

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94016 **Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,244

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 0.16 **2020 NF PE RVU:** 0.18
2007 Fac PE RVU 0.16 **2020 Fac PE RVU:**0.18

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94060 **Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration**

Global: XXX **Issue:** Spirometry **Screen:** MPC List / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,160,195

2007 Work RVU: 0.31 **2020 Work RVU:** 0.27
2007 NF PE RVU: 1.13 **2020 NF PE RVU:** 1.37
2007 Fac PE RVU 1.13 **2020 Fac PE RVU:**NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94200 **Maximum breathing capacity, maximal voluntary ventilation**

Global: XXX **Issue:** Lung Function Test **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 28 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 74,436

2007 Work RVU: 0.11 **2020 Work RVU:** 0.05
2007 NF PE RVU: 0.45 **2020 NF PE RVU:** 0.56
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.05

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94240 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 0.7 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

94250 **Expired gas collection, quantitative, single procedure (separate procedure)** **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 20,825

2007 Work RVU: 0.11 **2020 Work RVU:** 0.11
2007 NF PE RVU: 0.61 **2020 NF PE RVU:** 0.64
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

94260 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 / **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.13 **2020 Work RVU:**
2007 NF PE RVU: 0.63 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

94350 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 0.73 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94360 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 0.77 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94370 **Determination of airway closing volume, single breath tests**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 0.69 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94400 **Breathing response to CO2 (CO2 response curve)** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** **2019 est Medicare Utilization:** 1,310

2007 Work RVU: 0.40 **2020 Work RVU:** 0.40
2007 NF PE RVU: 0.89 **2020 NF PE RVU:** 1.16
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94450 **Breathing response to hypoxia (hypoxia response curve)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 56

2007 Work RVU: 0.40 **2020 Work RVU:** 0.40
2007 NF PE RVU: 0.89 **2020 NF PE RVU:** 1.44
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

94617 **Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)** **Global:** XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 9,892

2007 Work RVU: **2020 Work RVU:** 0.70
2007 NF PE RVU: **2020 NF PE RVU:** 1.83
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 0.70 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94618 **Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 271,019

2007 Work RVU: **2020 Work RVU:** 0.48
2007 NF PE RVU: **2020 NF PE RVU:** 0.44
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

94620 **Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)**

Global: **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.64 **2020 Work RVU:**
2007 NF PE RVU: 2.06 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94621 **Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** January 2016 **2019 est Medicare Utilization:** 21,378

2007 Work RVU: 1.42 **2020 Work RVU:** 1.42
2007 NF PE RVU: 2.45 **2020 NF PE RVU:** 2.97
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.42 **Referred to CPT** February 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94640 **Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 /CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 601,038

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.32 **2020 NF PE RVU:** 0.49
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94667 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 6,331

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.53 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94668 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 5,171

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.46 **2020 NF PE RVU:** 0.79
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs CPT Assistant article published **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

Status Report: CMS Requests and Relativity Assessment Issues

94669 **Mechanical chest wall oscillation to facilitate lung function, per session** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 324

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.81
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94681 **Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 7,816

2007 Work RVU: 0.20 **2020 Work RVU:** 0.20
2007 NF PE RVU: 2.16 **2020 NF PE RVU:** 1.27
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

94720 **Carbon monoxide diffusing capacity (eg, single breath, steady state)** **Global:** **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 1.04 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94725 **Membrane diffusion capacity**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.26 **2020 Work RVU:**
2007 NF PE RVU: 2.43 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94726 **Plethysmography for determination of lung volumes and, when performed, airway resistance**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 681,512

2007 Work RVU: **2020 Work RVU:** 0.26
2007 NF PE RVU: **2020 NF PE RVU:** 1.23
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 **Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 348,523

2007 Work RVU: **2020 Work RVU:** 0.26
2007 NF PE RVU: **2020 NF PE RVU:** 0.95
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94728 **Airway resistance by oscillometry**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010 **2019 est Medicare Utilization:** 4,985

2007 Work RVU: **2020 Work RVU:** 0.26

2007 NF PE RVU: **2020 NF PE RVU:** 0.87

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.31

Referred to CPT February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94729 **Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010 **2019 est Medicare Utilization:** 1,113,315

2007 Work RVU: **2020 Work RVU:** 0.19

2007 NF PE RVU: **2020 NF PE RVU:** 1.38

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.19

Referred to CPT February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94750 **Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 18,981

2007 Work RVU: 0.23 **2020 Work RVU:** 0.23

2007 NF PE RVU: 1.43 **2020 NF PE RVU:** 2.23

2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT

Referred to CPT

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 29,834

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.05 **2020 NF PE RVU:** 0.06
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 16,501

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.08 **2020 NF PE RVU:** 0.10
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2019 est Medicare Utilization:** 208,171

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.56 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94770 **Carbon dioxide, expired gas determination by infrared analyzer**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,724

2007 Work RVU: 0.15 **2020 Work RVU:** 0.15
2007 NF PE RVU: 0.76 **2020 NF PE RVU:** NA
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.05

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

95004 **Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 27 **Specialty Developing Recommendation:** AAAAI, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 10,738,966

2007 Work RVU: 0.00 **2020 Work RVU:** 0.01
2007 NF PE RVU: 0.12 **2020 NF PE RVU:** 0.10
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95010 **Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.15 **2020 Work RVU:**
2007 NF PE RVU: 0.31 **2020 NF PE RVU:**
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95012 **Nitric oxide expired gas determination** **Global:** XXX **Issue:** Exhaled Nitric Oxide Measurement (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab** 26 **Specialty Developing Recommendation:** AAAAI, ACAAI, ATS, CHEST **First Identified:** October 2018 **2019 est Medicare Utilization:** 136,728

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.48 **2020 NF PE RVU:** 0.55
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 **Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests** **Global:** **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.15 **2020 Work RVU:**
2007 NF PE RVU: 0.16 **2020 NF PE RVU:**
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95017 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests** **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 27,662

2007 Work RVU: **2020 Work RVU:** 0.07
2007 NF PE RVU: **2020 NF PE RVU:** 0.16
2007 Fac PE RVU **2020 Fac PE RVU:** 0.03

RUC Recommendation: 0.07 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95018 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 129,391

2007 Work RVU: **2020 Work RVU:** 0.14
2007 NF PE RVU: **2020 NF PE RVU:** 0.45
2007 Fac PE RVU **2020 Fac PE RVU:** 0.05

RUC Recommendation: 0.14 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95024 **Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,833,929

2007 Work RVU: 0.00 **2020 Work RVU:** 0.01
2007 NF PE RVU: 0.17 **2020 NF PE RVU:** 0.21
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.01

RUC Recommendation: New PE Inputs. **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95027 **Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 164,524

2007 Work RVU: 0.00 **2020 Work RVU:** 0.01
2007 NF PE RVU: 0.17 **2020 NF PE RVU:** 0.12
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95115 **Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,034,318

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.35 **2020 NF PE RVU:** 0.25
2007 Fac PE RVU 0.29 **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95117 **Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,769,382

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.44 **2020 NF PE RVU:** 0.29
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95144 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 178,622

2007 Work RVU: 0.06 **2020 Work RVU:** 0.06
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.35
2007 Fac PE RVU 0.02 **2020 Fac PE RVU:**0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95148 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms**

Global: XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 20,261

2007 Work RVU: 0.06 **2020 Work RVU:** 0.06
2007 NF PE RVU: 0.67 **2020 NF PE RVU:** 2.28
2007 Fac PE RVU 0.03 **2020 Fac PE RVU:**0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95165 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,687,749

2007 Work RVU: 0.06 **2020 Work RVU:** 0.06
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.34
2007 Fac PE RVU 0.02 **2020 Fac PE RVU:**0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95249 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 08 **Specialty Developing Recommendation:** AACE, ES, ACP **First Identified:** **2019 est Medicare Utilization:** 10,730

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.51
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: PE Only. Referral to CPT Assistant **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** June 2018

Status Report: CMS Requests and Relativity Assessment Issues

95250 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AACE, ES

First Identified: October 2013 **2019 est Medicare Utilization:** 76,885

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 3.95 **2020 NF PE RVU:** 4.18
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Re-review at RAW. New PE inputs.

Referred to CPT October 2015 & February 2017

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95251 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AACE, ES

First Identified: April 2013 **2019 est Medicare Utilization:** 248,288

2007 Work RVU: 0.85 **2020 Work RVU:** 0.70
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.27
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:** 0.27

RUC Recommendation: Re-review at RAW. 0.70.

Referred to CPT February 2017

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95700 **Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95705 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95706 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95707 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95708 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95709 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95710 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95711 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95712 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95713 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95714 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95715 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95716 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95717 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.82
2007 Fac PE RVU **2020 Fac PE RVU:** 0.78

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95718 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.19
2007 Fac PE RVU **2020 Fac PE RVU:** 1.13

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95719 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.34
2007 Fac PE RVU **2020 Fac PE RVU:** 1.29

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95720 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 3.86
2007 NF PE RVU: **2020 NF PE RVU:** 1.85
2007 Fac PE RVU **2020 Fac PE RVU:** 1.76

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95721 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 3.86
2007 NF PE RVU: **2020 NF PE RVU:** 1.90
2007 Fac PE RVU **2020 Fac PE RVU:** 1.78

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95722 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.70
2007 NF PE RVU: **2020 NF PE RVU:** 2.28
2007 Fac PE RVU **2020 Fac PE RVU:** 2.15

RUC Recommendation: 4.70 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95723 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 4.75
2007 NF PE RVU: **2020 NF PE RVU:** 2.37
2007 Fac PE RVU **2020 Fac PE RVU:** 2.21

RUC Recommendation: 4.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95724 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 6.00
2007 NF PE RVU: **2020 NF PE RVU:** 2.92
2007 Fac PE RVU **2020 Fac PE RVU:** 2.74

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95725 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 5.40
2007 NF PE RVU: **2020 NF PE RVU:** 2.73
2007 Fac PE RVU **2020 Fac PE RVU:** 2.52

RUC Recommendation: 5.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95726 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 7.58
2007 NF PE RVU: **2020 NF PE RVU:** 3.69
2007 Fac PE RVU **2020 Fac PE RVU:** 3.46

RUC Recommendation: 7.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95800 **Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 24,715

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 3.79
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.05 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95801 **Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 422

2007 Work RVU: **2020 Work RVU:** 0.85
2007 NF PE RVU: **2020 NF PE RVU:** 1.63
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** NA **2019 est Medicare Utilization:** 232

2007 Work RVU: **2020 Work RVU:** 0.90
2007 NF PE RVU: **2020 NF PE RVU:** 3.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.90 and New PE inputs **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95805 **Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,017

2007 Work RVU: 1.88 **2020 Work RVU:** 1.20
2007 NF PE RVU: 14.7 **2020 NF PE RVU:** 10.37
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.20 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95806 **Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 80,376

2007 Work RVU: 1.66 **2020 Work RVU:** 0.93
2007 NF PE RVU: 3.46 **2020 NF PE RVU:** 2.33
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.28 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 **Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,278

2007 Work RVU: 1.66 **2020 Work RVU:** 1.28
2007 NF PE RVU: 11.82 **2020 NF PE RVU:** 10.07
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.25 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95808 **Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,197

2007 Work RVU: 2.65 **2020 Work RVU:** 1.74
2007 NF PE RVU: 13.79 **2020 NF PE RVU:** 16.53
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** February 2010 **2019 est Medicare Utilization:** 272,131

2007 Work RVU: 3.52 **2020 Work RVU:** 2.50
2007 NF PE RVU: 17.54 **2020 NF PE RVU:** 14.51
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95811 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 333,381

2007 Work RVU: 3.79 **2020 Work RVU:** 2.60
2007 NF PE RVU: 19.32 **2020 NF PE RVU:** 15.18
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 2.60 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95812 **Electroencephalogram (EEG) extended monitoring; 41-60 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 24,822

2007 Work RVU: 1.08 **2020 Work RVU:** 1.08
2007 NF PE RVU: 4.49 **2020 NF PE RVU:** 8.13
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95813 **Electroencephalogram (EEG) extended monitoring; 61-119 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,299

2007 Work RVU: 1.73 **2020 Work RVU:** 1.63
2007 NF PE RVU: 5.4 **2020 NF PE RVU:** 9.79
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95816 **Electroencephalogram (EEG); including recording awake and drowsy** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 22 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 278,212

2007 Work RVU: 1.08 **2020 Work RVU:** 1.08
2007 NF PE RVU: 4.1 **2020 NF PE RVU:** 9.14
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95819 **Electroencephalogram (EEG); including recording awake and asleep** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 202,028

2007 Work RVU: 1.08 **2020 Work RVU:** 1.08
2007 NF PE RVU: 3.76 **2020 NF PE RVU:** 11.05
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95822 **Electroencephalogram (EEG); recording in coma or sleep only**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 26,955

2007 Work RVU: 1.08 **2020 Work RVU:** 1.08
2007 NF PE RVU: 4.82 **2020 NF PE RVU:** 9.91
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95827 **Electroencephalogram (EEG); all night recording**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:** 5,020

2007 Work RVU: 1.08 **2020 Work RVU:**
2007 NF PE RVU: 4.89 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95831 **Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 79,780

2007 Work RVU: 0.28 **2020 Work RVU:**
2007 NF PE RVU: 0.44 **2020 NF PE RVU:**
2007 Fac PE RVU 0.12 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95832 **Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 11,062

2007 Work RVU: 0.29 **2020 Work RVU:**
2007 NF PE RVU: 0.34 **2020 NF PE RVU:**
2007 Fac PE RVU 0.12 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95833 **Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 867

2007 Work RVU: 0.47 **2020 Work RVU:**
2007 NF PE RVU: 0.55 **2020 NF PE RVU:**
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95834 **Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 605

2007 Work RVU: 0.60 **2020 Work RVU:**
2007 NF PE RVU: 0.61 **2020 NF PE RVU:**
2007 Fac PE RVU 0.26 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95860 **Needle electromyography; 1 extremity with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,418

2007 Work RVU: 0.96 **2020 Work RVU:** 0.96
2007 NF PE RVU: 1.36 **2020 NF PE RVU:** 2.38
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.96 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95861 **Needle electromyography; 2 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,204

2007 Work RVU: 1.54 **2020 Work RVU:** 1.54
2007 NF PE RVU: 1.48 **2020 NF PE RVU:** 3.24
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.54 **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 157

2007 Work RVU: 1.87 **2020 Work RVU:** 1.87
2007 NF PE RVU: 1.79 **2020 NF PE RVU:** 4.06
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.87 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,620

2007 Work RVU: 1.99 **2020 Work RVU:** 1.99
2007 NF PE RVU: 2.53 **2020 NF PE RVU:** 4.98
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.99 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 **Needle electromyography; cranial nerve supplied muscle(s), unilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 1,113

2007 Work RVU: 0.79 **2020 Work RVU:** 0.79
2007 NF PE RVU: 0.98 **2020 NF PE RVU:** 2.20
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.79 **Referred to CPT** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95868 **Needle electromyography; cranial nerve supplied muscles, bilateral**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 5,630

2007 Work RVU: 1.18 **2020 Work RVU:** 1.18
2007 NF PE RVU: 1.26 **2020 NF PE RVU:** 2.76
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 1.18

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

95869 **Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 447

2007 Work RVU: 0.37 **2020 Work RVU:** 0.37
2007 NF PE RVU: 0.53 **2020 NF PE RVU:** 2.31
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.37

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

95870 **Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 52,835

2007 Work RVU: 0.37 **2020 Work RVU:** 0.37
2007 NF PE RVU: 0.53 **2020 NF PE RVU:** 2.16
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.37

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95885 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 141,249

2007 Work RVU: **2020 Work RVU:** 0.35
2007 NF PE RVU: **2020 NF PE RVU:** 1.41
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.35 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95886 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 962,501

2007 Work RVU: **2020 Work RVU:** 0.86
2007 NF PE RVU: **2020 NF PE RVU:** 1.86
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.92 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,870

2007 Work RVU: **2020 Work RVU:** 0.71
2007 NF PE RVU: **2020 NF PE RVU:** 1.66
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.73 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95900 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.42 **2020 Work RVU:**
2007 NF PE RVU: 1.18 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011& February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95903 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.60 **2020 Work RVU:**
2007 NF PE RVU: 1.15 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 and February 2012 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95904 **Nerve conduction, amplitude and latency/velocity study, each nerve; sensory**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.34 **2020 Work RVU:**
2007 NF PE RVU: 1.03 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95907 **Nerve conduction studies; 1-2 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 6,263

2007 Work RVU: **2020 Work RVU:** 1.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.65
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95908 **Nerve conduction studies; 3-4 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 58,348

2007 Work RVU: **2020 Work RVU:** 1.25
2007 NF PE RVU: **2020 NF PE RVU:** 2.13
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95909 **Nerve conduction studies; 5-6 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 134,007

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 2.55
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.77 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95910 **Nerve conduction studies; 7-8 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 157,766

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** 3.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 2.80 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95911 **Nerve conduction studies; 9-10 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 175,960

2007 Work RVU: **2020 Work RVU:** 2.50
2007 NF PE RVU: **2020 NF PE RVU:** 3.89
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 3.34 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95912 **Nerve conduction studies; 11-12 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 78,978

2007 Work RVU: **2020 Work RVU:** 3.00
2007 NF PE RVU: **2020 NF PE RVU:** 4.30
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 4.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95913 **Nerve conduction studies; 13 or more studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 81,707

2007 Work RVU: **2020 Work RVU:** 3.56
2007 NF PE RVU: **2020 NF PE RVU:** 4.89
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 4.20 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95921 **Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 / Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,178

2007 Work RVU: 0.90 **2020 Work RVU:** 0.90
2007 NF PE RVU: 0.82 **2020 NF PE RVU:** 1.49
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,986

2007 Work RVU: 0.96 **2020 Work RVU:** 0.96
2007 NF PE RVU: 1 **2020 NF PE RVU:** 1.76
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT Assistant. 0.96 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2008; Sep 2020

Status Report: CMS Requests and Relativity Assessment Issues

95923 **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2019 **2019 est Medicare Utilization:** 114,086

2007 Work RVU: 0.90 **2020 Work RVU:** 0.90
2007 NF PE RVU: 1.99 **2020 NF PE RVU:** 2.68
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95924 **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** **2019 est Medicare Utilization:** 21,055

2007 Work RVU: **2020 Work RVU:** 1.73
2007 NF PE RVU: **2020 NF PE RVU:** 2.42
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Refer to CPT Assistant. 1.73 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95925 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,861

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.63 **2020 NF PE RVU:** 3.36
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95926 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,658

2007 Work RVU: 0.54 **2020 Work RVU:** 0.54
2007 NF PE RVU: 1.59 **2020 NF PE RVU:** 3.18
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95928 **Central motor evoked potential study (transcranial motor stimulation); upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 325

2007 Work RVU: 1.50 **2020 Work RVU:** 1.50
2007 NF PE RVU: 3.25 **2020 NF PE RVU:** 4.81
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95929 **Central motor evoked potential study (transcranial motor stimulation); lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,333

2007 Work RVU: 1.50 **2020 Work RVU:** 1.50
2007 NF PE RVU: 3.48 **2020 NF PE RVU:** 5.00
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95930 **Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report**

Global: XXX **Issue:** Visual Evoked Potential Testing **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 11 **Specialty Developing Recommendation:** AAO, AOA (optometry), ACNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 53,881

2007 Work RVU: 0.35 **2020 Work RVU:** 0.35
2007 NF PE RVU: 2.34 **2020 NF PE RVU:** 1.51
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.35 **Referred to CPT** May 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95934 **H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2007 Work RVU: 0.51 **2020 Work RVU:**
2007 NF PE RVU: 0.55 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95936 **H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:**

First Identified: **2019 est Medicare Utilization:**

2007 Work RVU: 0.55 **2020 Work RVU:**

2007 NF PE RVU: 0.49 **2020 NF PE RVU:**

2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 & February 2012

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95938 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS

First Identified: January 2013 **2019 est Medicare Utilization:** 90,204

2007 Work RVU: **2020 Work RVU:** 0.86

2007 NF PE RVU: **2020 NF PE RVU:** 8.92

2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 0.86 and new PE inputs

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95939 **Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS

First Identified: January 2013 **2019 est Medicare Utilization:** 41,818

2007 Work RVU: **2020 Work RVU:** 2.25

2007 NF PE RVU: **2020 NF PE RVU:** 12.45

2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: 2.25 and new PE inputs

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95940 **Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 12 **Specialty Developing Recommendation:**

First Identified: January 2012 **2019 est Medicare Utilization:** 25,807

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.29

RUC Recommendation: 0.60

Referred to CPT February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95941 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 12 **Specialty Developing Recommendation:**

First Identified: January 2012 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: 2.00

Referred to CPT February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95943 **Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AAN, AANEM

First Identified: January 2018 **2019 est Medicare Utilization:** 22,723

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: February 2009 **2019 est Medicare Utilization:** 2,415

2007 Work RVU: 1.51 **2020 Work RVU:**
2007 NF PE RVU: 4.18 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

95951 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:**

First Identified: October 2016 **2019 est Medicare Utilization:** 188,070

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: February 2009 **2019 est Medicare Utilization:** 24,927

2007 Work RVU: 3.30 **2020 Work RVU:**
2007 NF PE RVU: 7.52 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

95954 **Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 623

2007 Work RVU: 2.45 **2020 Work RVU:** 2.45
2007 NF PE RVU: 4.38 **2020 NF PE RVU:** 8.41
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 5,307

2007 Work RVU: 3.08 **2020 Work RVU:**
2007 NF PE RVU: 15.47 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

95957 **Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)**

Global: XXX **Issue:** Electroencephalogram (EEG) Exended Monitoring **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 50 **Specialty Developing Recommendation:** AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,055

2007 Work RVU: 1.98 **2020 Work RVU:** 1.98
2007 NF PE RVU: 3.37 **2020 NF PE RVU:** 5.14
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95970 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,689

2007 Work RVU: 0.45 **2020 Work RVU:** 0.35
2007 NF PE RVU: 0.86 **2020 NF PE RVU:** 0.17
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:** 0.16

RUC Recommendation: 0.45 **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95971 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 21,590

2007 Work RVU: 0.78 **2020 Work RVU:** 0.78
2007 NF PE RVU: 0.66 **2020 NF PE RVU:** 0.58
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:** 0.31

RUC Recommendation: 0.78 **Referred to CPT** February 2015, June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 46,946

2007 Work RVU: 1.50 **2020 Work RVU:** 0.80
2007 NF PE RVU: 1.21 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU 0.48 **2020 Fac PE RVU:** 0.30

RUC Recommendation: 0.80 **Referred to CPT** May 2014 February , June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95973 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 21 **Specialty Developing Recommendation:** AANS/CNS, ACOG, ASA, AUA, ISIS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2007 Work RVU: 0.92 **2020 Work RVU:**
2007 NF PE RVU: 0.61 **2020 NF PE RVU:**
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95974 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 3.00 **2020 Work RVU:**
2007 NF PE RVU: 1.65 **2020 NF PE RVU:**
2007 Fac PE RVU 1.19 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95975 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.70 **2020 Work RVU:**
2007 NF PE RVU: 0.86 **2020 NF PE RVU:**
2007 Fac PE RVU 0.67 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

Status Report: CMS Requests and Relativity Assessment Issues

95976 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 8,660

2007 Work RVU: **2020 Work RVU:** 0.73
2007 NF PE RVU: **2020 NF PE RVU:** 0.37
2007 Fac PE RVU **2020 Fac PE RVU:** 0.35

RUC Recommendation: 0.95 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95977 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 7,130

2007 Work RVU: **2020 Work RVU:** 0.97
2007 NF PE RVU: **2020 NF PE RVU:** 0.48
2007 Fac PE RVU **2020 Fac PE RVU:** 0.46

RUC Recommendation: 1.19 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95978 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 3.50 **2020 Work RVU:**
2007 NF PE RVU: 1.91 **2020 NF PE RVU:**
2007 Fac PE RVU 1.24 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95979 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.64 **2020 Work RVU:**
2007 NF PE RVU: 0.84 **2020 NF PE RVU:**
2007 Fac PE RVU 0.64 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95980 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 570

2007 Work RVU: **2020 Work RVU:** 0.80
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.34

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95981 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 843

2007 Work RVU: **2020 Work RVU:** 0.30
2007 NF PE RVU: **2020 NF PE RVU:** 0.66
2007 Fac PE RVU **2020 Fac PE RVU:** 0.16

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95982 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,278

2007 Work RVU: **2020 Work RVU:** 0.65
2007 NF PE RVU: **2020 NF PE RVU:** 0.85
2007 Fac PE RVU **2020 Fac PE RVU:** 0.30

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95983 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 40,522

2007 Work RVU: **2020 Work RVU:** 0.91
2007 NF PE RVU: **2020 NF PE RVU:** 0.46
2007 Fac PE RVU **2020 Fac PE RVU:** 0.44

RUC Recommendation: 1.25 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95984 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 58,079

2007 Work RVU: **2020 Work RVU:** 0.80
2007 NF PE RVU: **2020 NF PE RVU:** 0.40
2007 Fac PE RVU **2020 Fac PE RVU:** 0.38

RUC Recommendation: 1.00 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95990 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,124

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.53 **2020 NF PE RVU:** 2.50
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.00 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:** 8,596

2007 Work RVU: 0.77 **2020 Work RVU:** 0.77
2007 NF PE RVU: 1.53 **2020 NF PE RVU:** 2.38
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.30

RUC Recommendation: 0.77 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95992 **Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day**

Global: XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 112,529

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 0.47
2007 Fac PE RVU **2020 Fac PE RVU:** 0.28

RUC Recommendation: Remove from Modifier -51 Exempt list. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96101 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.86 **2020 Work RVU:**
2007 NF PE RVU: 0.58 **2020 NF PE RVU:**
2007 Fac PE RVU 0.56 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96102 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 0.8 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96103 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.51 **2020 Work RVU:**
2007 NF PE RVU: 0.49 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS Request/Speech Language Pathology Request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,273

2007 Work RVU: 0.00 **2020 Work RVU:** 1.75
2007 NF PE RVU: 1.83 **2020 NF PE RVU:** 1.09
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 1.75 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96110 **Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.18 **2020 NF PE RVU:** 0.27
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96111 **Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 2.60 **2020 Work RVU:**
2007 NF PE RVU: 0.96 **2020 NF PE RVU:**
2007 Fac PE RVU 0.92 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96112 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 1,417

2007 Work RVU: **2020 Work RVU:** 2.56
2007 NF PE RVU: **2020 NF PE RVU:** 1.20
2007 Fac PE RVU **2020 Fac PE RVU:** 0.95

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96113 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 132

2007 Work RVU: **2020 Work RVU:** 1.16
2007 NF PE RVU: **2020 NF PE RVU:** 0.52
2007 Fac PE RVU **2020 Fac PE RVU:** 0.43

RUC Recommendation: 1.10 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96116 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,733

2007 Work RVU: 1.86 **2020 Work RVU:** 1.86
2007 NF PE RVU: 0.76 **2020 NF PE RVU:** 0.81
2007 Fac PE RVU 0.59 **2020 Fac PE RVU:** 0.45

RUC Recommendation: 1.86 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96118 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.86 **2020 Work RVU:**
2007 NF PE RVU: 1.25 **2020 NF PE RVU:**
2007 Fac PE RVU 0.56 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96119 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.55 **2020 Work RVU:**
2007 NF PE RVU: 1.15 **2020 NF PE RVU:**
2007 Fac PE RVU 0.17 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96120 **Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.51 **2020 Work RVU:**
2007 NF PE RVU: 1.04 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96121 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 47,794

2007 Work RVU: **2020 Work RVU:** 1.71
2007 NF PE RVU: **2020 NF PE RVU:** 0.59
2007 Fac PE RVU **2020 Fac PE RVU:** 0.42

RUC Recommendation: 1.71 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96125 **Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 4,262

2007 Work RVU: **2020 Work RVU:** 1.70
2007 NF PE RVU: **2020 NF PE RVU:** 1.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.70 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96127 **Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 492,372

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.13
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96130 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 99,759

2007 Work RVU: **2020 Work RVU:** 2.56
2007 NF PE RVU: **2020 NF PE RVU:** 0.73
2007 Fac PE RVU **2020 Fac PE RVU:** 0.43

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96131 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 80,133

2007 Work RVU: **2020 Work RVU:** 1.96
2007 NF PE RVU: **2020 NF PE RVU:** 0.55
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96132 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 194,323

2007 Work RVU: **2020 Work RVU:** 2.56
2007 NF PE RVU: **2020 NF PE RVU:** 1.13
2007 Fac PE RVU **2020 Fac PE RVU:** 0.39

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96133 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 339,426

2007 Work RVU: **2020 Work RVU:** 1.96
2007 NF PE RVU: **2020 NF PE RVU:** 0.80
2007 Fac PE RVU **2020 Fac PE RVU:** 0.30

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96136 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 173,801

2007 Work RVU: **2020 Work RVU:** 0.55
2007 NF PE RVU: **2020 NF PE RVU:** 0.75
2007 Fac PE RVU **2020 Fac PE RVU:** 0.12

RUC Recommendation: 0.55 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96137 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 379,620

2007 Work RVU: **2020 Work RVU:** 0.46
2007 NF PE RVU: **2020 NF PE RVU:** 0.74
2007 Fac PE RVU **2020 Fac PE RVU:** 0.07

RUC Recommendation: 0.46 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96138 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 157,925

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.06
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96139 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 353,021

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 1.06
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96146 **Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 27,702

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.05
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96150 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 54,601

2007 Work RVU: 0.50 **2020 Work RVU:**
2007 NF PE RVU: 0.16 **2020 NF PE RVU:**
2007 Fac PE RVU 0.16 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96151 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 10,113

2007 Work RVU: 0.48 **2020 Work RVU:**
2007 NF PE RVU: 0.16 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96152 **Health and behavior intervention, each 15 minutes, face-to-face; individual**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 103,595

2007 Work RVU: 0.46 **2020 Work RVU:**
2007 NF PE RVU: 0.15 **2020 NF PE RVU:**
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

96153 **Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 42,795

2007 Work RVU: 0.10 **2020 Work RVU:**
2007 NF PE RVU: 0.04 **2020 NF PE RVU:**
2007 Fac PE RVU 0.03 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96154 **Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:** APA (psychology), NASW

First Identified: April 2017 **2019 est Medicare Utilization:** 8,583

2007 Work RVU: 0.45 **2020 Work RVU:**
2007 NF PE RVU: 0.15 **2020 NF PE RVU:**
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96155 **Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: 0.44 **2020 Work RVU:**
2007 NF PE RVU: 0.16 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

96156 **Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.10
2007 NF PE RVU: **2020 NF PE RVU:** 0.58
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 2.10

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96158 **Health behavior intervention, individual, face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.39
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 1.45

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96159 **Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.14
2007 Fac PE RVU **2020 Fac PE RVU:** 0.07

RUC Recommendation: 0.50

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

96164 **Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.21
2007 NF PE RVU: **2020 NF PE RVU:** 0.06
2007 Fac PE RVU **2020 Fac PE RVU:** 0.03

RUC Recommendation: 0.21

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96165 **Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.10
2007 NF PE RVU: **2020 NF PE RVU:** 0.03
2007 Fac PE RVU **2020 Fac PE RVU:** 0.01

RUC Recommendation: 0.10

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96167 **Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.55
2007 NF PE RVU: **2020 NF PE RVU:** 0.42
2007 Fac PE RVU **2020 Fac PE RVU:** 0.22

RUC Recommendation: 1.55

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

96168 **Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.55
2007 NF PE RVU: **2020 NF PE RVU:** 0.15
2007 Fac PE RVU **2020 Fac PE RVU:** 0.08

RUC Recommendation: 0.55

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96170 **Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.69
2007 Fac PE RVU **2020 Fac PE RVU:** 0.58

RUC Recommendation: 1.50

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

96171 **Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.54
2007 NF PE RVU: **2020 NF PE RVU:** 0.25
2007 Fac PE RVU **2020 Fac PE RVU:** 0.21

RUC Recommendation: 0.54

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

96360 **Intravenous infusion, hydration; initial, 31 minutes to 1 hour**

Global: XXX **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 25 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 248,266

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.77
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96361 **Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 25 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 433,535

2007 Work RVU: **2020 Work RVU:** 0.09
2007 NF PE RVU: **2020 NF PE RVU:** 0.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.09 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96365 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**

Global: XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,269,889

2007 Work RVU: **2020 Work RVU:** 0.21
2007 NF PE RVU: **2020 NF PE RVU:** 1.74
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96366 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 558,744

RUC Recommendation: 0.18 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.42
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: Maintain

96367 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,292,846

RUC Recommendation: 0.19 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.19
2007 NF PE RVU: **2020 NF PE RVU:** 0.66
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: Maintain

96368 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 133,379

RUC Recommendation: 0.17 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.41
2007 Fac PE RVU **2020 Fac PE RVU:** NA
Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

96372 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 26 **Specialty Developing Recommendation:** ASCO, ASH, AAFP, ACRh **First Identified:** April 2013 **2019 est Medicare Utilization:** 9,458,412

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.22
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96374 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 272,442

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.91
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.18 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96375 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,416,745

2007 Work RVU: **2020 Work RVU:** 0.10
2007 NF PE RVU: **2020 NF PE RVU:** 0.35
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.10 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96377 **Application of on-body injector (includes cannula insertion) for timed subcutaneous injection**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** should be on N/R LOI just added to track **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 26 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** January 2016 **2019 est Medicare Utilization:** 60,948

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.38
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Not Part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

96401 **Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 758,701

2007 Work RVU: 0.21 **2020 Work RVU:** 0.21
2007 NF PE RVU: 1.34 **2020 NF PE RVU:** 1.96
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96402 **Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 403,494

2007 Work RVU: 0.19 **2020 Work RVU:** 0.19
2007 NF PE RVU: 0.94 **2020 NF PE RVU:** 0.68
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.19 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96405 **Chemotherapy administration; intralesional, up to and including 7 lesions** **Global:** 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 12,359

2007 Work RVU: 0.52 **2020 Work RVU:** 0.52
2007 NF PE RVU: 2.71 **2020 NF PE RVU:** 1.80
2007 Fac PE RVU 0.24 **2020 Fac PE RVU:**0.29

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96406 **Chemotherapy administration; intralesional, more than 7 lesions** **Global:** 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 566

2007 Work RVU: 0.80 **2020 Work RVU:** 0.80
2007 NF PE RVU: 3.08 **2020 NF PE RVU:** 2.75
2007 Fac PE RVU 0.29 **2020 Fac PE RVU:**0.45

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96409 **Chemotherapy administration; intravenous, push technique, single or initial substance/drug** **Global:** XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 79,884

2007 Work RVU: 0.24 **2020 Work RVU:** 0.24
2007 NF PE RVU: 2.88 **2020 NF PE RVU:** 2.73
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.24 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96411 **Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 165,078

2007 Work RVU: 0.20 **2020 Work RVU:** 0.20
2007 NF PE RVU: 1.58 **2020 NF PE RVU:** 1.41
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.20 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96413 **Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875,219

2007 Work RVU: 0.28 **2020 Work RVU:** 0.28
2007 NF PE RVU: 4.05 **2020 NF PE RVU:** 3.58
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.28 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

96415 **Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 891,855

2007 Work RVU: 0.19 **2020 Work RVU:** 0.19
2007 NF PE RVU: 0.74 **2020 NF PE RVU:** 0.64
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.19 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

96416 **Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2019 est Medicare Utilization:** 30,942

2007 Work RVU: 0.21 **2020 Work RVU:** 0.21
2007 NF PE RVU: 4.47 **2020 NF PE RVU:** 3.65
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

96417 **Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 388,626

2007 Work RVU: 0.21 **2020 Work RVU:** 0.21
2007 NF PE RVU: 1.89 **2020 NF PE RVU:** 1.66
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 60

2007 Work RVU: 2.37 **2020 Work RVU:** 2.12
2007 NF PE RVU: 7.48 **2020 NF PE RVU:** 22.64
2007 Fac PE RVU 1.17 **2020 Fac PE RVU:** 0.97

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96567 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day**

Global: XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth1 / CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 16 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 66,951

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 2.4 **2020 NF PE RVU:** 3.76
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.00 PE Only **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96573 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 16 **Specialty Developing Recommendation:** AAD

First Identified: January 2017 **2019 est Medicare Utilization:** 39,219

2007 Work RVU: **2020 Work RVU:** 0.48
2007 NF PE RVU: **2020 NF PE RVU:** 5.53
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48

Referred to CPT September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

96574 **Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 16 **Specialty Developing Recommendation:** AAD

First Identified: January 2017 **2019 est Medicare Utilization:** 48,673

2007 Work RVU: **2020 Work RVU:** 1.01
2007 NF PE RVU: **2020 NF PE RVU:** 6.52
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.01

Referred to CPT September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

96910 **Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B**

Global: XXX **Issue:** Photo-chemotherapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 44 **Specialty Developing Recommendation:** AAD

First Identified: July 2015 **2019 est Medicare Utilization:** 386,553

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 1.24 **2020 NF PE RVU:** 3.26
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: PE Only

Referred to CPT **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAD

First Identified: October 2008 **2019 est Medicare Utilization:** 118,570

2007 Work RVU: 1.15 **2020 Work RVU:** 1.15
2007 NF PE RVU: 2.8 **2020 NF PE RVU:** 3.41
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**0.68

RUC Recommendation: 1.15. Review in two years (Oct 2021)

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Result: Maintain

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAD

First Identified: February 2008 **2019 est Medicare Utilization:** 29,878

2007 Work RVU: 1.17 **2020 Work RVU:** 1.30
2007 NF PE RVU: 2.82 **2020 NF PE RVU:** 3.70
2007 Fac PE RVU 0.57 **2020 Fac PE RVU:**0.76

RUC Recommendation: 1.30. Review in two years (Oct 2021)

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Result: Increase

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAD

First Identified: October 2008 **2019 est Medicare Utilization:** 15,528

2007 Work RVU: 2.10 **2020 Work RVU:** 2.10
2007 NF PE RVU: 3.77 **2020 NF PE RVU:** 4.70
2007 Fac PE RVU 0.73 **2020 Fac PE RVU:**1.22

RUC Recommendation: 2.10. Review in two years (Oct 2021)

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

97001 **Physical therapy evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 1.20 **2020 Work RVU:**
2007 NF PE RVU: 0.73 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

97002 **Physical therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.60 **2020 Work RVU:**
2007 NF PE RVU: 0.43 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

97003 **Occupational therapy evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 1.20 **2020 Work RVU:**
2007 NF PE RVU: 0.86 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

97004 **Occupational therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2007 Work RVU: 0.60 **2020 Work RVU:**
2007 NF PE RVU: 0.64 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97010 **Application of a modality to 1 or more areas; hot or cold packs** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 41 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.06 **2020 Work RVU:** 0.06
2007 NF PE RVU: 0.06 **2020 NF PE RVU:** 0.11
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: No specialty society interest **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97012 **Application of a modality to 1 or more areas; traction, mechanical** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 560,317

2007 Work RVU: 0.25 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.13 **2020 NF PE RVU:** 0.17
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97014 **Application of a modality to 1 or more areas; electrical stimulation (unattended)** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.19 **2020 NF PE RVU:** 0.22
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97016 **Application of a modality to 1 or more areas; vasopneumatic devices**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA

First Identified: February 2010 **2019 est Medicare Utilization:** 864,521

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.2 **2020 NF PE RVU:** 0.16
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

97018 **Application of a modality to 1 or more areas; paraffin bath**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** AOTA, APTA

First Identified: February 2010 **2019 est Medicare Utilization:** 174,530

2007 Work RVU: 0.06 **2020 Work RVU:** 0.06
2007 NF PE RVU: 0.12 **2020 NF PE RVU:** 0.10
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.06

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

97022 **Application of a modality to 1 or more areas; whirlpool**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA

First Identified: April 2016 **2019 est Medicare Utilization:** 193,036

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.24 **2020 NF PE RVU:** 0.33
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

97032 **Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 849,666

2007 Work RVU: 0.25 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.17 **2020 NF PE RVU:** 0.16
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97033 **Application of a modality to 1 or more areas; iontophoresis, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 56,451

2007 Work RVU: 0.26 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.31 **2020 NF PE RVU:** 0.32
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97034 **Application of a modality to 1 or more areas; contrast baths, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,235

2007 Work RVU: 0.21 **2020 Work RVU:** 0.21
2007 NF PE RVU: 0.16 **2020 NF PE RVU:** 0.21
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97035 **Application of a modality to 1 or more areas; ultrasound, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,002,641

2007 Work RVU: 0.21 **2020 Work RVU:** 0.21
2007 NF PE RVU: 0.1 **2020 NF PE RVU:** 0.19
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97110 **Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 60,569,850

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.28 **2020 NF PE RVU:** 0.40
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97112 **Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,084,367

2007 Work RVU: 0.45 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.32 **2020 NF PE RVU:** 0.48
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97113 **Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,811,269

2007 Work RVU: 0.44 **2020 Work RVU:** 0.48
2007 NF PE RVU: 0.43 **2020 NF PE RVU:** 0.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97116 **Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,661,789

2007 Work RVU: 0.40 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.25 **2020 NF PE RVU:** 0.39
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97127 **Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** **First Identified:** January 2017 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 1.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97140 **Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA

First Identified: September 2011 **2019 est Medicare Utilization:** 29,711,740

2007 Work RVU: 0.43 **2020 Work RVU:** 0.43
2007 NF PE RVU: 0.26 **2020 NF PE RVU:** 0.35
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.43

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

97150 **Therapeutic procedure(s), group (2 or more individuals)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** **Specialty Developing Recommendation:** APTA

First Identified: April 2011 **2019 est Medicare Utilization:** 1,433,348

2007 Work RVU: 0.27 **2020 Work RVU:** 0.29
2007 NF PE RVU: 0.19 **2020 NF PE RVU:** 0.22
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

97161 **Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA

First Identified: February 2015 **2019 est Medicare Utilization:** 1,552,998

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.18
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.75

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

97162 **Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,386,353

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.18
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.18 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

97163 **Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 318,604

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.18
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.50 **Referred to CPT** February 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97164 **Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 585,829

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 0.89
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97165 **Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 146,443

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.33
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.88 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97166 **Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 101,883

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.20 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97167 **Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 22,637

2007 Work RVU: **2020 Work RVU:** 1.20
2007 NF PE RVU: **2020 NF PE RVU:** 1.32
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 1.70 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97168 **Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 33,480

2007 Work RVU: **2020 Work RVU:** 0.75
2007 NF PE RVU: **2020 NF PE RVU:** 1.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.80 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97530 **Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,151,706

2007 Work RVU: 0.44 **2020 Work RVU:** 0.44
2007 NF PE RVU: 0.34 **2020 NF PE RVU:** 0.66
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97532 **Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth2 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2007 Work RVU: 0.44 **2020 Work RVU:**
2007 NF PE RVU: 0.21 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97533 **Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 21,250

2007 Work RVU: 0.44 **2020 Work RVU:** 0.48
2007 NF PE RVU: 0.25 **2020 NF PE RVU:** 0.97
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97535 **Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,942,480

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.34 **2020 NF PE RVU:** 0.50
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Article no longer necessary

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97537 **Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 23,275

2007 Work RVU: 0.45 **2020 Work RVU:** 0.48
2007 NF PE RVU: 0.27 **2020 NF PE RVU:** 0.43
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97542 **Wheelchair management (eg, assessment, fitting, training), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,278

2007 Work RVU: 0.45 **2020 Work RVU:** 0.48
2007 NF PE RVU: 0.28 **2020 NF PE RVU:** 0.44
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97597 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

Global: 000 **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 897,614

2007 Work RVU: 0.58 **2020 Work RVU:** 0.77
2007 NF PE RVU: 0.77 **2020 NF PE RVU:** 1.91
2007 Fac PE RVU 0.53 **2020 Fac PE RVU:** 0.22

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97598 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 135,670

2007 Work RVU: 0.80 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.91 **2020 NF PE RVU:** 0.75
2007 Fac PE RVU 0.64 **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97602 **Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0 **2020 NF PE RVU:** 0.00
2007 Fac PE RVU 0 **2020 Fac PE RVU:**0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97605 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 51,268

2007 Work RVU: 0.55 **2020 Work RVU:** 0.55
2007 NF PE RVU: 0.36 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU 0.2 **2020 Fac PE RVU:**0.17

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97606 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,612

2007 Work RVU: 0.60 **2020 Work RVU:** 0.60
2007 NF PE RVU: 0.37 **2020 NF PE RVU:** 0.84
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97607 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 5,825

2007 Work RVU: **2020 Work RVU:** 0.41
2007 NF PE RVU: **2020 NF PE RVU:** 9.01
2007 Fac PE RVU **2020 Fac PE RVU:** 0.16

RUC Recommendation: 0.11 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

97608 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,172

2007 Work RVU: **2020 Work RVU:** 0.46
2007 NF PE RVU: **2020 NF PE RVU:** 8.98
2007 Fac PE RVU **2020 Fac PE RVU:** 0.18

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

97610 **Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 12,331

2007 Work RVU: **2020 Work RVU:** 0.40
2007 NF PE RVU: **2020 NF PE RVU:** 8.73
2007 Fac PE RVU **2020 Fac PE RVU:** 0.12

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Tests and Measures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,693

2007 Work RVU: 0.62 **2020 Work RVU:** 0.62
2007 NF PE RVU: 0.28 **2020 NF PE RVU:** 0.45
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

97760 **Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 57,907

2007 Work RVU: 0.45 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.36 **2020 NF PE RVU:** 0.88
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97761 **Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,698

2007 Work RVU: 0.45 **2020 Work RVU:** 0.50
2007 NF PE RVU: 0.29 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97762 **Checkout for orthotic/prosthetic use, established patient, each 15 minutes** **Global:** **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.25 **2020 Work RVU:**
2007 NF PE RVU: 0.5 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

97763 **Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes** **Global:** XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 38,754

2007 Work RVU: **2020 Work RVU:** 0.48
2007 NF PE RVU: **2020 NF PE RVU:** 1.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes** **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 224,711

2007 Work RVU: 0.45 **2020 Work RVU:** 0.53
2007 NF PE RVU: 0.39 **2020 NF PE RVU:** 0.51
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:** 0.41

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 211,418

2007 Work RVU: 0.37 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.38 **2020 NF PE RVU:** 0.45
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**0.34

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98925 **Osteopathic manipulative treatment (OMT); 1-2 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 65,014

2007 Work RVU: 0.45 **2020 Work RVU:** 0.46
2007 NF PE RVU: 0.31 **2020 NF PE RVU:** 0.40
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:**0.19

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98926 **Osteopathic manipulative treatment (OMT); 3-4 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 109,622

2007 Work RVU: 0.65 **2020 Work RVU:** 0.71
2007 NF PE RVU: 0.4 **2020 NF PE RVU:** 0.53
2007 Fac PE RVU 0.23 **2020 Fac PE RVU:**0.27

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98927 **Osteopathic manipulative treatment (OMT); 5-6 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 99,716

2007 Work RVU: 0.87 **2020 Work RVU:** 0.96
2007 NF PE RVU: 0.49 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU 0.28 **2020 Fac PE RVU:**0.34

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98928 **Osteopathic manipulative treatment (OMT); 7-8 body regions involved** **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 99,045

2007 Work RVU: 1.03 **2020 Work RVU:** 1.21
2007 NF PE RVU: 0.57 **2020 NF PE RVU:** 0.78
2007 Fac PE RVU 0.32 **2020 Fac PE RVU:**0.42

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98929 **Osteopathic manipulative treatment (OMT); 9-10 body regions involved** **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 76,576

2007 Work RVU: 1.19 **2020 Work RVU:** 1.46
2007 NF PE RVU: 0.65 **2020 NF PE RVU:** 0.90
2007 Fac PE RVU 0.35 **2020 Fac PE RVU:**0.52

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98940 **Chiropractic manipulative treatment (CMT); spinal, 1-2 regions** **Global:** 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,600,246

2007 Work RVU: 0.45 **2020 Work RVU:** 0.46
2007 NF PE RVU: 0.23 **2020 NF PE RVU:** 0.33
2007 Fac PE RVU 0.12 **2020 Fac PE RVU:**0.17

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

98941 **Chiropractic manipulative treatment (CMT); spinal, 3-4 regions** **Global:** 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:** 13,626,398

2007 Work RVU: 0.65 **2020 Work RVU:** 0.71
2007 NF PE RVU: 0.29 **2020 NF PE RVU:** 0.43
2007 Fac PE RVU 0.17 **2020 Fac PE RVU:**0.26

RUC Recommendation: 0.71 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98942 **Chiropractic manipulative treatment (CMT); spinal, 5 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:** 948,986

2007 Work RVU: 0.87 **2020 Work RVU:** 0.96
2007 NF PE RVU: 0.36 **2020 NF PE RVU:** 0.52
2007 Fac PE RVU 0.23 **2020 Fac PE RVU:**0.35

RUC Recommendation: 0.96

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

98943 **Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions**

Global: XXX **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:**

2007 Work RVU: 0.40 **2020 Work RVU:** 0.46
2007 NF PE RVU: 0.22 **2020 NF PE RVU:** 0.28
2007 Fac PE RVU 0.14 **2020 Fac PE RVU:**0.18

RUC Recommendation: 0.46

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

99143 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI

First Identified: January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

99144 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99148 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99149 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99150 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.00 **2020 Work RVU:**
2007 NF PE RVU: 0 **2020 NF PE RVU:**
2007 Fac PE RVU 0 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99151 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 11

2007 Work RVU: **2020 Work RVU:** 0.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.55
2007 Fac PE RVU **2020 Fac PE RVU:** 0.12

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99152 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,909,615

2007 Work RVU: **2020 Work RVU:** 0.25
2007 NF PE RVU: **2020 NF PE RVU:** 1.16
2007 Fac PE RVU **2020 Fac PE RVU:** 0.08

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99155 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 30

2007 Work RVU: **2020 Work RVU:** 1.90
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.32

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99156 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 7,955

2007 Work RVU: **2020 Work RVU:** 1.65
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.42

RUC Recommendation: 1.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99174 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 09 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.15
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99177 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 09 **Specialty Developing Recommendation:** **First Identified:** May 2014 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.12
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99183 **Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session**

Global: XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 33 **Specialty Developing Recommendation:** ACEP, ACP, ACS, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 386,280

2007 Work RVU: 2.34 **2020 Work RVU:** 2.11
2007 NF PE RVU: 3.08 **2020 NF PE RVU:** 0.78
2007 Fac PE RVU 0.69 **2020 Fac PE RVU:** 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99281 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 67,730

2007 Work RVU: 0.45 **2020 Work RVU:** 0.48
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.09 **2020 Fac PE RVU:** 0.11
Result: Increase

RUC Recommendation: 0.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99282 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 352,496

2007 Work RVU: 0.88 **2020 Work RVU:** 0.93
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:** 0.21
Result: Increase

RUC Recommendation: 0.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99283 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 2,744,710

2007 Work RVU: 1.34 **2020 Work RVU:** 1.42
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.3 **2020 Fac PE RVU:** 0.29
Result: Increase

RUC Recommendation: 1.42

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99284 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,415,650

2007 Work RVU: 2.56 **2020 Work RVU:** 2.60
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.47 **2020 Fac PE RVU:** 0.51
Result: Increase

RUC Recommendation: 2.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99285 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 11,514,274

2007 Work RVU: 3.80 **2020 Work RVU:** 3.80
2007 NF PE RVU: NA **2020 NF PE RVU:** NA
2007 Fac PE RVU 0.71 **2020 Fac PE RVU:**0.71

RUC Recommendation: 3.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99358 **Prolonged evaluation and management service before and/or after direct patient care; first hour**

Global: XXX **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 12 **Specialty Developing Recommendation:** AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE **First Identified:** November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: 2.10 **2020 Work RVU:** 2.10
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.92
2007 Fac PE RVU 0.51 **2020 Fac PE RVU:**0.92

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99359 **Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 12 **Specialty Developing Recommendation:** AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE **First Identified:** November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: 1.00 **2020 Work RVU:** 1.00
2007 NF PE RVU: 0.26 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.26 **2020 Fac PE RVU:** 0.46

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99363 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 1.65 **2020 Work RVU:**
2007 NF PE RVU: 1.29 **2020 NF PE RVU:**
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99364 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 0.63 **2020 Work RVU:**
2007 NF PE RVU: 0.38 **2020 NF PE RVU:**
2007 Fac PE RVU 0.15 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99375 **Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 1.35 **2020 NF PE RVU:** 1.10
2007 Fac PE RVU 1.26 **2020 Fac PE RVU:**0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

99378 **Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 1.64 **2020 NF PE RVU:** 1.10
2007 Fac PE RVU 1.56 **2020 Fac PE RVU:**0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99491 **Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.**

Global: XXX **Issue:** Chronic Care Management Services **Screen:** New and Revised Service (Not part of RAW) **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 09 **Specialty Developing Recommendation:** AAFP, AAN, ACP, AGS **First Identified:** NA **2019 est Medicare Utilization:** 48,091

2007 Work RVU: **2020 Work RVU:** 1.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.79
2007 Fac PE RVU **2020 Fac PE RVU:** 0.79

RUC Recommendation: 1.45. Refer to CPT Assistant

Referred to CPT **Result:** Not part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2018

99492 **Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,445

2007 Work RVU: **2020 Work RVU:** 1.70
2007 NF PE RVU: **2020 NF PE RVU:** 2.54
2007 Fac PE RVU **2020 Fac PE RVU:** 0.69

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99493 **Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 14,660

2007 Work RVU: **2020 Work RVU:** 1.53
2007 NF PE RVU: **2020 NF PE RVU:** 1.88
2007 Fac PE RVU **2020 Fac PE RVU:** 0.63

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

99494 **Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 27,335

2007 Work RVU: **2020 Work RVU:** 0.82
2007 NF PE RVU: **2020 NF PE RVU:** 0.90
2007 Fac PE RVU **2020 Fac PE RVU:** 0.33

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99497 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate**

Global: XXX **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,825,276

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 0.82
2007 Fac PE RVU **2020 Fac PE RVU:** 0.64

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

99498 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 60,204

2007 Work RVU: **2020 Work RVU:** 1.40
2007 NF PE RVU: **2020 NF PE RVU:** 0.62
2007 Fac PE RVU **2020 Fac PE RVU:** 0.61

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

G0101 **Cervical or vaginal cancer screening; pelvic and clinical breast examination**

Global: XXX **Issue:** **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2010 **2019 est Medicare Utilization:** 929,962

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.51 **2020 NF PE RVU:** 0.60
2007 Fac PE RVU NA **2020 Fac PE RVU:** 0.28

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0102 **Prostate cancer screening; digital rectal examination** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 30,358

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.37 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:**0.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0104 **Colorectal cancer screening; flexible sigmoidoscopy** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,724

2007 Work RVU: 0.96 **2020 Work RVU:** 0.84
2007 NF PE RVU: 2.33 **2020 NF PE RVU:** 4.03
2007 Fac PE RVU 0.53 **2020 Fac PE RVU:**0.66

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0105 **Colorectal cancer screening; colonoscopy on individual at high risk** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 262,478

2007 Work RVU: 3.69 **2020 Work RVU:** 3.26
2007 NF PE RVU: 6.2 **2020 NF PE RVU:** 5.75
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**1.68

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0108 **Diabetes outpatient self-management training services, individual, per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 172,612

2007 Work RVU: 0.00 **2020 Work RVU:** 0.90
2007 NF PE RVU: 0.77 **2020 NF PE RVU:** 0.63
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0109 **Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes**

Global: XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 111,248

2007 Work RVU: 0.00 **2020 Work RVU:** 0.25
2007 NF PE RVU: 0.44 **2020 NF PE RVU:** 0.18
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0121 **Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215,409

2007 Work RVU: 3.69 **2020 Work RVU:** 3.26
2007 NF PE RVU: 6.2 **2020 NF PE RVU:** 5.75
2007 Fac PE RVU 1.57 **2020 Fac PE RVU:**1.68

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0124 **Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 47,978

2007 Work RVU: 0.42 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.46

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0127 **Trimming of dystrophic nails, any number**

Global: 000 **Issue:** **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** APMA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,109,311

2007 Work RVU: 0.17 **2020 Work RVU:** 0.17
2007 NF PE RVU: 0.28 **2020 NF PE RVU:** 0.49
2007 Fac PE RVU 0.07 **2020 Fac PE RVU:**0.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0141 **Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 3,666

2007 Work RVU: 0.42 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.46

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0166 **External counterpulsation, per treatment session**

Global: XXX **Issue:** External Counterpulsation **Screen:** CMS-Other - Utilization over 100,000 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 14 **Specialty Developing Recommendation:** ACC **First Identified:** April 2016 **2019 est Medicare Utilization:** 95,502

2007 Work RVU: 0.07 **2020 Work RVU:** 0.00
2007 NF PE RVU: 3.81 **2020 NF PE RVU:** 2.86
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.00 (PE Only) **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0168 **Wound closure utilizing tissue adhesive(s) only**

Global: 000 **Issue:** Wound Closure by Adhesive **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 34 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** July 2016 **2019 est Medicare Utilization:** 44,921

2007 Work RVU: 0.45 **2020 Work RVU:** 0.31
2007 NF PE RVU: 1.84 **2020 NF PE RVU:** 2.66
2007 Fac PE RVU 0.22 **2020 Fac PE RVU:**0.17

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0179 **Physician re-certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 806,300

2007 Work RVU: 0.45 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.89 **2020 NF PE RVU:** 0.67
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0180 **Physician certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,169,998

2007 Work RVU: 0.67 **2020 Work RVU:** 0.67
2007 NF PE RVU: 1.09 **2020 NF PE RVU:** 0.78
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0181 **Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 386,948

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 1.32 **2020 NF PE RVU:** 1.18
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G0182 **Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 26,148

2007 Work RVU: 1.73 **2020 Work RVU:** 1.73
2007 NF PE RVU: 1.46 **2020 NF PE RVU:** 1.20
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

Status Report: CMS Requests and Relativity Assessment Issues

G0202 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.70 **2020 Work RVU:**
2007 NF PE RVU: 2.74 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

G0204 **Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.87 **2020 Work RVU:**
2007 NF PE RVU: 2.87 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

G0206 **Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR

First Identified: February 2008 **2019 est Medicare Utilization:**

2007 Work RVU: 0.70 **2020 Work RVU:**
2007 NF PE RVU: 2.31 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,969

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.41 **2020 NF PE RVU:** 0.25
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G0238 **Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 49,322

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 0.43 **2020 NF PE RVU:** 0.26
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G0248 **Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** ACC **First Identified:** January 2016 **2019 est Medicare Utilization:** 23,312

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 5.8 **2020 NF PE RVU:** 1.62
2007 Fac PE RVU NA **2020 Fac PE RVU:** NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

G0249 **Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:** 1,211,835

2007 Work RVU: 0.00 **2020 Work RVU:** 0.00
2007 NF PE RVU: 3.57 **2020 NF PE RVU:** 1.63
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0250 **Physician review, interpretation, and patient management of home inr testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:** 185,069

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.07 **2020 NF PE RVU:** 0.07
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Impacted Cerumen **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 35 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2008 **2019 est Medicare Utilization:** 166,164

2007 Work RVU: 0.61 **2020 Work RVU:** 0.61
2007 NF PE RVU: 0.63 **2020 NF PE RVU:** 0.73
2007 Fac PE RVU 0.23 **2020 Fac PE RVU:**0.26

RUC Recommendation: 0.61

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2019 est Medicare Utilization:** 81,177

2007 Work RVU: 0.37 **2020 Work RVU:** 0.45
2007 NF PE RVU: 0.38 **2020 NF PE RVU:** 0.45
2007 Fac PE RVU 0.38 **2020 Fac PE RVU:**0.34

RUC Recommendation: Maintain/Remove from screen **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0279 **Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)**

Global: ZZZ **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 783,467

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** 0.92
2007 Fac PE RVU **2020 Fac PE RVU:**NA

RUC Recommendation: Recommend CMS delete **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,523,149

2007 Work RVU: 0.18 **2020 Work RVU:** 0.18
2007 NF PE RVU: 0.12 **2020 NF PE RVU:** 0.20
2007 Fac PE RVU NA **2020 Fac PE RVU:**NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0296 **Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 50,164

2007 Work RVU: **2020 Work RVU:** 0.52
2007 NF PE RVU: **2020 NF PE RVU:** 0.26
2007 Fac PE RVU **2020 Fac PE RVU:** 0.20

RUC Recommendation: Submit action plan

Referred to CPT **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0297 **Low dose ct scan (ldct) for lung cancer screening**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 07 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:** 260,400

2007 Work RVU: 0.00 **2020 Work RVU:** 1.02
2007 NF PE RVU: 0 **2020 NF PE RVU:** 5.62
2007 Fac PE RVU 0 **2020 Fac PE RVU:** NA

RUC Recommendation: Recommend CMS delete. Cat I code created.

Referred to CPT May 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0364 **Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:**

2007 Work RVU: 0.16 **2020 Work RVU:**
2007 NF PE RVU: 0.15 **2020 NF PE RVU:**
2007 Fac PE RVU 0.06 **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0365 **Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)**

Global: **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 17 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 38,289

2007 Work RVU: 0.25 **2020 Work RVU:**
2007 NF PE RVU: 4.28 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0389 **Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening**

Global: **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 12 **Specialty Developing Recommendation:** ACC, ACP, ACR, SCAI, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2007 Work RVU: 0.58 **2020 Work RVU:**
2007 NF PE RVU: 1.81 **2020 NF PE RVU:**
2007 Fac PE RVU NA **2020 Fac PE RVU:**

RUC Recommendation: CPT Assistant article published **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

G0396 **Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** AAFP, ASA, ASAM **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,068

2007 Work RVU: **2020 Work RVU:** 0.65
2007 NF PE RVU: **2020 NF PE RVU:** 0.32
2007 Fac PE RVU **2020 Fac PE RVU:** 0.24

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0399 **Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation**

Global: XXX **Issue:** **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 112,455

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: CMS delete **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0402 **Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment**

Global: XXX **Issue:** Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 526,509

2007 Work RVU: **2020 Work RVU:** 2.43
2007 NF PE RVU: **2020 NF PE RVU:** 2.11
2007 Fac PE RVU **2020 Fac PE RVU:** 1.02

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0403 **Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report**

Global: XXX **Issue:** EKG for Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 129,413

2007 Work RVU: **2020 Work RVU:** 0.17
2007 NF PE RVU: **2020 NF PE RVU:** 0.29
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0407 **Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.39
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.56

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0408 **Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 2.00
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.81

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0416 **Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method**

Global: XXX **Issue:** Prostate Biopsy - Pathology **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 16 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2014 **2019 est Medicare Utilization:** 133,021

2007 Work RVU: **2020 Work RVU:** 3.60
2007 NF PE RVU: **2020 NF PE RVU:** 5.95
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0422 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.65
2007 NF PE RVU: **2020 NF PE RVU:** 1.31
2007 Fac PE RVU **2020 Fac PE RVU:** 1.31

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0423 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 1.65
2007 NF PE RVU: **2020 NF PE RVU:** 1.31
2007 Fac PE RVU **2020 Fac PE RVU:** 1.31

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0436 **Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0438 **Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,114,054

2007 Work RVU: **2020 Work RVU:** 2.43
2007 NF PE RVU: **2020 NF PE RVU:** 2.23
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0439 **Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 8,360,475

2007 Work RVU: **2020 Work RVU:** 1.50
2007 NF PE RVU: **2020 NF PE RVU:** 1.66
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0442 **Annual alcohol misuse screening, 15 minutes**

Global: XXX **Issue:** Annual Alcohol Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 893,133

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.32
2007 Fac PE RVU **2020 Fac PE RVU:** 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0444 **Annual depression screening, 15 minutes**

Global: XXX **Issue:** Annual Depression Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,127,052

2007 Work RVU: **2020 Work RVU:** 0.18
2007 NF PE RVU: **2020 NF PE RVU:** 0.32
2007 Fac PE RVU **2020 Fac PE RVU:** 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0446 **Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes**

Global: XXX **Issue:** Intensive Behavioral Therapy for Cardiovascular Disease **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** October 2017 **2019 est Medicare Utilization:** 253,992

2007 Work RVU: **2020 Work RVU:** 0.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.26
2007 Fac PE RVU **2020 Fac PE RVU:** 0.19

RUC Recommendation: Survey, but no specialty interest, so no recommendation.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0447 **Face-to-face behavioral counseling for obesity, 15 minutes**

Global: XXX **Issue:** Behavioral Counseling for Obesity **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 336,973

2007 Work RVU: **2020 Work RVU:** 0.45
2007 NF PE RVU: **2020 NF PE RVU:** 0.26
2007 Fac PE RVU **2020 Fac PE RVU:** 0.19

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0452 **Molecular pathology procedure; physician interpretation and report**

Global: **Issue:** Molecular Pathology Interpretation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 128,942

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: 0.93

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0453 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:**

First Identified: April 2016 **2019 est Medicare Utilization:** 402,739

2007 Work RVU: **2020 Work RVU:** 0.60
2007 NF PE RVU: **2020 NF PE RVU:** NA
2007 Fac PE RVU **2020 Fac PE RVU:** 0.29

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0456 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: November 2012 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0457 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: November 2012 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0500 **Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.10
2007 NF PE RVU: **2020 NF PE RVU:** 1.48
2007 Fac PE RVU **2020 Fac PE RVU:** 0.04

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0506 **Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)**

Global: ZZZ **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.87
2007 NF PE RVU: **2020 NF PE RVU:** 0.83
2007 Fac PE RVU **2020 Fac PE RVU:** 0.36

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G6001 **Ultrasonic guidance for placement of radiation therapy fields**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.58
2007 NF PE RVU: **2020 NF PE RVU:** 2.70
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G6002 **Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization: 1,291,326

2007 Work RVU: **2020 Work RVU:** 0.39

2007 NF PE RVU: **2020 NF PE RVU:** 1.71

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G6012 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization:

2007 Work RVU: **2020 Work RVU:** 0.00

2007 NF PE RVU: **2020 NF PE RVU:** 7.27

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6013 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization:

2007 Work RVU: **2020 Work RVU:** 0.00

2007 NF PE RVU: **2020 NF PE RVU:** 7.28

2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

G6014 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 22,014

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 7.28
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G6015 **Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 10.20
2007 Fac PE RVU **2020 Fac PE RVU:** NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6017 **Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment**

Global: YYY **Issue:** **Screen:** CMS-Other - Utilization over 20,000 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab** 23 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:** 0.00
2007 NF PE RVU: **2020 NF PE RVU:** 0.00
2007 Fac PE RVU **2020 Fac PE RVU:** 0.00

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

GPCX1 **Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)**

Global: **Issue:** Visit Complexity E/M Add-On **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab** 34 **Specialty Developing Recommendation:**

First Identified: November 2019 **2019 est Medicare Utilization:**

2007 Work RVU: **2020 Work RVU:**
2007 NF PE RVU: **2020 NF PE RVU:**
2007 Fac PE RVU **2020 Fac PE RVU:**

RUC Recommendation: No recommendation on physician work, time or PE for this code. CMS estimates of utilization for code GPC1X should be more conservative.

Referred to CPT

Result: N/A

Referred to CPT Asst ☐ **Published in CPT Asst:**

P3001 **Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 1,599

2007 Work RVU: 0.42 **2020 Work RVU:** 0.26
2007 NF PE RVU: 0.21 **2020 NF PE RVU:** 0.46
2007 Fac PE RVU 0.21 **2020 Fac PE RVU:**0.46

RUC Recommendation: 0.42

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Q0091 **Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab** 37 **Specialty Developing Recommendation:** No Specialty Society Interest

First Identified: October 2018 **2019 est Medicare Utilization:** 533,729

2007 Work RVU: 0.37 **2020 Work RVU:** 0.37
2007 NF PE RVU: 0.69 **2020 NF PE RVU:** 0.81
2007 Fac PE RVU 0.13 **2020 Fac PE RVU:**0.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0446T	**Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	Time uncertain

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that “the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems.” Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0447T	**Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	Time uncertain

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that “the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems.” Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0448T	**Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	Time uncertain

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that "the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems." Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37220	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37221	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37222	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37223	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37224	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37225	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37226	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37227	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37228	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37229	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37230	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37231	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37232	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37233	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37234	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37235	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
49565	**Repair recurrent incisional or ventral hernia; reducible**	Site of Service Anomaly - 2019	January 2020	ACS, SAGES	February 2021

Background: In October 2019, the Relativity Assessment Workgroup identified CPT code 49565 as performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2018e Medicare utilization over 5,000. The RUC recommended this service be surveyed for January 2020. In January 2020, the specialty societies requested that CPT code 49565 be referred to the May 2020 CPT Editorial Panel to update the descriptor to current standard of practice and typical patient presentation; for example, mesh insertion and removal, and size and number or defects. The RUC questioned if CPT codes 49560, 49561, 49566 and/or 49568 are considered part of this family of services. The specialty society indicated they will define the family of services on the correct coding application (CCA). The RUC recommends that these services be referred to the May 2020 CPT Editorial Panel. The specialties are will submit a CCA for the CPT 2023 cycle.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50080	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	February 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50081	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	February 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus**	CMS Fastest Growing	October 2018	AAPM, ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth2	October 2018	ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**	part of New/Revised Review	October 2018	ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64446	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth1	October 2018	ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64447	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve**	CMS Fastest Growing	October 2018	AAPM, ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64448	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	October 2018	ASA	February 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
73580	**Radiologic examination, knee, arthrography, radiological supervision and interpretation**	High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3	October 2020	AAOS	February 2021

Background: The Workgroup discussed the long history of the identification of code 73580 and noted that this service has never been surveyed and remains CMS/Other sourced. The specialty societies noted that the increased utilization was due to miscoding of the related CPT code 27370 Injection of contrast for knee arthrography. To address this miscoding, CPT code 27370 was deleted and replaced with a new CPT code 27369 Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography. The new CPT code was valued by the RUC in October 2017. CPT code 27370 was deleted in 2019 and a CPT Assistant article was published in August 2019. CPT code 73580 utilization has decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes. The specialty societies noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. However, the Workgroup noted that codes 73580 and 27369 will always be reported in conjunction with one another. The Workgroup also noted that that Rheumatology and Family Medicine are the primary providers of code 73580 and should be involved with the review of this service. The Workgroup recommends that CPT code 73580 be referred to CPT to be bundled with CPT code 27369 Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76377	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**	CMS Request - Final Rule for 2020	January 2020	ACR, ASNR, SIR	February 2021

Background: In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation as potentially misvalued. The Agency views CPT code 76377 to be part of the same family as CPT code 76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76376 also be reviewed to maintain relativity within the code family. The specialty societies disagreed with CMS' rationale for the nomination of CPT code 76377 as potentially misvalued and the specialties do not believe that CPT codes 76376 and 76377 are in the same code family, although the descriptors are similar. The societies noted that the two codes are different because they are utilized on different patient populations (as evidenced by the ICD-10 diagnoses.) They also noted that the technical and professional resources required for 76376 and 76377 are significantly different. For these reasons, the specialty societies recommended, and the RUC agreed to refer CPT codes 76377 and 76376 to the CPT Editorial Panel for further review and potential revision. The specialty societies noted that they will determine the family of services including whether the codes remain a family, based on the recommendations of the CPT Editorial Panel.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3	April 2014	AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76998	**Ultrasonic guidance, intraoperative**	CMS-Other - Utilization over 20,000	October 2019	STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS	February 2021

Background: In October 2018, the Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000. In October 2019, the RUC refers this issued to CPT Editorial Panel (May 2020) to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
92065	**Orthoptic and/or pleoptic training, with continuing medical direction and evaluation**	Harvard Valued - Utilization over 30,000-Part4	October 2020	AAO, AOA (optometry)	February 2021 May 2020-Tab 37

Background: This service was identified in October 2019 as Harvard Valued utilization over 30,000. The Workgroup requested action plans to examine this service. In January 2020, the RUC recommended that this service be referred to CPT May 2020. This service with an “and/or” connector should be two different codes given their different patient populations and techniques used for the treatment. For that reason, this code should go back to CPT for a descriptor edit as well as creation of separate codes. At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes in order to delineate when the training is provided directly by the provider and when it is provided by a technician under the supervision of the provider. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for CPT 2023. The RUC recommends CPT code 92065 be referred to CPT.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99358	**Prolonged evaluation and management service before and/or after direct patient care; first hour**	CMS Request - Final Rule for 2020	October 2020	AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE	February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99359	**Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)**	CMS Request - Final Rule for 2020	October 2020	AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE	February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G0396	**Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**	CMS-Other - Utilization over 30,000	January 2018	AAFP, ASA, ASAM	February 2021

Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening” from 99408 and 99409 to “assessment” to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel said that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined, and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel’s additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

Physician Time from RUC Meeting:
October 2020 (CPT 2022)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
28001	17	3	5	20	15	0	0	0	0	0	0	0	0	0	0	0	0	60
28002	30	5	15	30	20	0	0	0	0	0	0	0	0	0	0	0	0	100
28003	40	10	15	45	20	0	0	0	0	0	0	0	0	0	0	0	0	130
33267	45	10	15	90	30	0	0	1	0	0	0	2	0	1	0	1	0	401
33268	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20
33269	42	15	15	65	30	0	0	1	0	0	0	1	1	1	0	0	0	323
33509	0	0	0	45	0	0	0	0	0	0	0	0	0	0	0	0	0	45
35600	0	0	0	42	0	0	0	0	0	0	0	0	0	0	0	0	0	42
38505	13	1	5	20	10	0	0	0	0	0	0	0	0	0	0	0	0	49
43497	33	3	10	120	50	0	0	2	0	0	0	0	0	0.5	0	0	0	281
46020	30	10	10	30	20	0	0	0	0	0	0	0	0	0	0	0	0	100
46030	17	10	10	15	15	0	0	0	0	0	0	0	0	0	0	0	0	67
64633	18	5	5	20	10	0	0	1	0	0	0	0	0	0.5	0	0	0	100
64634	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20
64635	18	5	5	20	10	0	0	1	0	0	0	0	0	0.5	0	0	0	100
64636	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	15
67141	5	1	5	15	5	0	0	2	0	0	0	0	0	0	0	0	0	77
67145	5	1	3	16	5	0	0	2	0	0	0	0	0	0	0	0	0	76
67311	10	5	15	25	15	0	2	1	0	0	0	0	0	0.5	0	0	0	144
67312	10	5	15	40	15	0	2	1	0	0	0	0	0	0.5	0	0	0	159
67314	10	5	15	26	15	0	2	1	0	0	0	0	0	0.5	0	0	0	145
67316	10	5	15	45	15	0	2	1	0	0	0	0	0	0.5	0	0	0	164
67318	10	5	15	40	15	0	1	2	0	0	0	0	0	0.5	0	0	0	166
67320	0	0	0	23	0	0	0	0	0	0	0	0	0	0	0	0	0	23
67331	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	15
67332	0	0	0	24	0	0	0	0	0	0	0	0	0	0	0	0	0	24
67334	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	15
67335	0	0	0	30	0	0	0	0	0	0	0	0	0	0	0	0	0	30
67340	0	0	0	45	0	0	0	0	0	0	0	0	0	0	0	0	0	45
74300	2	0	0	5	2	0	0	0	0	0	0	0	0	0	0	0	0	9
74301	0	0	0	5	1	0	0	0	0	0	0	0	0	0	0	0	0	6
74328	5	0	0	10	5	0	0	0	0	0	0	0	0	0	0	0	0	20
74329	5	0	0	10	5	0	0	0	0	0	0	0	0	0	0	0	0	20
74330	6	0	0	12	6	0	0	0	0	0	0	0	0	0	0	0	0	24
93228	5	0	0	10	8	0	0	0	0	0	0	0	0	0	0	0	0	23
93319	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20
93593	40	3	15	45	45	0	0	0	0	0	0	0	0	0	0	0	0	148
93594	46	3	15	60	48	0	0	0	0	0	0	0	0	0	0	0	0	172
93595	46	3	15	48	46	0	0	0	0	0	0	0	0	0	0	0	0	158
93596	50	3	15	60	53	0	0	0	0	0	0	0	0	0	0	0	0	181
93597	55	3	15	83	60	0	0	0	0	0	0	0	0	0	0	0	0	216
93598	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20
93621	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20
00537	30	0	0	195	12	0	0	0	0	0	0	0	0	0	0	0	0	238

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY				NON-FAC	
		1	2	3	4	5**	6
	Total Pre-Service Time	**20**	**25**	**51**	**63**	**8**	**23**
	CATEGORY SUBTOTALS						
A	Pre-Service Evaluation (IWPUT =0.0224)	13	18	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	6	15	20	1	5
	DETAILS						
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	5	5	2	3
A	Communicate with other professionals	0	0	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	0	0
B	Perform/ supervise patient positioning	1	1	3	3	0	1
C	Administer local/topical anesthesia	1	1	0	0	1	5
C	Observe (wait anesthesia care)	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	0	0

**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

- **1** Straightforward Patient/Straightforward Procedure (No anesthesia care)
- **2** Difficult Patient/Straightforward Procedure (No anesthesia care)
- **3** Straightforward Patient/Difficult Procedure
- **4** Difficult Patient/Difficult Procedure
- **5** Procedure with minimal anesthesia care (If no anesthesia care deduct 1 minute)
- **6** Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes

Additional Positioning Times for Spinal Injection Procedures

SI1	Anterior Neck Injection (Supine) (eg discogram)	7 Minutes
SI2	Posterior Neck Injection (Prone) (eg facet)	5 Minutes
SI3	Posterior Thoracic/Lumbar (Prone) (eg epidural)	5 Minutes
SI4	Lateral Thoracic/Lumbar (Lateral) (eg discogram)	7 Minutes

Additional Positioning Times for Urological Procedures

U1	Dorsal Lithotomy	5 Minutes

Notes:

- Roll-over cells for additional detail where available
- Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

Detailed Description of Facility Based Post-Service Time Packages (Minutes)						
	7A Local Anesthesia/ Straightforward Procedure	**7B Local Anesthesia/ Complex Procedure**	**8A IV Sedation/ Straightforward Procedure**	**8B IV Sedation/ Complex Procedure**	**9A General Anesthesia or Complex Regional Block/ Straightforward Procedure**	**9B General Anesthesia or Complex Regional Block/Complex Procedure**
Total Post-Service Time	**18**	**21**	**25**	**28**	**30**	**33**
Details:						
Application of Dressing[1]	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

1 This represents a simple dressing

CPT	RUC Recommended PLI Crosswalk
28001	28001
28002	28002
28003	28803
33267	33254
33268	33257
33269	32665
33509	35600
35600	35600
38505	38505
43497	43279
46020	46020
46030	46030
64633	64633
64634	64634
64635	64635
64636	64636
67141	67141
67145	67145
67311	67311
67312	67312
67314	67314
67316	67316
67318	67318
67320	67320
67331	67331
67332	67332
67334	67334
67335	67335
67340	67340
74300	74300
74301	74301
74328	74328
74329	74329
74330	74330
93228	93228
93229	93229
93319	93312
93593	93530
93594	93530
93595	93458
93596	93531
93597	93531
93598	93561
93621	93621

00537 00537

CPT	BETOS Class	BETOS Subclass	BETOS Subclass2
28001	Procedures	Major procedure	Other
28002	Procedures	Major procedure	Other
28003	Procedures	Major procedure	Other
33267	Procedures	Major procedure	Cardiovascular-Other
33268	Procedures	Major procedure	Cardiovascular-Other
33269	Procedures	Major procedure	Cardiovascular-Other
33509	Procedures	Major procedure	Cardiovascular-CABG
35600	Procedures	Major procedure	Cardiovascular-CABG
38505	Procedures	Minor procedure	Other
43497	Procedures	Major procedure	Other
46020	Procedures	Major procedure	Other
46030	Procedures	Major procedure	Other
64633	Procedures	Minor procedure	Other
64634	Procedures	Minor procedure	Other
64635	Procedures	Minor procedure	Other
64636	Procedures	Minor procedure	Other
67141	Procedures	Eye procedure	Treatment of retinal lesions
67145	Procedures	Eye procedure	Treatment of retinal lesions
67311	Procedures	Eye procedure	Other
67312	Procedures	Eye procedure	Other
67314	Procedures	Eye procedure	Other
67316	Procedures	Eye procedure	Other
67318	Procedures	Eye procedure	Other
67320	Procedures	Eye procedure	Other
67331	Procedures	Eye procedure	Other
67332	Procedures	Eye procedure	Other
67334	Procedures	Eye procedure	Other
67335	Procedures	Eye procedure	Other
67340	Procedures	Eye procedure	Other
74300	Imaging	Standard imaging	Contrast Gastrointestinal
74301	Imaging	Standard imaging	Contrast Gastrointestinal
74328	Imaging	Standard imaging	Contrast Gastrointestinal
74329	Imaging	Standard imaging	Contrast Gastrointestinal
74330	Imaging	Standard imaging	Contrast Gastrointestinal
93228	Tests	Other tests	EKG monitoring
93229	Tests	Other tests	EKG monitoring
93319	Imaging	NA	NA
93593	Procedures	Major procedure	Cardiovascular-Other
93594	Procedures	Major procedure	Cardiovascular-Other
93595	Procedures	Major procedure	Cardiovascular-Other
93596	Procedures	Major procedure	Cardiovascular-Other
93597	Procedures	Major procedure	Cardiovascular-Other
93598	Procedures	Major procedure	Cardiovascular-Other
93621	Procedures	Major procedure	Cardiovascular-Other
00537	Other	NA	NA

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
33999		2,305	33267	100	0.043	0.00	18.50	05 Exclusion of Left Atrial Appendage	1,850	0
33999		2,305	33268	100	0.043	0.00	2.50	05 Exclusion of Left Atrial Appendage	250	0
33999		2,305	33269	100	0.043	0.00	14.31	05 Exclusion of Left Atrial Appendage	1,431	0
35600		2,479	33509	1,081	0.436	4.94	4.04	06 Harvest of Upper Extremity Artery, Endoscopic and Open	4,367	5,339
35600		2,479	35600	1,398	0.564	4.94	3.73	06 Harvest of Upper Extremity Artery, Endoscopic and Open	5,215	6,907
43499		1,169	43497	234	0.200	0.00	15.50	07 Per-Oral Endoscopic Myotomy	3,624	0
67141		1,395	67141	1,395	1.000	6.15	2.53	08 Retinal Detachment Prophylaxis	3,529	8,579
67145		31,865	67145	31,865	1.000	6.32	2.53	08 Retinal Detachment Prophylaxis	80,618	201,387
93530	D	287	93593	287	1.000	3.97	3.99	10 Cardiac Catheterization for Congenital Defects	1,145	1,139
93530	D	287	93594	-	0.000	3.97	6.10	10 Cardiac Catheterization for Congenital Defects	0	0
93799		1,200	93595	-	0.000	0.00	6.00	10 Cardiac Catheterization for Congenital Defects	0	0
93531	D	354	93596	354	1.000	8.34	7.91	10 Cardiac Catheterization for Congenital Defects	2,800	2,952
93532	D	46	93596	46	1.000	9.99	7.91	10 Cardiac Catheterization for Congenital Defects	364	460
93533	D	24	93596	24	1.000	6.69	7.91	10 Cardiac Catheterization for Congenital Defects	190	161
93531	D	354	93597	-	0.000	8.34	9.99	10 Cardiac Catheterization for Congenital Defects	0	0
93532	D	46	93597	-	0.000	9.99	9.99	10 Cardiac Catheterization for Congenital Defects	0	0
93533	D	24	93597	-	0.000	6.69	9.99	10 Cardiac Catheterization for Congenital Defects	0	0
93799		1,200	93598	-	0.000	0.00	1.75	10 Cardiac Catheterization for Congenital Defects	0	0
93561	D	6	savings	6	1.000	0.95	0.00	10 Cardiac Catheterization for Congenital Defects	0	6
93562	D	14	savings	14	1.000	0.77	0.00	10 Cardiac Catheterization for Congenital Defects	0	11
93799		1,200	93319	100	0.083	0.00	0.50	11 3D Imaging of Cardiac Structures	50	0
28001		3,770	28001	3,770	1.000	2.78	2.00	14 Treatment of Foot Infection	7,540	10,481
28002		6,661	28002	6,661	1.000	5.34	3.50	14 Treatment of Foot Infection	23,314	35,570
28003		5,470	28003	5,470	1.000	9.06	5.28	14 Treatment of Foot Infection	28,882	49,558
38505		33,584	38505	33,584	1.000	1.14	1.59	15 Needle Biopsy of Lymph Nodes	53,399	38,286
46020		1,325	46020	1,325	1.000	3.00	3.50	16 Placement-Removal of Seton	4,638	3,975
46030		339	46030	339	1.000	1.26	2.00	16 Placement-Removal of Seton	678	427
64633		86,013	64633	86,013	1.000	3.84	3.42	17 Destruction by Neurolytic Agent	294,164	330,290
63634		135,589	63634	135,589	1.000	1.32	1.32	17 Destruction by Neurolytic Agent	178,977	178,977
63635		358,450	63635	358,450	1.000	3.78	3.42	17 Destruction by Neurolytic Agent	1,225,899	1,354,941
63636		539,040	63636	539,040	1.000	1.16	1.16	17 Destruction by Neurolytic Agent	625,286	625,286
67311		4,955	67311	4,955	1.000	7.77	5.93	18 Strabismus Surgery	29,383	38,500
67312		1,514	67312	1,514	1.000	9.66	9.50	18 Strabismus Surgery	14,383	14,625
67314		2,533	67314	2,533	1.000	8.79	5.93	18 Strabismus Surgery	15,021	22,265
67316		168	67316	168	1.000	10.93	10.31	18 Strabismus Surgery	1,732	1,836
67318		205	67318	205	1.000	9.12	9.80	18 Strabismus Surgery	2,009	1,870
67320		362	67320	362	1.000	5.40	3.00	18 Strabismus Surgery	1,086	1,955
67331		902	67331	902	1.000	5.13	2.00	18 Strabismus Surgery	1,804	4,627
67332		1,753	67332	1,753	1.000	5.56	3.50	18 Strabismus Surgery	6,136	9,747
67334		128	67334	128	1.000	5.05	2.06	18 Strabismus Surgery	264	646
67335		1,681	67335	1,681	1.000	2.49	3.23	18 Strabismus Surgery	5,430	4,186
67340		88	67340	88	1.000	6.00	5.00	18 Strabismus Surgery	440	528
74301		63	74301	63	1.000	0.21	0.21	19 X-Rays at Surgery Add-On	13	13
93228		186,123	93228	186,123	1.000	0.52	0.52	20 External Cardiovascular Device Monitoring	96,784	96,784
93229		271,792	93229	271,792	1.000	0.00	0.00	20 External Cardiovascular Device Monitoring	0	0
93621		29,892		29,892	1.000	2.10	1.75	21 Electrophysiologic Evaluation	52,311	62,773
00537		89,969	00537	89,969	1.000	7.00	12.00	13 Anesthesia for Cardiac Electrophysiologic Procedures	1,079,628	629,783
									2,674,120	2,892,875

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs

Total Source RVUs		3,115,088
Total New/Revised RVUs		2,775,005
RVU Difference		340,083
CF		36.0896
CF Redistribution	**$**	**12,273,451**

New Technology/New Services List

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	October 2015	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Oct 2016	Intraoperative Radiation Therapy Applicator Procedures	07	CPT 2018	October 2021		☐
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	October 2023		☐
20561	Needle insertion(s) without injection(s); 3 or more muscles	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	October 2023		☐
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20700	Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20701	Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20703	Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20705	Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Apr 2014	Cryoablation Treatment of the Bone Tumors	04	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	☑
20986	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
20987	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Apr 2014	Total Disc Arthroplasty Additional Cervical Level Add-On Code	07	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021		☐
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Apr 2014	Sacroiliac Joint Fusion	08	CPT 2015	October 2018	Surveyed in April 2018 for a CMS Request in the Final Rule for 2018	☑
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Sep 2014	Sacroiliac Joint Fusion	06	CPT 2016	October 2019	Remove form list, was only identified with 27279 and that code has been resurveyed April 2018.	☑
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
29582	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29583	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2021	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	☑
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	October 2016	Review practice expense January 2014. Review data again in 3 years (Sept 2016).	☑
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Jan 2017	Cryoablation of Pulmonary Tumors	08	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		☐
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		☐
33286	Removal, subcutaneous cardiac rhythm monitor	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		☐
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		☐
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Jan 2016	Closure Left Atrial Appendage with Endocardial Implant	10	CPT 2017	October 2022	Review in two years (October 2022); new FDA indication recently released, suggesting this service is still changing.	☐
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022		☐
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Jan 2015	Transcatheter Pulmonary Valve Implantation	06	CPT 2016	October 2022	Review in 3 years (Oct 2022); pediatric procedure with some CMS utilization.	☑
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	Jan 2018	Hemi-Aortic Arch Replacement	06	CPT 2019	October 2022		☐
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	Oct 2018	Aortic Graft Procedures	06	CPT 2020	October 2023		☐
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	October 2024		☐
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	October 2024		☐
33XX3		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
33XX4		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
33XX5		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
34806	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
35600	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)	Oct 2020	Harvest of Upper Extremity Artery, Endoscopic and Open	06	CPT 2022	October 2025		☐
35XX0		Oct 2020	Harvest of Upper Extremity Artery, Endoscopic and Open	06	CPT 2022	October 2025		☐
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2021	Review in October 2021 with the other codes in this family identified via the 2021 new technology/new services screen (36475-36479).	☐
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2021	Review in October 2021 with the other codes in this family identified via the 2021 new technology/new services screen (36475-36479).	☐
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Apr 2014	Transcatheter Placement of Carotid Stents	12	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐
38221	Diagnostic bone marrow; biopsy(ies)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Jan 2014	Endoscopic Hypopharyngeal Diverticulotomy	7	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Apr 2015	Esophagogatric Fundoplasty Trans-Oral Approach	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	☑
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2023	Review in 3 years (October 2023). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2023	Review in 3 years (October 2023). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
434XX		Oct 2020	Per-Oral Endoscopic Myotomy (POEM)	07	CPT 2022	October 2025		☐
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013	Remove from list, carrier priced.	☑
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In Octobre 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	☐
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	Oct 2018	Transanal Hemorrhoidal Dearterialization	07	CPT 2020	October 2023		☐
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Apr 2014	Cryoablation of Liver Tumor	15	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Jan 2018	Transurethral Destruction of Prostate Tissue	13	CPT 2019	October 2022		☐
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Jan 2017	Peri-Prostatic Implantation of Biodegradable Material	13	CPT 2018	October 2021		☐
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Oct 2019	Transrectal High Intesity Focused US Prostate Ablation	06	CPT 2021	October 2024		☐
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)	Jan 2020	Computer-Aided Mapping of Cervix Uteri	14	CPT 2021	October 2024		☐
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Jan 2016	Laparoscopic Radiofrequency Ablation of Uterine Fibroids	18	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	October 2023		☐
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	October 2023		☐
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Jan 2016	Endoscopic Decompression of Spinal Cord Nerve	19	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	October 2023		☐
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	October 2019	Surveyed for April 2015, RUC recommended to review utilization again in 2 years (Oct 2019). In Oct 2019, recommended to remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	October 2023		☐
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	☑
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated.	☑
65778	Placement of amniotic membrane on the ocular surface; without sutures	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014	Survey for April 2015.	☑
65785	Implantation of intrastromal corneal ring segments	Jan 2015	Intrastomal Corneal Ring Implantation	11	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Apr 2013	Insertion of Anterior Segment	14	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	October 2024		☐
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	October 2024		☐
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Oct 2019	Screening CT of Thorax	07	CPT 2021	October 2024		☐
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	☑
75558	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75560	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	☑
75562	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75564	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
76391	Magnetic resonance (eg, vibration) elastography	Jan 2018	Magnetic Resonance Elastography	16	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2021	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2021	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		☐
76981	Ultrasound, elastography; parenchyma (eg, organ)	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
76982	Ultrasound, elastography; first target lesion	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77061	Diagnostic digital breast tomosynthesis; unilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77062	Diagnostic digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)	Jan 2013	Respiratory Motion Management Simulation	14	CPT 2014	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	October 2015	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	☑
77520	Proton treatment delivery; simple, without compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77522	Proton treatment delivery; simple, with compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77523	Proton treatment delivery; intermediate	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77525	Proton treatment delivery; complex	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							parathyroid scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponed and reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							parathyroid scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponed and reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	October 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81244	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), Y438N variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion CLRN1 (clarin 1) (eg, Usher syndrome, type 3), N48K variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant FGFR1 (fibroblast growth factor receptor 1) (eg, Pfeiffer syndrome type 1, craniosynostosis), P252R variant FGFR3 (fibroblast growth factor receptor 3) (eg, Muenke syndrome), P250R variant FKTN (fukutin) (eg, Fukuyama congenital muscular dystrophy), retrotransposon insertion variant GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), M712T variant IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), A282V variant LCT (lactase-phlorizin hydrolase) (eg, lactose intolerance), 13910 C>T variant NEB (nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant PCDH15	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(protocadherin-related 15) (eg, Usher syndrome type 1F), R245X variant SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), S2G variant SRY (sex determining region Y) (eg, 46,XX testicular disorder of sex development, gonadal dysgenesis), gene analysis TOR1A (torsin family 1, member A [torsin A]) (eg, early-onset primary dystonia [DYT1]), 907_909delGAG (904_906delGAG) variant							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9G>A [c.3992-9G>A], F1388del) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B), common variants (eg, R3500Q, R3500W) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), common variants (eg, I278T, G307S) CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) DEK/NUP214 (t(6;9)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed E2A/PBX1 (t(1;19)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EML4/ALK (inv(2)) (eg, non-small cell lung cancer), translocation or inversion analysis ETV6/RUNX1 (t(12;21)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EWSR1/ATF1 (t(12;22)) (eg, clear cell sarcoma), translocation analysis, qualitative, and quantitative, if performed	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	EWSR1/ERG (t(21;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/FLI1 (t(11;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/WT1 (t(11;22)) (eg, desmoplastic small round cell tumor), translocation analysis, qualitative, and quantitative, if performed F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), common variants (eg, 1138G>A, 1138G>C, 1620C>A, 1620C>G) FIP1L1/PDGFRA (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed FLG (filaggrin) (eg, ichthyosis vulgaris), common variants (eg, R501X, 2282del4, R2447X, S3247X, 3702delG) FOXO1/PAX3 (t(2;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FOXO1/PAX7 (t(1;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FUS/DDIT3 (t(12;16)) (eg, myxoid liposarcoma), translocation analysis, qualitative, and quantitative, if performed GALC (galactosylceramidase) (eg, Krabbe disease), common variants (eg, c.857G>A, 30-kb deletion) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D) H19 (imprinted maternally expressed transcript [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; single breakpoint (eg, major breakpoint region [MBR] or minor cluster region [mcr]), qualitative or							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	quantitative (When both MBR and mcr breakpoints are performed, use 81278) KCNQ1OT1 (KCNQ1 overlapping transcript 1 [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis LINC00518 (long intergenic non-protein coding RNA 518) (eg, melanoma), expression analysis LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), common variants (eg, R1441G, G2019S, I2020T) MED12 (mediator complex subunit 12) (eg, FG syndrome type 1, Lujan syndrome), common variants (eg, R961W, N1007S) MEG3/DLK1 (maternally expressed 3 [non-protein coding]/delta-like 1 homolog [Drosophila]) (eg, intrauterine growth retardation), methylation analysis MLL/AFF1 (t(4;11)) (eg, acute lymphoblastic leukemia), translocation analysis, qualitative, and quantitative, if performed MLL/MLLT3 (t(9;11)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed MT-ATP6 (mitochondrially encoded ATP synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome), common variants (eg, m.8993T>G, m.8993T>C) MT-ND4, MT-ND6 (mitochondrially encoded NADH dehydrogenase 4, mitochondrially encoded NADH dehydrogenase 6) (eg, Leber hereditary optic neuropathy [LHON]), common variants (eg, m.11778G>A, m.3460G>A, m.14484T>C) MT-ND5 (mitochondrially encoded tRNA leucine 1 [UUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A>G, m.3271T>C, m.3252A>G, m.13513G>A) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), common variants (eg, m.1555A>G, m.1494C>T) MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A>G, m.8356T>C) MT-TL1							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(mitochondrially encoded tRNA leucine 1 [UUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A>G, m.14709 T>C) MT-TL1 MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN], mitochondrially encoded 12S RNA) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A>G, m.1555A>G) MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), common variants (eg, Y165C, G382D) NOD2 (nucleotide-binding oligomerization domain containing 2) (eg, Crohn's disease, Blau syndrome), common variants (eg, SNP 8, SNP 12, SNP 13) NPM1/ALK (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis PAX8/PPARG (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis PRAME (preferentially expressed antigen in melanoma) (eg, melanoma), expression analysis PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, N29I, A16V, R122H) PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), common variants (eg, R50X, G205S) RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SS18/SSX1 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed SS18/SSX2 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M,							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) TRD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), duplication/deletion analysis CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY]), targeted sequence analysis of exon 11 (eg, c.1785delC, c.1686delT) CTNNB1 (catenin [cadherin-associated protein], beta 1, 88kDa) (eg, desmoid tumors), targeted sequence analysis (eg, exon 3) DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) DNMT3A (DNA [cytosine-5-]-methyltransferase 3 alpha) (eg, acute myeloid leukemia), targeted sequence analysis (eg, exon 23) EPCAM (epithelial cell adhesion molecule) (eg, Lynch syndrome), duplication/deletion analysis F8 (coagulation factor VIII) (eg, hemophilia A), inversion analysis, intron 1 and intron 22A F12 (coagulation factor XII [Hageman factor]) (eg, angioedema, hereditary, type III; factor XII deficiency), targeted sequence analysis of exon 9 FGFR3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (For targeted sequence analysis of multiple FGFR3 exons, use 81404) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence GNAQ (guanine nucleotide-binding protein G[q] subunit alpha) (eg, uveal melanoma), common variants (eg, R183, Q209) Human erythrocyte antigen gene analyses (eg, SLC14A1 [Kidd blood group], BCAM [Lutheran blood group], ICAM4 [Landsteiner-Wiener blood	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	group], SLC4A1 [Diego blood group], AQP1 [Colton blood group], ERMAP [Scianna blood group], RHCE [Rh blood group, CcEe antigens], KEL [Kell blood group], DARC [Duffy blood group], GYPA, GYPB, GYPE [MNS blood group], ART4 [Dombrock blood group]) (eg, sickle-cell disease, thalassemia, hemolytic transfusion reactions, hemolytic disease of the fetus or newborn), common variants HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), exon 2 sequence KCNC3 (potassium voltage-gated channel, Shaw-related subfamily, member 3) (eg, spinocerebellar ataxia), targeted sequence analysis (eg, exon 2) KCNJ2 (potassium inwardly-rectifying channel, subfamily J, member 2) (eg, Andersen-Tawil syndrome), full gene sequence KCNJ11 (potassium inwardly-rectifying channel, subfamily J, member 11) (eg, familial hyperinsulinism), full gene sequence Killer cell immunoglobulin-like receptor (KIR) gene family (eg, hematopoietic stem cell transplantation), genotyping of KIR family genes Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, or identified during a genomic sequencing procedure, DNA sequence analysis, each variant exon (For a known familial variant that is considered a common variant, use specific common variant Tier 1 or Tier 2 code) MC4R (melanocortin 4 receptor) (eg, obesity), full gene sequence MICA (MHC class I polypeptide-related sequence A) (eg, solid organ transplantation), common variants (eg, *001, *002) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), duplication/deletion analysis NHLRC1 (NHL repeat containing 1) (eg, progressive myoclonus epilepsy), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome),							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	duplication/deletion analysis PLN (phospholamban) (eg, dilated cardiomyopathy, hypertrophic cardiomyopathy), full gene sequence RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene) RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene), performed on cell-free fetal DNA in maternal blood (For human erythrocyte gene analysis of RHD, use a separate unit of 81403) SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), duplication/deletion analysis TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), duplication/deletion analysis UBA1 (ubiquitin-like modifier activating enzyme 1) (eg, spinal muscular atrophy, X-linked), targeted sequence analysis (eg, exon 15) VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), full gene sequence AVPR2 (arginine vasopressin receptor 2) (eg, nephrogenic diabetes insipidus), full gene sequence BBS10 (Bardet-Biedl syndrome 10) (eg, Bardet-Biedl syndrome), full gene sequence BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence C10orf2 (chromosome 10 open reading frame 2) (eg, mitochondrial DNA depletion syndrome), full gene sequence CAV3 (caveolin 3) (eg, CAV3-related distal myopathy, limb-girdle muscular dystrophy type 1C), full gene sequence CD40LG (CD40 ligand) (eg, X-linked hyper IgM syndrome), full gene sequence CDKN2A (cyclin-dependent kinase inhibitor 2A) (eg, CDKN2A-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence CLRN1 (clarin 1) (eg, Usher syndrome, type 3), full gene sequence COX6B1 (cytochrome c oxidase subunit VIb polypeptide 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPT2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase II deficiency), full gene sequence CRX (cone-rod homeobox) (eg, cone-rod dystrophy 2, Leber congenital amaurosis), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence EGR2 (early growth response 2) (eg, Charcot-Marie-	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	Tooth), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), duplication/deletion analysis EPM2A (epilepsy, progressive myoclonus type 2A, Lafora disease [laforin]) (eg, progressive myoclonus epilepsy), full gene sequence FGF23 (fibroblast growth factor 23) (eg, hypophosphatemic rickets), full gene sequence FGFR2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, Apert syndrome, Crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) FHL1 (four and a half LIM domains 1) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence FKRP (fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence FOXG1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) GH1 (growth hormone 1) (eg, growth hormone deficiency), full gene sequence GP1BB (glycoprotein Ib [platelet], beta polypeptide) (eg, Bernard-Soulier syndrome type B), full gene sequence (For common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), full gene sequence HSD3B2 (hydroxy-delta-5-steroid dehydrogenase, 3 beta- and steroid delta-isomerase 2) (eg, 3-beta-hydroxysteroid dehydrogenase type II deficiency), full gene sequence HSD11B2 (hydroxysteroid [11-beta]							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	dehydrogenase 2) (eg, mineralocorticoid excess syndrome), full gene sequence HSPB1 (heat shock 27kDa protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence INS (insulin) (eg, diabetes mellitus), full gene sequence KCNJ1 (potassium inwardly-rectifying channel, subfamily J, member 1) (eg, Bartter syndrome), full gene sequence KCNJ10 (potassium inwardly-rectifying channel, subfamily J, member 10) (eg, SeSAME syndrome, EAST syndrome, sensorineural hearing loss), full gene sequence LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), duplication/deletion analysis MMACHC (methylmalonic aciduria [cobalamin deficiency] cblC type, with homocystinuria) (eg, methylmalonic acidemia and homocystinuria), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), duplication/deletion analysis NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), full gene sequence NDUFA1 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, 1, 7.5kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFAF2 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, assembly factor 2) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS4 (NADH dehydrogenase [ubiquinone] Fe-S protein 4, 18kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NIPA1 (non-imprinted in Prader-Willi/Angelman syndrome 1) (eg, spastic paraplegia), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), duplication/deletion analysis NPC2 (Niemann-Pick disease, type C2 [epididymal secretory protein E1]) (eg, Niemann-							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	Pick disease type C2), full gene sequence NR0B1 (nuclear receptor subfamily 0, group B, member 1) (eg, congenital adrenal hypoplasia), full gene sequence PDX1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), duplication/deletion analysis PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), duplication/deletion analysis PRNP (prion protein) (eg, genetic prion disease), full gene sequence PROP1 (PROP paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence PRPH2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma), common variants (eg, M918T, 2647_2648delinsTT, A883F) RHO (rhodopsin) (eg, retinitis pigmentosa), full gene sequence RP1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence SCN1B (sodium channel, voltage-gated, type I, beta) (eg, Brugada syndrome), full gene sequence SCO2 (SCO cytochrome oxidase deficient homolog 2 [SCO1L]) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence SGCG							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), duplication/deletion analysis SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), duplication/deletion analysis SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), duplication/deletion analysis SLC25A4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence SOD1 (superoxide dismutase 1, soluble) (eg, amyotrophic lateral sclerosis), full gene sequence SPINK1 (serine peptidase inhibitor, Kazal type 1) (eg, hereditary pancreatitis), full gene sequence STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), duplication/deletion analysis TACO1 (translational activator of mitochondrial encoded cytochrome c oxidase I) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence THAP1 (THAP domain containing, apoptosis associated protein 1) (eg, torsion dystonia), full gene sequence TOR1A (torsin family 1, member A [torsin A]) (eg, torsion dystonia), full gene sequence TTPA (tocopherol [alpha] transfer protein) (eg, ataxia), full gene sequence TTR (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), full gene sequence TYR (tyrosinase [oculocutaneous albinism IA]) (eg, oculocutaneous albinism IA), full gene sequence UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, hereditary unconjugated hyperbilirubinemia [Crigler-Najjar syndrome]) full gene sequence USH1G (Usher							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	syndrome 1G [autosomal recessive]) (eg, Usher syndrome, type 1), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37) ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), duplication/deletion analysis ZNF41 (zinc finger protein 41) (eg, X-linked mental retardation 89), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence ANKRD1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence ARSA (arylsulfatase A) (eg, arylsulfatase A deficiency), full gene sequence BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), full gene sequence BCS1L (BCS1-like [S. cerevisiae]) (eg, Leigh syndrome, mitochondrial complex III deficiency, GRACILE syndrome), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), duplication/deletion analysis CASQ2 (calsequestrin 2 [cardiac muscle]) (eg, catecholaminergic polymorphic ventricular tachycardia), full gene sequence CASR (calcium-sensing receptor) (eg, hypocalcemia), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), duplication/deletion analysis CHRNA4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence CHRNB2 (cholinergic receptor, nicotinic, beta 2 [neuronal]) (eg, nocturnal frontal lobe epilepsy), full gene sequence COX10	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(COX10 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence COX15 (COX15 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPOX (coproporphyrinogen oxidase) (eg, hereditary coproporphyria), full gene sequence CTRC (chymotrypsin C) (eg, hereditary pancreatitis), full gene sequence CYP11B1 (cytochrome P450, family 11, subfamily B, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP17A1 (cytochrome P450, family 17, subfamily A, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence Cytogenomic constitutional targeted microarray analysis of chromosome 22q13 by interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (When performing genome-wide cytogenomic constitutional microarray analysis, see 81228, 81229) (Do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (Do not report 88271 when performing cytogenomic microarray analysis) DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis DCX (doublecortin) (eg, X-linked lissencephaly), full gene sequence DES (desmin) (eg, myofibrillar myopathy), full gene sequence DFNB59 (deafness, autosomal recessive 59) (eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence DGUOK (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial DNA depletion syndrome), full gene sequence DHCR7 (7-dehydrocholesterol							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	reductase) (eg, Smith-Lemli-Opitz syndrome), full gene sequence EIF2B2 (eukaryotic translation initiation factor 2B, subunit 2 beta, 39kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), duplication/deletion analysis EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), duplication/deletion analysis FGFR1 (fibroblast growth factor receptor 1) (eg, Kallmann syndrome 2), full gene sequence FH (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), duplication/deletion analysis GABRG2 (gamma-aminobutyric acid [GABA] A receptor, gamma 2) (eg, generalized epilepsy with febrile seizures), full gene sequence GCH1 (GTP cyclohydrolase 1) (eg, autosomal dominant dopa-responsive dystonia), full gene sequence GDAP1 (ganglioside-induced differentiation-associated protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence GFAP (glial fibrillary acidic protein) (eg, Alexander disease), full gene sequence GHR (growth hormone receptor) (eg, Laron syndrome), full gene sequence GHRHR (growth hormone releasing hormone receptor) (eg, growth hormone deficiency), full gene sequence GLA (galactosidase, alpha) (eg, Fabry disease), full gene sequence HNF1A (HNF1 homeobox A) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HTRA1 (HtrA serine peptidase 1) (eg, macular degeneration), full gene sequence IDS (iduronate 2-sulfatase) (eg, mucopolysacchridosis, type II), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence IL2RG (interleukin 2 receptor, gamma) (eg, X-linked severe combined immunodeficiency), full gene sequence ISPD (isoprenoid synthase domain containing) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, Noonan syndrome), full gene sequence LAMP2 (lysosomal-associated membrane protein 2) (eg, Danon disease), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), duplication/deletion analysis MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), full gene sequence MMAA (methylmalonic aciduria [cobalamine deficiency] type A) (eg, MMAA-related methylmalonic acidemia), full gene sequence MMAB (methylmalonic aciduria [cobalamine deficiency] type B) (eg, MMAA-related methylmalonic acidemia), full gene sequence MPI (mannose phosphate isomerase) (eg, congenital disorder of glycosylation 1b), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), duplication/deletion analysis MYL2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYL3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYOT (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence NDUFS7 (NADH dehydrogenase [ubiquinone] Fe-S protein 7, 20kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS8 (NADH dehydrogenase [ubiquinone] Fe-S protein 8, 23kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	deficiency), full gene sequence NDUFV1 (NADH dehydrogenase [ubiquinone] flavoprotein 1, 51kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), duplication/deletion analysis NLGN3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), deletion analysis, and duplication analysis, if performed NPHS2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), duplication/deletion analysis OTC (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), duplication/deletion analysis PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), duplication/deletion analysis PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis PCDH19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), duplication/deletion analysis PDHB (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence PINK1 (PTEN induced putative kinase 1) (eg, Parkinson disease), full gene sequence PKLR (pyruvate kinase, liver and RBC) (eg, pyruvate kinase deficiency), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), full gene sequence POU1F1 (POU class 1 homeobox 1) (eg, combined							

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	pituitary hormone deficiency), full gene sequence PRX (periaxin) (eg, Charcot-Marie-Tooth disease), full gene sequence PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), full gene sequence PSEN1 (presenilin 1) (eg, Alzheimer disease), full gene sequence RAB7A (RAB7A, member RAS oncogene family) (eg, Charcot-Marie-Tooth disease), full gene sequence RAI1 (retinoic acid induced 1) (eg, Smith-Magenis syndrome), full gene sequence REEP1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) RPS19 (ribosomal protein S19) (eg, Diamond-Blackfan anemia), full gene sequence RRM2B (ribonucleotide reductase M2 B [TP53 inducible]) (eg, mitochondrial DNA depletion), full gene sequence SCO1 (SCO cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence SGCA (sarcoglycan, alpha [50kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCB (sarcoglycan, beta [43kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCD (sarcoglycan, delta [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SHOC2 (soc-2							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), full gene sequence SHOX (short stature homeobox) (eg, Langer mesomelic dysplasia), full gene sequence SIL1 (SIL1 homolog, endoplasmic reticulum chaperone [S. cerevisiae]) (eg, ataxia), full gene sequence SLC2A1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [GLUT 1] deficiency syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), full gene sequence SLC22A5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis SPAST (spastin) (eg, spastic paraplegia), duplication/deletion analysis SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), duplication/deletion analysis SPRED1 (sprouty-related, EVH1 domain containing 1) (eg, Legius syndrome), full gene sequence STAT3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-IgE syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), full gene sequence SURF1 (surfeit 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence TARDBP (TAR DNA binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence TBX5 (T-box 5) (eg, Holt-Oram syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins							

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	syndrome), duplication/deletion analysis TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TK2 (thymidine kinase 2, mitochondrial) (eg, mitochondrial DNA depletion syndrome), full gene sequence TNNC1 (troponin C type 1 [slow]) (eg, hypertrophic cardiomyopathy or dilated cardiomyopathy), full gene sequence TNNI3 (troponin I, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TPM1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis TYMP (thymidine phosphorylase) (eg, mitochondrial DNA depletion syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25) WT1 (Wilms tumor 1) (eg, Denys-Drash syndrome, familial Wilms tumor), full gene sequence ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons) ACADVL (acyl-CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence AFG3L2 (AFG3 ATPase family gene 3-like 2 [S. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldehyde dehydrogenase 7 family, member A1) (eg, pyridoxine-dependent epilepsy), full gene sequence ANO5 (anoctamin 5) (eg, limb-girdle muscular dystrophy), full gene sequence ANOS1 (anosmin-1) (eg, Kallmann syndrome 1), full gene sequence APP (amyloid beta [A4] precursor protein) (eg, Alzheimer disease), full gene sequence ASS1 (argininosuccinate synthase 1) (eg, citrullinemia type I), full gene sequence ATL1 (atlastin GTPase 1) (eg, spastic paraplegia), full gene sequence ATP1A2 (ATPase, Na+/K+ transporting, alpha 2 polypeptide) (eg, familial hemiplegic migraine), full gene sequence ATP7B (ATPase, Cu++ transporting, beta polypeptide) (eg, Wilson disease), full gene sequence BBS1 (Bardet-Biedl syndrome 1) (eg, Bardet-Biedl syndrome), full gene sequence BBS2 (Bardet-Biedl syndrome 2) (eg, Bardet-Biedl syndrome), full gene sequence BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease, type 1B), full gene sequence BEST1 (bestrophin 1) (eg, vitelliform macular dystrophy), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), full gene sequence BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, Noonan syndrome),	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	full gene sequence BSCL2 (Berardinelli-Seip congenital lipodystrophy 2 [seipin]) (eg, Berardinelli-Seip congenital lipodystrophy), full gene sequence BTK (Bruton agammaglobulinemia tyrosine kinase) (eg, X-linked agammaglobulinemia), full gene sequence CACNB2 (calcium channel, voltage-dependent, beta 2 subunit) (eg, Brugada syndrome), full gene sequence CAPN3 (calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), full gene sequence CDH1 (cadherin 1, type 1, E-cadherin [epithelial]) (eg, hereditary diffuse gastric cancer), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), full gene sequence CLCN1 (chloride channel 1, skeletal muscle) (eg, myotonia congenita), full gene sequence CLCNKB (chloride channel, voltage-sensitive Kb) (eg, Bartter syndrome 3 and 4b), full gene sequence CNTNAP2 (contactin-associated protein-like 2) (eg, Pitt-Hopkins-like syndrome 1), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), duplication/deletion analysis CPT1A (carnitine palmitoyltransferase 1A [liver]) (eg, carnitine palmitoyltransferase 1A [CPT1A] deficiency), full gene sequence CRB1 (crumbs homolog 1 [Drosophila]) (eg, Leber congenital amaurosis), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), duplication/deletion analysis DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), full gene sequence DLAT (dihydrolipoamide S-acetyltransferase) (eg, pyruvate dehydrogenase E2 deficiency), full gene sequence DLD (dihydrolipoamide dehydrogenase) (eg, maple syrup urine disease, type III), full gene sequence DSC2 (desmocollin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence DSG2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence DSP (desmoplakin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 8), full gene sequence EFHC1 (EF-hand domain [C-terminal] containing 1) (eg, juvenile myoclonic epilepsy), full gene sequence EIF2B3 (eukaryotic translation initiation factor 2B, subunit 3 gamma, 58kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B4 (eukaryotic translation initiation factor 2B, subunit 4 delta, 67kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B5 (eukaryotic translation initiation factor 2B, subunit 5 epsilon, 82kDa) (eg, childhood ataxia with central nervous system hypomyelination/vanishing white matter), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), full gene sequence EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), duplication/deletion analysis FAH (fumarylacetoacetate hydrolase [fumarylacetoacetase]) (eg, tyrosinemia, type 1), full gene sequence FASTKD2 (FAST kinase domains 2) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence FIG4 (FIG4 homolog, SAC1 lipid phosphatase domain containing [S. cerevisiae]) (eg, Charcot-Marie-Tooth disease), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), full gene sequence FUS (fused in sarcoma) (eg, amyotrophic lateral sclerosis), full gene sequence GAA (glucosidase, alpha; acid) (eg, glycogen storage disease type II [Pompe disease]), full gene sequence GALC (galactosylceramidase) (eg, Krabbe disease), full gene sequence GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence GARS (glycyl-tRNA synthetase) (eg, Charcot-Marie-Tooth disease), full gene sequence GCDH (glutaryl-CoA dehydrogenase) (eg, glutaricacidemia type 1), full gene sequence GCK (glucokinase [hexokinase 4]) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence GLUD1 (glutamate dehydrogenase 1) (eg, familial hyperinsulinism), full gene sequence GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), full gene sequence GRN (granulin) (eg, frontotemporal dementia), full gene sequence HADHA (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein] alpha subunit) (eg, long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence HADHB (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein], beta subunit) (eg, trifunctional protein deficiency), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence HLCS (HLCS holocarboxylase synthetase) (eg, holocarboxylase synthetase deficiency), full gene sequence HMBS (hydroxymethylbilane synthase) (eg, acute intermittent porphyria), full gene sequence HNF4A (hepatocyte nuclear factor 4, alpha) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence IDUA (iduronidase, alpha-L-) (eg, mucopolysaccharidosis type I), full gene sequence INF2 (inverted formin, FH2 and WH2 domain containing) (eg, focal segmental glomerulosclerosis), full gene sequence IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), duplication/deletion analysis JUP (junction plakoglobin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence KCNH2 (potassium voltage-gated							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	channel, subfamily H [eag-related], member 2) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ1 (potassium voltage-gated channel, KQT-like subfamily, member 1) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2) (eg, epileptic encephalopathy), full gene sequence LDB3 (LIM domain binding 3) (eg, familial dilated cardiomyopathy, myofibrillar myopathy), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), full gene sequence LEPR (leptin receptor) (eg, obesity with hypogonadism), full gene sequence LHCGR (luteinizing hormone/choriogonadotropin receptor) (eg, precocious male puberty), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence LRP5 (low density lipoprotein receptor-related protein 5) (eg, osteopetrosis), full gene sequence MAP2K1 (mitogen-activated protein kinase 1) (eg, cardiofaciocutaneous syndrome), full gene sequence MAP2K2 (mitogen-activated protein kinase 2) (eg, cardiofaciocutaneous syndrome), full gene sequence MAPT (microtubule-associated protein tau) (eg, frontotemporal dementia), full gene sequence MCCC1 (methylcrotonoyl-CoA carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-CoA carboxylase deficiency), full gene sequence MCCC2 (methylcrotonoyl-CoA carboxylase 2 [beta]) (eg, 3-methylcrotonyl carboxylase deficiency), full gene sequence MFN2 (mitofusin 2) (eg, Charcot-Marie-Tooth disease), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), full gene sequence MUT (methylmalonyl CoA mutase) (eg, methylmalonic acidemia), full gene sequence MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), full gene sequence NDUFS1 (NADH								

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	dehydrogenase [ubiquinone] Fe-S protein 1, 75kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), full gene sequence NOTCH3 (notch 3) (eg, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy [CADASIL]), targeted sequence analysis (eg, exons 1-23) NPC1 (Niemann-Pick disease, type C1) (eg, Niemann-Pick disease), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis OPTN (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), full gene sequence PAX2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence PC (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence PCCB (propionyl CoA carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), duplication/deletion analysis PCSK9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence PDHX (pyruvate dehydrogenase complex, component X) (eg, lactic acidosis), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence PHEX (phosphate-regulating endopeptidase homolog, X-linked) (eg, hypophosphatemic rickets), full gene sequence PKD2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PKP2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence PNKD (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence POLG (polymerase [DNA directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence PPOX (protoporphyrinogen oxidase) (eg, variegate porphyria), full gene sequence PRKAG2 (protein kinase, AMP-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic cardiomyopathy with Wolff-Parkinson-White syndrome, lethal congenital glycogen storage disease of heart), full gene sequence PRKCG (protein kinase C, gamma) (eg, spinocerebellar ataxia), full gene sequence PSEN2 (presenilin 2 [Alzheimer disease 4]) (eg, Alzheimer disease), full gene sequence PTPN11 (protein tyrosine phosphatase, non-receptor type 11) (eg, Noonan syndrome, LEOPARD syndrome), full gene sequence PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), full gene sequence RET (ret proto-oncogene) (eg, Hirschsprung disease), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence RPE65 (retinal pigment epithelium-specific protein 65kDa) (eg, retinitis pigmentosa, Leber congenital amaurosis), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations SCN4A (sodium channel, voltage-gated, type IV, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence SCNN1A (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence SCNN1B (sodium channel, nonvoltage-gated 1, beta) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SCNN1G (sodium channel, nonvoltage-gated 1, gamma) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SDHA (succinate dehydrogenase complex, subunit A, flavoprotein [Fp]) (eg, Leigh syndrome, mitochondrial complex II deficiency), full gene sequence SETX (senataxin) (eg, ataxia), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), full gene sequence SH3TC2 (SH3 domain and tetratricopeptide repeats 2) (eg, Charcot-Marie-Tooth disease), full gene sequence SLC9A6 (solute carrier family 9 [sodium/hydrogen exchanger], member 6) (eg, Christianson syndrome), full gene sequence SLC26A4 (solute carrier family 26, member 4) (eg, Pendred syndrome), full gene sequence SLC37A4 (solute carrier family 37 [glucose-6-phosphate transporter], member 4) (eg, glycogen storage disease type Ib), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), full gene sequence SOS1 (son of sevenless homolog 1) (eg, Noonan syndrome, gingival fibromatosis), full gene sequence SPAST (spastin) (eg, spastic paraplegia), full gene sequence SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), full gene sequence STXBP1 (syntaxin-binding protein 1) (eg, epileptic								

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	encephalopathy), full gene sequence TAZ (tafazzin) (eg, methylglutaconic aciduria type 2, Barth syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), full gene sequence TH (tyrosine hydroxylase) (eg, Segawa syndrome), full gene sequence TMEM43 (transmembrane protein 43) (eg, arrhythmogenic right ventricular cardiomyopathy), full gene sequence TNNT2 (troponin T, type 2 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TRPC6 (transient receptor potential cation channel, subfamily C, member 6) (eg, focal segmental glomerulosclerosis), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), duplication/deletion analysis UBE3A (ubiquitin protein ligase E3A) (eg, Angelman syndrome), full gene sequence UMOD (uromodulin) (eg, glomerulocystic kidney disease with hyperuricemia and isosthenuria), full gene sequence VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52) WAS (Wiskott-Aldrich syndrome [eczema-thrombocytopenia]) (eg, Wiskott-Aldrich syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B) full gene sequence ASPM (asp [abnormal spindle] homolog, microcephaly associated [Drosophila]) (eg, primary microcephaly), full gene sequence CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence COL4A4 (collagen, type IV, alpha 4) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), duplication/deletion analysis COL6A1 (collagen, type VI, alpha 1) (eg, collagen type VI-related disorders), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), full gene sequence COL6A3 (collagen, type VI, alpha 3) (eg, collagen type VI-related disorders), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence KDM5C (lysine [K]-specific demethylase 5C) (eg, X-linked mental retardation), full gene sequence KIAA0196 (KIAA0196) (eg, spastic paraplegia), full gene sequence L1CAM (L1 cell adhesion molecule) (eg, MASA syndrome, X-linked hydrocephaly), full gene sequence LAMB2 (laminin, beta 2 [laminin S]) (eg, Pierson syndrome), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence MYO7A (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence NPHS1 (nephrosis 1, congenital, Finnish type [nephrin]) (eg, congenital Finnish nephrosis), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence PKD1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PLCE1 (phospholipase C, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence SLC12A1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, Bartter syndrome), full gene sequence SLC12A3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, Gitelman syndrome), full gene sequence SPG11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence SPTBN2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence TMEM67 (transmembrane protein 67) (eg, Joubert syndrome), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast])							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, Cohen syndrome), duplication/deletion analysis WDR62 (WD repeat domain 62) (eg, primary autosomal recessive microcephaly), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence CEP290 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, type I, alpha 2) (eg, osteogenesis imperfecta, type I), full gene sequence COL4A1 (collagen, type IV, alpha 1) (eg, brain small-vessel disease with hemorrhage), full gene sequence COL4A3 (collagen, type IV, alpha 3 [Goodpasture antigen]) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), full gene sequence DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy), full gene sequence DYSF (dysferlin, limb girdle muscular dystrophy 2B [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence ITPR1 (inositol 1,4,5-trisphosphate receptor, type 1) (eg, spinocerebellar ataxia), full gene sequence LAMA2 (laminin, alpha 2) (eg, congenital muscular dystrophy), full gene sequence LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), full gene sequence MYH11 (myosin, heavy chain 11, smooth muscle) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence NEB (nebulin) (eg, nemaline myopathy 2), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence PKHD1 (polycystic kidney and hepatic disease 1) (eg, autosomal recessive polycystic kidney disease), full gene sequence RYR1 (ryanodine receptor 1, skeletal)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, malignant hyperthermia), full gene sequence RYR2 (ryanodine receptor 2 [cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic right ventricular dysplasia), full gene sequence or targeted sequence analysis of > 50 exons USH2A (Usher syndrome 2A [autosomal recessive, mild]) (eg, Usher syndrome, type 2), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence							
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, part of CLFS.	☑
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Feb 2010	Archival Retrieval for Mutational Analysis	17	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Jan 2013	Optical Endomicroscopy	15	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdisection	12	CPT 2008	September 2011	Survey for January 2014 (added 88380 as part of the family).	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdisection	12	CPT 2008	September 2013	Survey for January 2014 (added 88380 as part of the family).	☑
88384	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88385	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
90769	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	April 2015	Liver Elastography	19	CPT 2016	January 2020	Surveyed for January 2020. Decreased.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	April 2015	Survey for October 2015. The RUC noted that it is the specialty societies decision whether 92133 and 92134 need to be surveyed with this service.	☑
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Apr 2014	Corneal Hysteresis Determination	23	CPT 2015	October 2018	Survey for January 2019.	☑
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Apr 2015	Arterial Pressure Waveform Analysis	20	CPT 2016	October 2021	Review in 2 years (October 2021)	☐
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93299	Code Deleted CPT 2020	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
933X0		Oct 2020	3D Imaging of Cardiac Structures	09	CPT 2022	October 2025		☐
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Jan 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93982	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
93X1X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X2X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X3X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X4X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93X5X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X6X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Jan 2018	Electrocorticography	18	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Oct 2013	HCPAC - Ultrasonic Wound Assessment	17	CPT 2015	October 2018	Survey for January 2019.	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99363	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99364	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		☐
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		☐
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		☐
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2023		☐
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	Jan 2019	Chronic Care Remote Physiologic Monitoring	20	CPT 2020	October 2023		☐
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	Jan 2019	Self-Measured Blood Pressure Monitoring	19	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		☐
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	October 2020	Survey for January 2021 with the principal care management code that is under consideration at the October 2020 CPT meeting.	☐
99488	Code Deleted	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	October 2017	Code Deleted	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	October 2020	Survey for January 2021 with the principal care management code that is under consideration at the October 2020 CPT meeting.	☐
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Apr 2014	Chronic Care Management	28	CPT 2015	October 2020	Survey for January 2021 with the principal care management code that is under consideration at the October 2020 CPT meeting.	☐
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	Apr 2017	Chronic Care Management Services	09	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identifiedPsychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identifiedPsychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

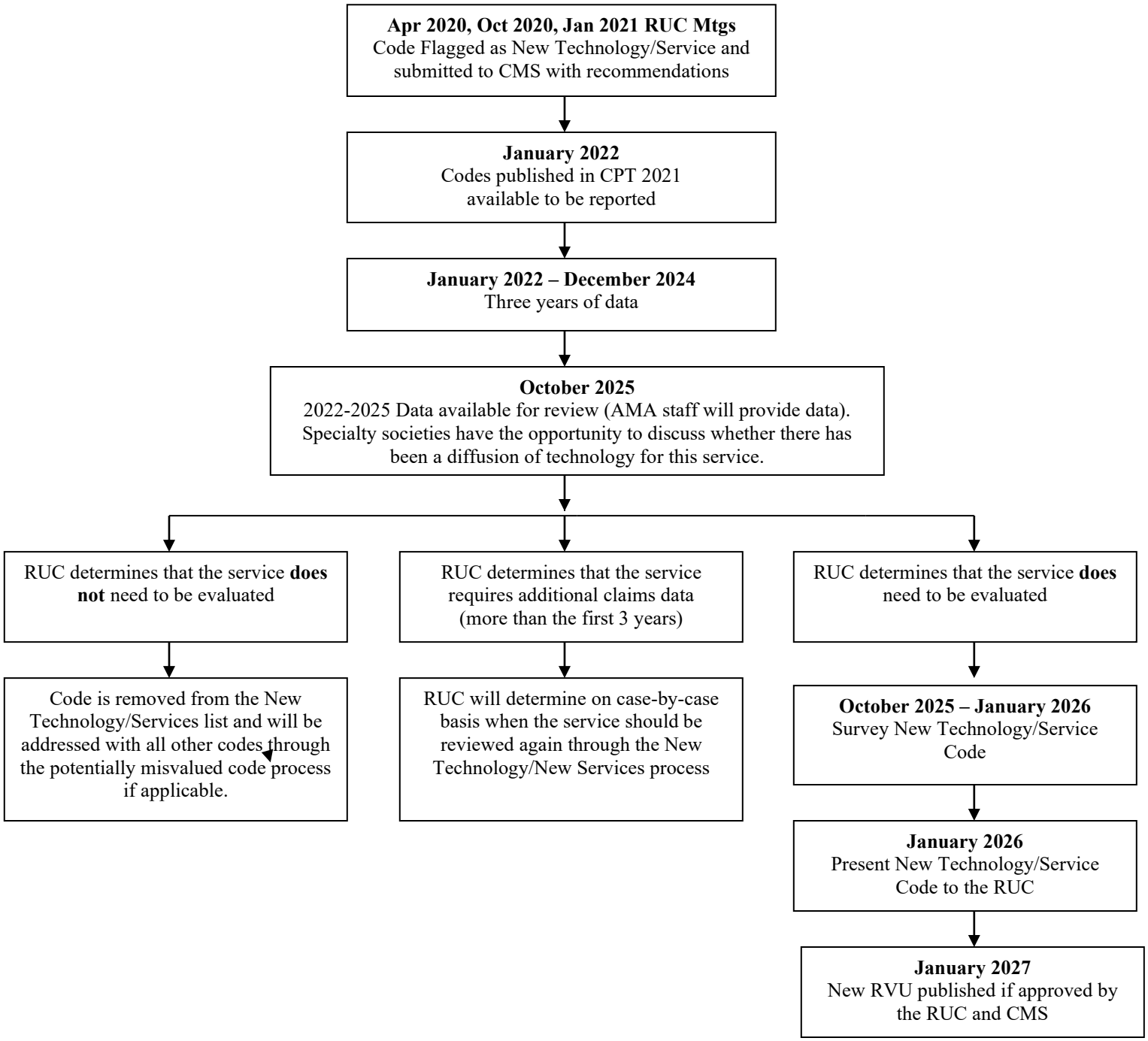
CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Jan 2014	Advance Care Planning	19	CPT 2015	October 2021	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (October 2021).	☐
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Jan 2014	Advance Care Planning	19	CPT 2015	October 2021	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (October 2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes		Fecal Bacteriotherapy		CPT 2013	October 2018		☑

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Revised October 2020

Society	Acronym
Academy of Nutrition and Dietetics	ANDi
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Audiology	AAA
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology Association	AADA
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of PAs	AAPA
American Academy of Pediatrics	AAP
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Sleep Medicine	AASM
American Association for Thoracic Surgery	AATS
American Association of Clinical Endocrinologists	AACE
American Association of Clinical Urologist, Inc.	AACU
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic Medicine	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS
American College of Allergy, Asthma & Immunology	ACAAI
American College of Cardiology	ACC
American College of Chest Physicians	CHEST
American College of Emergency Physicians	ACEP
American College of Gastroenterology	ACG
American College of Medical Genetics	ACMG
American College of Mohs Surgery	ACMS

American College of Nuclear Medicine	ACNM
American College of Obstetricians and Gynecologists	ACOG
American College of Physicians	ACP
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Medical Association	AMA
American Medical Women's Association	AMWA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Rhinologic Society	ARS
American Roentgen Ray Society	ARRS
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Radiation Oncology	ASTRO
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Transplantation and Cellular Therapy	ASTCT
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)

American Society of Cytopathology	ASC
American Society of Dermatopathology	ASDP
American Society of Echocardiography	ASE
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Interventional Pain Physicians	ASIPP
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS
American Society of Retina Specialists	ASRS
American Speech-Language-Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
American Vein and Lymphatic Society	AVLS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Heart Rhythm Society	HRS
Infectious Diseases Society of America	IDSA
International Society for the Advancement of Spine Surgery	ISASS
National Association of Social Workers	NASW
North American Neuromodulation Society	NANS
North American Spine Society	NASS
Obstetrics and Gynecology	ACOG
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine and Molecular Imaging	SNMMI
Society of Thoracic Surgeons	STS
The Endocrine Society	ES
The Society for Cardiovascular Angiography and Interventions	SCAI
The Spine Intervention Society	SIS
Underseas and Hyperbaric Medical Society	UHMS

CPT Code	Short Descriptor	Global	99204	99211	99212	99213	99214	99215	Total CY2021 CMS Proposed NPRM Physician Time - Current	Total CY2020 CMS Proposed NPRM Physician Time with RUC Proposed Office Visit Times	Change in Total Physician Time	Total CY2022 RUC Proposed Surgical Global wRVU - Before Adjustment	RUC Recommended Surgical Global wRVU After Incorporating RUC Proposal for Bundled Visits	Change in Surgical Global wRVU	Percent Change - Work RVU	Change in Clinical Staff Time
33267	Exclusion of left atrial appendage,	090	0	0	0	1	0	0	401	408	7	18.50	18.83	0.33	2%	0
33269	Exclusion of left atrial appendage,	090	0	0	0	1	0	0	323	330	7	14.31	14.64	0.33	2%	0
43497	Lower esophageal myotomy, trans	090	0	0	0	2	0	0	281	295	14	15.50	16.16	0.66	4%	0
64633	Destruction by neurolytic agent, pa	010	0	0	0	1	0	0	100	107	7	3.42	3.75	0.33	10%	0
64635	Destruction by neurolytic agent, pa	010	0	0	0	1	0	0	100	107	7	3.42	3.75	0.33	10%	0
67141	Prophylaxis of retinal detachment	090	0	0	0	2	0	0	77	91	14	2.53	3.19	0.66	26%	0
67145	Prophylaxis of retinal detachment	090	0	0	0	2	0	0	76	90	14	2.53	3.19	0.66	26%	0
67311	Strabismus surgery, recession or re	090	0	0	2	1	0	0	144	155	11	5.93	6.70	0.77	13%	0
67312	Strabismus surgery, recession or re	090	0	0	2	1	0	0	159	170	11	9.50	10.27	0.77	8%	0
67314	Strabismus surgery, recession or re	090	0	0	2	1	0	0	145	156	11	5.93	6.70	0.77	13%	0
67316	Strabismus surgery, recession or re	090	0	0	2	1	0	0	164	175	11	10.31	11.08	0.77	7%	0
67318	Strabismus surgery, any procedure	090	0	0	1	2	0	0	166	182	16	9.80	10.68	0.88	9%	0

Office Visit Times	Current Times	RUC Proposal	Current W	Proposed Work RVU
99204	45	60	2.43	2.6
99211	7	7	0.18	0.18
99212	16	18	0.48	0.7
99213	23	30	0.97	1.3
99214	40	49	1.5	1.92
99215	55	70	2.11	2.8

Current Clinical Staff Time	RUC Proposal Clinical Staff Time
62	54
19	17
28	28
36	36
53	51
63	62

Evaluating Anesthesia Survey Base Unit Recommendations

October 2020 RUC Meeting

American Society of Anesthesiologists™

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Background

- In 2016, the RUC Anesthesia Workgroup convened to develop a robust method to evaluate anesthesia base unit recommendations. This had not been done in over a decade
- The RUC Anesthesia Workgroup met multiple times per year (in-person and via conference call) using an iterative approach to develop a final methodology which was approved by the RUC
- This method is to be used for review of anesthesia services utilizing the following components:
  - An Anesthesia Reference Service List (RSL) which was validated through the new Building Block Methodology (BBM)*
  - The BBM will be used as a supplement to magnitude estimation or other RUC methods for code valuation
- The October 2020 RUC meeting is the first opportunity for the Committee to evaluate the results from an anesthesia survey for valuation of anesthesia base units using these new RUC-approved tools

* A BBM methodology was established by the RUC Anesthesia Workgroup in 2007 and the new BBM was validated in 2018

Differences Between RVUs and Base Units

- Unlike RBRVS codes, anesthesia codes have a **single base unit** value rather than separate RVUs for work, PE and PLI
- Base units are whole numbers whereas RVUs extend to the hundredths decimal place
- Medicare maintains a separate conversion factor (CF) for anesthesia services
  - 2021 Proposed Medicare Anesthesia CF: $19.9631
  - 2021 Proposed Medicare Physician CF: $32.2605

Differences Between RVUs and Base Units

- Anesthesia Base Unit valuation includes:
  - Pre-anesthesia period work
    - Patient evaluation
    - Equipment, drug and supply preparation
  - Intra-anesthesia differences in intensity and complexity*
  - Post-anesthesia evaluation work

* Time for intra-service anesthesia care is reported separately and paid the same amount per minute for **all types of cases**. This is different than work RVU.

RUC Approved Evaluation Tools to Assist in Properly Valuing Anesthesia Services

- Anesthesia base unit recommendations are based on survey using a RUC-approved survey instrument, similar to the RBRVS RUC survey instrument
- There are additional RUC approved tools to evaluate the unique aspects of anesthesia services and validate base unit recommendations
- These tools help evaluate base unit recommendations and assist in the unique process of determining appropriate relativity within the Anesthesia RSL
  - BBM and RSL Regression Analysis
  - Post-Induction Period Procedure Anesthesia (PIPPA)

BBM Overview

- The anesthesia building block methodology is to be used to **compare relativity among anesthesia services**, it is **NOT** to be used to establish anesthesia base unit value
- The RUC anesthesia survey will continue to be used to establish anesthesia base unit values. The anesthesia building block methodology serves to **validate the recommendations** presented
- For survey recommendations, the BBM value is calculated using recommended time values for each component; this calculated value is known as a “proxy RVU”

BBM Overview

The BBM is a methodology to value anesthesia services in a way that is similar to the codes valued under RBRVS in order to assess the **relativity among anesthesia services**

- The anesthesia service is broken down into five components that correspond to the RBRVS service periods
- Proxy RVU values are calculated for each component based on time recommendations and summed for a total proxy RVU
- The results from the BBM reflect the range of values among anesthesia services relative to each other

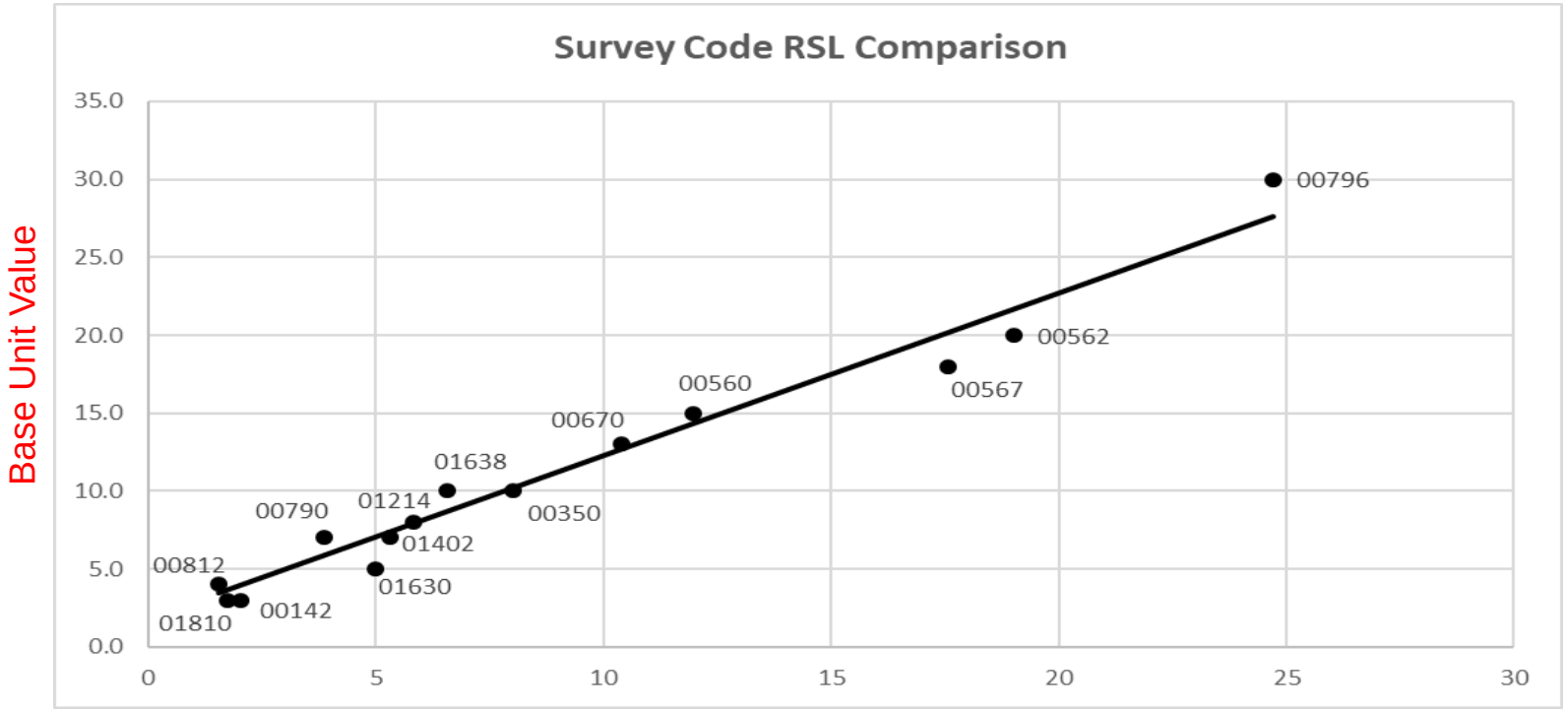
Building Block Methodology	RBRVS Service Period
STEP 1: Pre-service evaluation	Pre-service
STEP 2: Equipment, drug and supply preparation	
STEP 3: Induction period procedure	Intra-service
STEP 4: Post-induction period procedure anesthesia (PIPPA)	
STEP 5: Post-anesthesia evaluation	Post-service

RSL Regression Analysis Comparison

- Proxy RVUs will be plotted on the Survey Code RSL Comparison graph
- As these new proxy RVU data points are graphed, the closer a point is to the regression line, the better the proxy RVU and the base unit align
- This will be used to evaluate the **appropriateness of the recommendation** against the RSL services
- Placement on the regression line is not to be used to value anesthesia services
- This regression tool is critical to help evaluate any potential rank order anomalies

RSL Regression Analysis Comparison

A linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values (“proxy RVUs”) demonstrated that there is a strong (R^2 = 0.968) relationship between anesthesia base unit values and the anesthesia building block methodology values (“proxy RVU value”)



Using the Regression Line to Validate Base Unit Recommendations

- Once the BBM Value is calculated, and the specialty makes a base unit recommendation, the below data point is plotted onto the regression line graph
- The closer a recommendation data point is to the regression line, the better the recommendation fits the RUC approved BBM model

X-Axis	Y-Axis
BBM Value	Base Unit Value

Post-Induction Period Procedure Anesthesia (PIPPA)

- PIPPA is a relative **intensity methodology** used by the RUC to validate anesthesia base unit values
  - The post-induction period has varying levels of intensity
  - Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels
- Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another

Post-Induction Period Procedure Anesthesia (PIPPA)

- PIPPA **does not capture the entire value** of an anesthesia service as intensity and duration during the other anesthesia service periods contribute to the valuation of an anesthesia service
- PIPPA **does not include the difference** in work and intensity of all of the intra-service work
  - Thus, comparing PIPPA intensity alone is insufficient in providing a whole picture of the value of anesthesia services

PIPPA vs IWPUT

PIPPA is a measure of intensity that is similar, but not identical to, IWPUT

	RBRVS	Anesthesia Base Unit
Name	IWPUT	PIPPA
Intensity	Single average intensity	Varying level of intensity
Time Period	Entire intra-service period	<u>Intra-Service Period</u> • Pre-Induction: No • Induction: No • Post-Induction: Yes

RUC-Approved Anesthesia RSL

Code	Descriptor	Base Unit
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3
00142	Anesthesia for procedures on eye; lens surgery	4
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10

RUC-Approved Anesthesia RSL

Code	Descriptor	Base Unit
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30

RUC Tools for the Review of Anesthesia Base Units

- Standard RUC anesthesia survey
- There are additional RUC approved tools to evaluate the unique aspects of anesthesia services and validate base unit recommendations including:
  - BBM and RSL Regression Analysis
  - PIPPA
- These tools help evaluate base unit recommendations and assist in the unique process of determining appropriate relativity within the Anesthesia RSL

Thank You

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Appendix

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Overview of BBM

STEP 1: Pre-Service Evaluation	• Survey for time • Time multiplied by IWPUT for pre-service evaluation (0.0224)
STEP 2: Equipment, drug, supply preparation	• Survey for time • Based on survey results established time packages and clinical expertise, ASA will recommend time for equipment, drug, supply preparation • Time multiplied by IWPUT for scrub, dress and wait (0.0081)
STEP 3: Induction Period Procedure	<u>Pre-induction Assessment</u> • Establish two levels for patient assessment prior to induction: straightforward patient (2 minutes) and difficult patient (4 minutes); multiply by IWPUT for pre-service evaluation (0.0224) <u>Induction</u> • Survey for time • Based on survey results, established time packages and clinical expertise, ASA will recommend time for Induction • *Straightforward services*: time associated with the package will be multiplied by the IWPUT for code 31622 (Dx bronchoscope/wash) (IWPUT = 0.0636) • *Complex services*: time associated with the package will be multiplied by the IWPUT for code 31575 (*Diagnostic laryngoscopy)* (IWPUT = 0.1172)
STEP 4: Post-induction period procedure anesthesia	• Survey for post induction time • Survey for allocation across five PIPPA levels • Post induction time is allocated across the five PIPPA levels based on results of survey • Time is multiplied by the intensity for each PIPPA level
STEP 5: Post-anesthesia evaluation	• Survey for time • Time multiplied by IWPUT for pre-service evaluation (0.0224)

Selecting Time Packages

BBM Time Packages

- Step 2: Equipment, Drug, Supply Preparation
- Step 3: Induction Period

Selecting an Appropriate Time Package:

- ASA will survey for time
- Based on survey results and clinical expertise, ASA will recommend an appropriate time package
- Intensity of service is either Straightforward or Complex
  - Complexity of care is determined by “Complex” patient (co-morbidities)
  - Complexity of anesthetic as determined by the surgical procedure

Equipment, Drug, Supply Preparation Time Packages	
Description	**Time (minutes)**
Straightforward Patient/Straightforward Anesthetic	7
Complex Patient/Straightforward Anesthetic	15
Straightforward Patient/Complex Anesthetic	12
Complex Patient/Complex Anesthetic	25

Induction Period Time Packages	
Description	**Time (minutes)**
Straightforward Patient/Straightforward Anesthetic	2
Complex Patient/Straightforward Anesthetic	8
Straightforward Patient/Complex Anesthetic	5
Complex Patient/Complex Anesthetic	15

AMA/Specialty Society RVS Update Committee (RUC)
RUC Member Guide to Reviewing Anesthesia Base Unit Recommendations

Background

By statute, anesthesia services are valued using anesthesia base units and time units which are distinct from the Resource-based Relative Value Scale (RBRVS). At the October 2019 RUC meeting, after a multi-year effort of the Anesthesia Workgroup, the RUC approved an anesthesia reference service list (RSL) and a method to assess the relativity among services on the anesthesia fee schedule to determine base unit values for anesthesia services. This document provides guidance to the RUC on the RUC-approved criteria for reviewing anesthesia base unit recommendations. It reflects the recommendations of the Anesthesia Workgroup as approved by the RUC.

Anesthesia Base Units vs Relative Value Units (RVUs)

Unlike RBRVS codes, anesthesia codes have a **single base unit** value rather than separate RVUs for work, PE and PLI. The percent of anesthesia base units allocated to physician work and the anesthesia conversion factor are updated annually by the Centers for Medicare and Medicaid Services (CMS). Base units are whole numbers whereas RVUs extend to the hundredths decimal place.

An important distinction between the two systems is that while intra-time is bundled into the value of the work RVU, time is reported and billed separately for anesthesia services.

Table 1
RVUs vs Anesthesia Base Units

Inputs	Work RVUs	Anesthesia Base Unit
Pre-Time	Work RVUs	Anesthesia Base Unit
Intra-Time	Work RVUs	Time Units (15 minute increments out to 1 decimal place) (reported separately)
Post-Time	Work RVUs	Anesthesia Base Unit
Intra-service Intensity Independent of Time	N/A	Anesthesia Base Unit
Practice Expense	PE RVUs	Anesthesia Base Unit
Professional Liability Insurance (PLI)	PLI RVUs	Anesthesia Base Unit

Medicare Payment for Anesthesia Services = (Base Units + Time Units) x Anesthesia CF

Example: An anesthesia service valued at 6 anesthesia base units with reported anesthesia time of 36 minutes

[6 Anesthesia Base Units + 2.4 Time Units] x $22.2016 [2020 Medicare Anesthesia CF] = $186.49

Service Period Descriptions

Pre-Anesthesia Period

- Patient Evaluation
    - Includes service prior to the day of surgery (not separately reported) as well as time on the day of surgery prior to reportable anesthesia time
    - Time spent reviewing records, communicating with other professionals, obtaining the patient's history, performing an examination, formulating the anesthesia plan, obtaining consent, ordering studies, reviewing results of diagnostic studies and communicating with the patient's family when needed

- Equipment, Drug and Supply Preparation
    - The period in which the anesthesiologists acquires, prepares and checks anesthetic drugs, supplies and equipment, includes acquiring, preparing and labeling anesthetic and/or cardiovascular drugs, assembling and checking airway management, connecting and calibrating monitoring equipment, preparing infusion pumps, and performing the anesthesia machine checkout routine
    - Does not include time spent by technicians or other staff

Intra-Anesthesia Period

- Induction Period
    - The time from the initiation of reportable anesthesia time until induction of general anesthesia, establishment of adequate regional anesthesia (spinal, epidural or peripheral neural blockade), or completing establishment of sedation in conjunction with a monitored anesthetic care case
    - One can consider the end of the induction period as the "anesthesia ready time" or the time when the surgical team may begin to prepare the patient for the planned procedure after initiation of anesthesia.
- Post Induction Period
    - The time from the end of the induction period until the end of reportable anesthesia time.

Post-Anesthesia Period

- Post-Anesthesia Evaluation Period
    - Manage pain, respiratory, cardiovascular or other clinical issues in the post-anesthesia care unit, critical care unit or ward.
    - Time spent assessing the patient's postanesthetic course and any necessary visits, documentation, follow-up or communication with other professionals.
    - Does not include time associated with separately reportable visits or services.

RUC-Approved Criteria for Anesthesia Base Unit Recommendations

The RUC established the Anesthesia Workgroup to address issues for evaluating anesthesia services, as the methodology had not been reviewed since 2007. The following criteria for RUC review of anesthesia base units were approved by the RUC:

- Anesthesia codes will be surveyed using the RUC-approved anesthesia survey template. The RUC will be provided with the results of this survey as well as the calculation of the "proxy RVUs" which are the output of the anesthesia building block methodology and that will be compared against the RSL regression line. The new anesthesia building block methodology will be used as a supplement to other RUC methods for code valuation.

- The anesthesia building block methodology is to be used to **compare relativity among anesthesia services**, it is not to be used to establish anesthesia base unit value. Furthermore, it is not a calculation of physician work (RVUs), therefore the term "proxy RVU" is used.

- The results from the anesthesia survey using established RUC methods for code valuation will be the primary method used to determine anesthesia base unit valuation.

Anesthesia RSL
The RUC approved the following 14 codes to be placed on the Anesthesia RSL.

Table 2 Anesthesia RSL

CPT Code	Long Descriptor	Anesthesia Base Units
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3
00142	Anesthesia for procedures on eye; lens surgery	4
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30

- A linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values demonstrated that there is a strong ($R^2 = 0.968$) relationship between anesthesia base unit values and the anesthesia building block methodology values

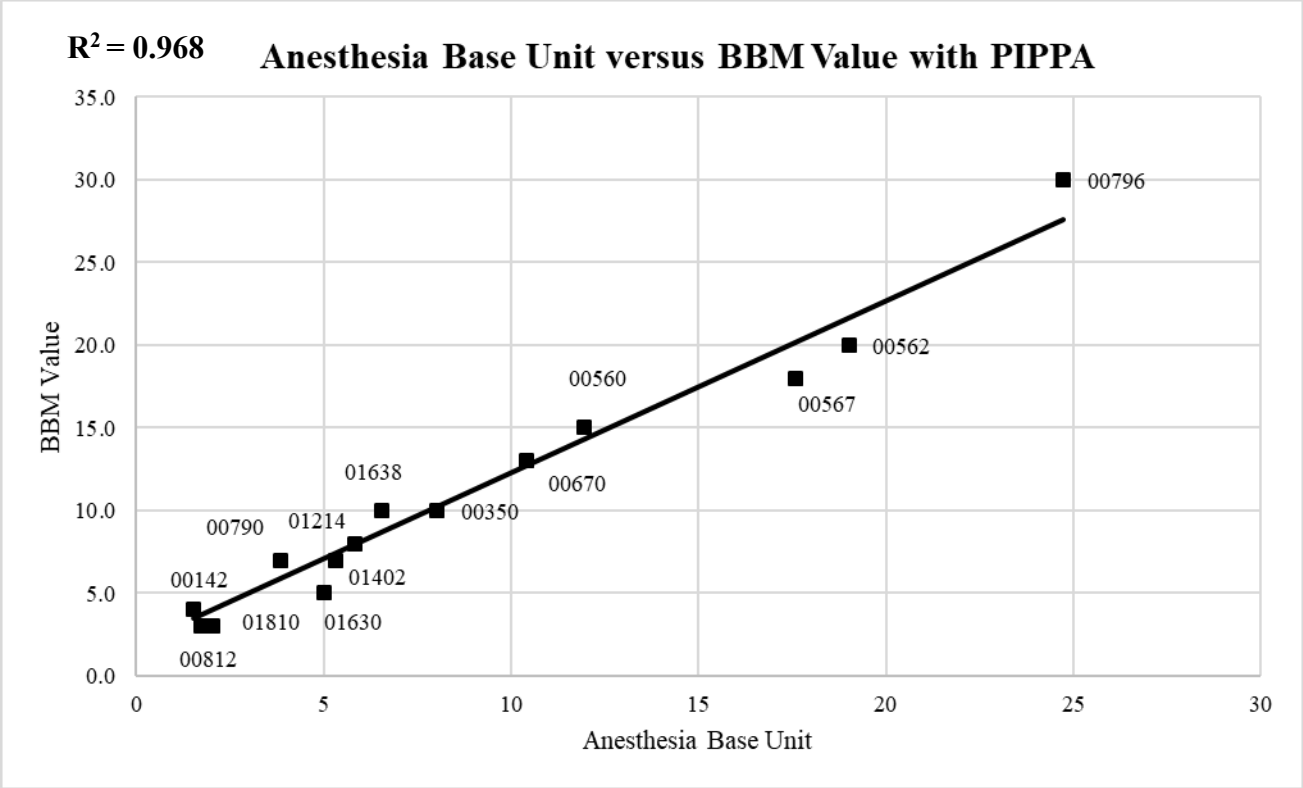
- Anesthesia codes will be surveyed using the RUC-approved anesthesia survey

- For newly surveyed codes the anesthesia building block methodology value will also be calculated; the value will be compared to the regression line derived from the other codes on the anesthesia RSL and this relationship will be used to supplement the analysis when reviewing anesthesia base unit recommendations

- In applying the anesthesia building block methodology when reviewing anesthesia services, the RUC should only consider the relativity of codes on the anesthesia fee schedule; it is not meaningful to do a direct comparison of anesthesia base units to RVUs

- The RUC anesthesia survey will continue to be used to establish anesthesia base unit value, the anesthesia building block methodology serves to validate the recommendations presented

Figure 1
Regression analysis of codes on the Anesthesia RSL



Overview of the Anesthesia Building Block Methodology

The anesthesia building block methodology is used to value anesthesia services in a way that is similar to the codes valued under RBRVS in order to assess the relativity among anesthesia services. Anesthesia base units reflect the complexity, risk, and skill required to perform a service. Under the anesthesia building block methodology, a bottom-up building block model is used to determine what have been termed "proxy" RVU values for anesthesia services. These results reflect the range of RVU values compared to base units among anesthesia services relative to each other.

Calculation of the Anesthesia building block methodology:

Anesthesia Proxy Value = Pre-service evaluation value + Equipment, drug and supply preparation value + Induction period procedure value + Post-induction period procedure anesthesia value + Post-anesthesia evaluation value

Table 3

Anesthesia Building Block Methodology

STEP 1: Pre-Service Evaluation	• Survey for time • Time multiplied by IWPUT for pre-service evaluation (0.0224)
STEP 2: Equipment, drug, supply preparation	• Survey for time • Based on survey results, established time packages and clinical expertise, the specialty will select a time package for equipment, drug, supply preparation • Equipment, Drug, Supply Preparation Time Packages: Straightforward Patient/Straightforward Anesthetic (7 min); Complex Patient/Straightforward Anesthetic (15 min); Straightforward Patient/Complex Anesthetic (12 min); Complex Patient/Complex Anesthetic (25 min) • Time associated with selected time package is multiplied by IWPUT for scrub, dress and wait (0.0081)
STEP 3: Induction Period Procedure	<u>Pre-induction Assessment</u> • Establish two levels for patient assessment prior to induction: straightforward patient (2 minutes) and difficult patient (4 minutes); multiply by IWPUT for pre-service evaluation (0.0224) • Specialty will select level based on their clinical expertise and experience with the procedure <u>Induction</u> • Survey for time • Based on survey results, established time packages and clinical expertise, the specialty will select time package for Induction • Induction Period Time Packages: Straightforward Patient/Straightforward Anesthetic (2 min); Complex Patient/Straightforward Anesthetic (8 min); Straightforward Patient/Complex Anesthetic (5 min); Complex Patient/Complex Anesthetic (15 min) • Specialty will select complexity of service (Straightforward Services or Complex Services) • *Straightforward Patient Services*: time associated with the package will be multiplied by the IWPUT for code 31622 (Dx bronchoscope/wash) (IWPUT = 0.0636) • *Complex Patient Services*: time associated with the package will be multiplied by the IWPUT for code 31575 (Diagnostic laryngoscopy) (IWPUT = 0.1172)
STEP 4: Post-induction period procedure anesthesia (PIPPA)	• Survey for post induction time • Survey for allocation across five PIPPA levels • Post induction time is allocated across the five PIPPA levels based on results of survey • Time is multiplied by the intensity for each PIPPA level
STEP 5: Post-anesthesia evaluation	• Survey for time • Time multiplied by IWPUT for pre-service evaluation (0.0224)

Purpose of Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is calculated in step 4 of the anesthesia building block methodology. The code is surveyed for allocation across five PIPPA levels. Intensity is assigned to each level. Survey respondents are asked to allocate a percentage of their post-induction time to the different levels based on their personal experience providing the service. Survey respondents are provided with level descriptions and examples but **not** with the actual intensity measures.

Table 4

PIPPA Intensity Levels

Level	Description	Intensity
1	Problems are self-limited or minor; straightforward medical decision making and treatment Examples include but are not limited to: • *Monitoring and recording standard physiologic monitors (EKG, $ETCO_2$, SpO_2, BP, respiratory parameters) in a stable patient* • *Positioning a patient for surgery (ie, supine)* • *Titrating anesthetic level to achieve optimal surgical condition*	0.031
2	Problems are of low severity; medical decision making and treatment are of low complexity Examples include but are not limited to: • *Evaluating and managing transient aberrations in hemodynamic or respiratory status such as moderate tachycardia or hypotension* • *Responding to abrupt changes in surgical activity (eg, visceral traction, orthopedic cement application, abdominal insufflation)* • *Positioning an unconscious patient (ie, prone, sitting, decubitus) for surgery* • *Maintenance of cardiopulmonary bypass*	0.044
3	Problems are of moderate severity; medical decision making and treatment are of moderate complexity Examples include but are not limited to: • *Inducing intentional hypotension (eg, starting a vasodilator)* • *Evaluation and management of sustained hypertension using vasoactive agents* • *Preparing and evaluating a patient for anesthetic emergence and tracheal extubation* • *Initiation of cardiopulmonary bypass* • *Maintenance of single-lung ventilation*	0.055
4	Problems are of moderate to high severity; medical decision making of moderate to high complexity and treatment of high complexity critically ill or critically injured patient Examples include but are not limited to: • *Evaluating and managing intraoperative myocardial ischemia, sustained hypotension, serious cardiac arrhythmias* • *Maintenance of hypotension and associated fluid, drug and transfusion requirements during cerebral aneurysm clipping* • *Initiating single lung ventilation*	0.07
5	Problems are of high severity; medical decision making and treatment of high complexity critically ill or critically injured patient Examples include but are not limited to: • *Managing separation from cardiopulmonary bypass* • *Managing clamping or unclamping of abdominal aorta* • *Managing massive transfusion for resuscitation of hemorrhagic shock*	0.0957

When considering valuation of an anesthesia service, it is important to remember these important elements regarding PIPPA:

- PIPPA MEASURES THE INTENSITY OF THE POST-INDUCTION PERIOD: PIPPA provides a means to assess the relative intensity of the post-induction anesthesia services furnished; without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

- PIPPA DOES NOT CAPTURE THE ENTIRE VALUE OF AN ANESTHESIA SERVICE: While PIPPA provides important information about the intensity of anesthesia services during the post-induction period, intensity and duration during the other anesthesia service periods, outlined in the anesthesia building block methodology, contribute to the valuation of anesthesia services. Thus, comparing PIPPA intensity alone is insufficient in providing a whole picture of the value of anesthesia services.

- PIPPA IS A MEASURE OF INTENSITY THAT IS SIMILAR, BUT NOT IDENTICAL, TO IWPUT: In the case of billing for anesthesia, time is a constant payment for which there is no adjustment for intensity. The base unit accounts for preoperative preparation and postoperative evaluation and with the addition of PIPPA is the mechanism for introducing a factor that accounts for varying intensity that is similar to IWPUT but not identical. The IWPUT metric is for the entire physician intra-service period, whereas PIPPA is only for post-induction and does not include the induction period which is also part of intra-anesthesia work.

Criteria Used to Evaluate Base Unit Recommendations

Anesthesia codes will be surveyed using the RUC-approved anesthesia survey template. The RUC will be provided with the results of this survey as well as the calculation of the "proxy RVUs" which are the output of the building block method and that will be compared against the RSL regression line. The new anesthesia building block methodology is to be used as a supplement to other RUC methods for code valuation.

The anesthesia building block methodology is to be used to **compare relativity among anesthesia services**, it is not to be used to establish anesthesia base unit value. Furthermore, it is not a calculation of physician work (RVUs), therefore the term "proxy RVU" is used.

The results from the anesthesia survey using other established RUC methods for code valuation will be used to determine anesthesia base unit valuation.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2020

Exclusion of Left Atrial Appendage – Tab 5

In May 2020, the CPT Editorial Panel approved the creation of three new codes to describe open and thoracoscopic left atrial appendage management procedures when performed as stand-alone procedures or in conjunction with other procedures performed via a transthoracic (sternotomy or thoracotomy) approach other than Maze and mitral valve repair/replacement procedures.

33267 ***Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)***
The RUC reviewed the survey results from 73 cardiothoracic surgeons and determined that the survey 25th percentile work RVU of 18.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 45 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time and 30 minutes immediate post-service time, 1-99291 critical visit, 2-99232 subsequent hospital care visits, 1-99238 discharge visit, and 1-99213 office visit. The RUC noted that the additional 5 minutes of pre-service time is necessary to discuss the risk of adverse embolic phenomena and/or anti-coagulation events with the family and patient and that this is standard for open codes in this family. However, the RUC noted that these discussions would be unnecessary for the endoscopic code 33269 in this family given the nature of the procedure.

The RUC compared CPT code 33267 to the top key reference code 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* (work RVU = 14.50 75 minutes intra-service time and 332 minutes total time) and noted both the lower total time associated with CPT code 32666 as well as 91% of survey respondents that selected this key reference code indicated that the work associated with CPT code 33267 is either somewhat or much more intense/complex than the work associated with CPT code 32666.To further support a work RVU of 18.50, the RUC compared the survey code 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-service time of 90 minutes, total time of 367 minutes) and noted that both services involve identical intra-service time, whereas the survey code involves 25 more minutes of total time. **The RUC recommends a work RVU of 18.50 for CPT code 33267.**

33268 ***Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 93 cardiothoracic surgeons and determined that a direct work RVU crosswalk to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and 20 minutes total time) correctly reflects the physician work necessary to perform this service. The RUC recommends 20 minutes intra-service time for CPT code 33268.

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The specialty societies indicated, and the RUC agreed that the survey 25th percentile work RVU of 5.15 would overvalue this add-on service. Therefore, the RUC determined for CPT code 33268 to have its work value crosswalked to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service time of 20 minutes), because they both have the same intra-service and total time – both services also involve the same overall amount of physician work. The RUC noted that the intensity of code 33268 compares favorably to the intensity of key reference codes 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes total time) and 34714 *Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 5.25, 52 minutes total time). **The RUC recommends a work RVU of 2.50 for CPT code 33268.**

33269 ***Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)***
The RUC reviewed the survey results from 77 cardiothoracic surgeons and determined that a direct work RVU crosswalk to CPT code 33020 *Pericardiotomy for removal of clot or foreign body (primary procedure)* (work RVU = 14.31, 60 minutes intra-service time and 321 minutes total time.) accurately reflects the physician work necessary to perform this service. The RUC recommends 42 minutes pre-evaluation time, 15 minutes pre-positioning time, and 15 minutes pre-scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time.

The RUC determined that this crosswalk was appropriate given the similarity in physician work intensity and total time. The RUC noted that the survey 25th percentile work RVU of 18.00 was too high and would not represent a large enough difference with the open procedure described in 33267. For additional support, the RUC referenced top key reference service 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* (work RVU = 14.50, 75 minutes intra-service time and 332 minutes total time). In their intensity/complexity comparison, the survey respondents that selected this key reference code indicated that the survey code was more or somewhat more complex than 32666 for all of the intensity/complexity measures except the physical effort required; thus 33269 is appropriately more intense but has a slightly lower work RVU. **The RUC recommends a work RVU of 14.31 for CPT code 33269.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the standard 90-day global inputs for CPT code 33267 and 33269 and made no changes to the societies' request. CPT code 33268 is a ZZZ global code and has no practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology
CPT codes 33267, 33268, 33269 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** **Electrophysiologic Operative Procedures** *This family of codes …* ***Definitions*** *Limited operative ablation and reconstruction includes: Surgical isolation of triggers of supraventricular dysrhythmias by operative ablation that isolates the pulmonary veins or other anatomically defined triggers in the left or right atrium.* ***Extensive** operative ablation and reconstruction includes:* *1. The services included in "limited"* *2. Additional ablation of atrial tissue to eliminate sustained supraventricular dysrhythmias. This must include operative ablation that involves either the right atrium, the atrial septum, or left atrium in continuity with the atrioventricular annulus.* Codes 33267, 33268, and 33269 describe surgical left atrial appendage (LAA) exclusion (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) performed to treat atrial fibrillation and mitigate postoperative thromboembolic complications. Surgical LAA exclusion may be performed as a stand-alone procedure via a sternotomy, thoracotomy, or thoracoscopic approach. More commonly it is performed in conjunction with other procedures requiring a sternotomy or thoracotomy approach. Surgical LAA exclusion is inherent to maze procedures (33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266) and mitral valve repair/replacement procedures (33420, 33422, 33425, 33426, 33427, 33430) and may not be reported separately when performed in the same operative session. Code 33267 may only be reported when there is no concurrently performed procedure that requires a sternotomy or thoracotomy approach. Add-on code 33268, if performed concurrently, may be reported in conjunction with a primary procedure performed via a sternotomy or thoracotomy. Code 33269 may be reported for thoracoscopic LAA exclusion, other than with maze or mitral valve procedures (33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266, 33420, 33422, 33425, 33426, 33427, 33430), when performed during the same operative session.			

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Incision				
33250	*Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass* *(For intraoperative pacing and mapping by a separate provider, use 93631)*			
33251	*with cardiopulmonary bypass*			
	...			
33261	*Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass*			
●33267	A1	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (Do not report 33267 in conjunction with 33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266, 33420, 33422, 33425, 33426, 33427, 33430) (Do not report 33267 in conjunction with other sternotomy or thoracotomy procedures performed during the same session)	090	18.50
✚●33268	A2	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure) (Use 33268 in conjunction with primary procedures performed via sternotomy or thoracotomy approaches) (Do not report 33268 in conjunction with 33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266, 33420, 33422, 33425, 33426, 33427, 33430)	ZZZ	2.50

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Endoscopy				
●33269	A3	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (Do not report 33269 in conjunction with 33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266, 33420, 33422, 33425, 33426, 33427, 33430)	090	14.31
33265	*Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass*			
33266	*operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass* *(Do not report 33265-33266 in conjunction with 32551, 33210, 33211)*			

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33267 Tracking Number A1 Original Specialty Recommended RVU: **18.50**
Presented Recommended RVU: **18.50**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **18.50**

CPT Descriptor: Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male who is status post left lung resection presents with persistent atrial fibrillation and CHADS2 (stroke risk) score of 4. Recurrent, significant GI bleeding episodes preclude anticoagulation therapy. He is deemed a poor candidate for LAA endovascular occlusion device. Because of anticipated dense adhesions within the left chest cavity, a thoracoscopic approach is contraindicated and an open approach to left atrial appendage exclusion (eg, ligation, plication, clip) is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 7% , Overnight stay-more than 24 hours 93%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 55%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed. Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging and laboratory studies are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure including education of the patient on the expected surgcial approch and method of left atrial appendage exclusion and possible alternatives, the expected recovery, and expected outcomes, including potential complications, are reviewed with the family. The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Availability of the surgical assistant is confirmed. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen. . Ensure that the patient is properly positioned with left side slightly elevated. Appropriate padding is positioned so as to prevent untoward peripheral neurologic injury during the operation.

Description of Intra-Service Work: Under general anesthesia, a thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. The left lung is collapsed and single lung ventilation of the right lung is instituted to facilitate exposure. Adhesions between the lung and the pericardium are carefully separated so as to avoid lung parenchymal injury, as well as injury to the phrenic nerve. The pericardium is opened posterior to the phrenic nerve. Any adhesions are carefully dissected off the left atrial appendage (LAA) and the base is exposed and carefully measured. Under transesophageal echocardiography (TEE) guidance the base of the LAA is stapled, clipped or ligated. TEE confirms no flow into the LAA. This can be done either off (most commonly) or on cardiopulmonary bypass (femoral cannulation) (reported separately).
The pericardium is left open. An intercostal nerve block is usually performed for postoperative analgesia. A left chest tube or drain is placed. The left lung is expanded. A careful check hemostasis and/or lung parenchymal air leaks is conducted.

The thoracotomy incision is closed in layers by approximating the muscles, subcutaneous tissue and skin. The patient is extubated and taken to the recovery area.

Description of Post-Service Work: Perform post procedure debriefing. Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to cart. Monitor transport of patient from operating room to recovery room. Review nursing/other staff patient chart notes. Answer patient and family questions. Answer nursing/other staff questions. Write orders for following days laboratory tests, films, medications, diet, and patient activity. Discuss procedure outcome with family. Review postoperative chest X ray, arterial blood gas, mixed venous saturation blood gas, cardiac output and index and pulmonary pressure parameters, postoperative lab work including CBC, CMP. Discuss procedure outcome with referring physician. Coordinate care with other physicians. Dictate full operative note for patient's chart. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company.

Same day postoperative critical care: Assess patient’s neurological state. Administer sedatives, paralyzing agents, and analgesics as needed. Assess patient’s hemodynamic condition including pulmonary artery catheter readings and parameters and mixed venous saturation, rate and conduction abnormalities and arrhythmias. Initiate and adjust temporary pacing as needed. Monitor blood pressure, central venous pressure, pulmonary artery pressures, cardiac output and index, mixed venous saturation, lactic acid. Administer inotropic and vasoactive agents to minimize adverse end-organ effects. Monitor chest tube output and data to determine if blood and/or blood products are needed and if other adjunctive pharmacologic therapies should be considered for coagulopathy. Assess respiratory system, urine output, renal function. Assess chest xray. Discuss interval plans with nursing staff and set parameters for interval adjustments in patient treatment

Postoperative hospital work beginning on postoperative day 1 until discharge day: Review the patient’s chart notes with nursing and other staff. Examine patient daily. Inspect the wound, review chest tube output volume and consistency and patient progress. Assess postoperative pain and use of analgesics. Assess respiration, character of pulmonary secretions and the patient’s ability to clear airway. Review vital signs, intake and output and laboratory results. Review chest radiograph, echocardiogram, and evaluate the cardiac monitor for rate, rhythm, and presence or absence of arrhythmia. Encourage ambulation and pulmonary physiotherapy. Monitor postoperative nutritional status. Remove pacing wires and chest tube when appropriate (usually 24 to 48 hours postoperatively). Obtain and review chest X rays after tube removal. Answer questions from the patient, family, and nursing or other staff (oral and written). Discuss the patient’s progress (orally and in writing) with the referring physician. Coordinate care with other physicians. Document evaluation, patient progress, and the care plan in the medical record.

Discharge day work: Check the final pathology, laboratory, or film reports and discuss with the patient’s family or caregiver. Check wounds. Explain wound care, dietary management, activities permitted, bathing, handling of wound, return appointment to office. Outline expectations for recovery and describe potential complications. Coordinate care with other physicians. Answer questions from the patient, family, and nursing and other staff. Write post discharge orders for laboratory tests, films, and medications. Explain new medications, home medications and homeopathic agents to ensure that additional agents are compatible or will not be used. Dictate a discharge summary. Communicate with patient’s primary care physician(s).

Postoperative office work: Review medications, and determine compliance. Review interval encounters with other care providers. Check wounds and patient progress. Remove sutures if necessary. Review post discharge laboratory tests or films. Write orders for medications. Answer questions from the patient and family. Discuss the patient’s progress (orally and in writing) with the referring physician. Coordinate the patient’s care with other physicians. Discuss progress with the patient and family. Dictate a patient progress note for the medical chart, and send letters to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	James Levett, MD; Stephen Lahey, MD; Joseph Turek, MD; Jacob Schroder, MD; Kirk Kanter, MD; Prashanath Vallabhajosyula, MD; Richard Freeman, MD					
Specialty Society(ies):	STS; AATS					
CPT Code:	33267					
Sample Size:	850	**Resp N:**	73			
Description of Sample:	Random sample of 850 US self-identified cardiac surgeons					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	3.00	10.00
Survey RVW:	5.00	18.50	**23.15**	28.46	39.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	2.00	60.00	**90.00**	110.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**40.00**	99224x **0.00** 99225x **1.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33267	**Recommended Physician Work RVU: 18.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**45.00**	**40.00**	**5.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**40.00**	99224x **0.00** 99225x **1.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32666	090	14.50	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33030	090	36.00	**RUC Time**

CPT Descriptor Pericardiectomy, subtotal or complete; without cardiopulmonary bypass

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
43770	090	18.00	**RUC Time**

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 15.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 12.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 33267	Top Key Reference CPT Code: 32666	2nd Key Reference CPT Code: **33030**
Median Pre-Service Time	70.00	75.00	63.00
Median Intra-Service Time	90.00	75.00	180.00
Median Immediate Post-service Time	30.00	30.00	45.00
Median Critical Care Time	70.0	0.00	140.00
Median Other Hospital Visit Time	80.0	75.00	210.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	23.0	39.00	63.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	40.0	0.00	0.00
Median Total Time	**441.00**	**332.00**	**739.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	9%	64%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	18%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	36%	64%
Physical effort required	0%	27%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	9%	91%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	78%	11%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	78%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	22%	56%	22%
Physical effort required	33%	67%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	56%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 5 includes 3 new codes that represent surgical exclusion of the left atrial appendage (LAA). Surgical exclusion of the left atrial appendage is integral to and should not be separately reported with the Maze (33254–33259, 33265-33266) or the surgical mitral valve repair or replacement procedures (33420, 33422, 33425, 33426, 33427, 33430). There is an existing code for percutaneous LAA closure, 33440 *Percutaneous transcatheter closure of the left atrial appendage with*

endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation. The three new codes represent new technology and surgical techniques that may be used to treat atrial fibrillation at the time of another surgical procedure (other than Maze or mitral valve repair or replacement) that involves an approach via median sternotomy or thoracotomy or as a stand-alone procedure performed via median sternotomy, thoracotomy or thoracoscopy where the left atrial appendage is excluded by any method which may include excision, isolation via stapling, oversewing, ligation, plication or application of a clip.

Rationale 33267
Code 33267 is a 90-day global procedure that represents a stand-alone open cardiac procedure, which is performed via median sternotomy or thoracotomy without cardiopulmonary bypass to access the heart and exclude the left atrial appendage.

Pre-Time Package 4

Pre-Time Changes:
The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 45 minutes): For the evaluation, the Expert Panel is recommending a 5-minute increase in time over the package for a total evaluation time of 45 minutes. This is supported by the survey data with 45 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the education efforts that go into each case. The additional evaluation time of 5 minutes accounts for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure, including the planned approach, method of LAA exclusion and the associated aftercare. The surgeon reviews the preoperative echocardiogram to evaluate the preoperative flow in the LAA which will be compared to the intraoperative TEE upon LAA exclusion to ensure there is no blood flow in a LAA stump. The Expert Panel felt that adding 5 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the work for pre-service evaluation involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 7-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 7-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient and/or positioning the patient for a thoracotomy.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 30 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 3-minute decrease in time over the package for a total immediate post time of 30 minutes, which is supported by the median immediate post-service time from the survey.

Critical Care Visits: 100% of the survey respondents replied that the procedure was performed in the hospital, and 93% of the respondents indicated that the patients stayed overnight for more than 24 hours. 55% of the respondents indicated that they provided an E&M Visit on the same day of surgery.
The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure for a total of one critical care visits for the procedure. The critical care visit covers the time that the physician spends with the patient directly related to the procedure providing critical care services. The survey supported one critical care visit for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure: 73 surveys were completed by a random sample of 850 US self-identified cardiac surgeons. 11 respondents selected code 32666, *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* as a reference code making it the 1st key reference service (KRS). That code has a lower value, a shorter intraservice time and a shorter total time then the survey code. In their intensity/complexity comparison,

the survey respondents indicated that the survey code was more or somewhat more complex than 32666 for all of the intensity/complexity measures. 9 respondents selected code 33030 *Pericardiectomy, subtotal or complete; without cardiopulmonary bypass* as a reference code making it the 2nd KRS. This code has a higher value with a longer intraservice and total service time. In their intensity/complexity comparison, the majority of the survey respondents indicated that the survey code was identical to 33030 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33267 (open exclusion of the left atrial appendage) has a median intra-operative time of 90 minutes. The surveys also supported one critical care visit on the day of the procedure. The survey showed a 3-day hospital LOS with two 99232 visits and a 99238 for discharge day management services. The survey also supported one 99225 subsequent observation care visit. The Expert Panel felt that the survey accurately represented the hospital length of stay, the level of subsequent hospital visits and the level of discharge day management services. However, the Expert Panel did not agree that there was one subsequent observation care visit associated with the procedure and are not recommending that an observation care visit be added to the global period. The survey also supported one 99213 office visit after the patient is discharged from the hospital. The Expert Panel is recommending the 25th percentile RVW of 18.50 for the survey code, which falls between the RVWs of the 1st (14.50) and 2nd (36.00) KRS codes. The intraservice time of the survey code is 15 minutes more than the intra-service time of the 1st KRS and 90 minutes lower than that of the 2nd KRS. The total time for the survey code is 401 minutes, which is 69 minutes more than the total time of the 1st KRS and 338 minutes lower than the 2nd KRS. The Expert panel felt that 25th percentile RVW is representative of the work involved in the procedure and fits well between the two KRS codes.

For code 33267, the Expert Panel is recommending the 25th percentile work RVW of 18.50, with a median intra-service time of 90 minutes, and total time of 401 minutes. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 70 minutes. Immediate post-service time package 9b was selected with recommended decrease of 3- minutes based on the survey for a total time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1386
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on a review of the 2016 Part A discharge data and vendor data, it is estimated that 6000 surgical LAA exclusions outside of Maze and mitral valve procedures are performed nationally per year in heart centers around the country. Of those, approximately 70% (4200) are performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268). Of the 1800 stand-alone procedures performed nationally per year, it is estimated that 77% (1386) are performed using the open technique (33267) and 23% (414) are performed thoracoscopically (33269).

Specialty Cardiothoracic Surgery Frequency 1386 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 924
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the surgical LAA procedures are performed in Medicare patients with an estimated 2800 add-on surgical LAA exclusions performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268), 924 stand-alone open LAA exclusions (33267) and 276 thoracoscopic LAA exclusions.

Specialty Cardiothoracic Surgery Frequency 924 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33254

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33268 Tracking Number A2 Original Specialty Recommended RVU: **3.00**
Presented Recommended RVU: **3.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **2.50**

CPT Descriptor: Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female with severe peripheral vascular disease, bicuspid aortic valve with severe stenosis but undergoes surgical aortic valve replacement and surgical LAA exclusion (eg, ligation, plication, clip).

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: In addition to a procedure performed via sternotomy or thoracotomy approach (reported separately), the left atrial appendage is exposed by mobilizing the left ventricle towards the right side. This can be facilitated by dividing the pericardium on the right side to avoid right ventricular compression and decreasing venous return. Extreme care is used to avoid injury to the right phrenic nerve. The hemodynamic stability of the patient is carefully monitored. The base of the LAA is exposed and carefully measured. Under transesophageal echocardiography (TEE) guidance the base of the LAA is stapled, clipped or ligated. TEE confirms no flow into the LAA. Once completed, attention is then returned to the final procedural elements of the primary operation.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	James Levett, MD; Stephen Lahey, MD; Joseph Turek, MD; Jacob Schroder, MD; Kirk Kanter, MD; Prashanath Vallabhajosyula, MD; Richard Freeman, MD					
Specialty Society(ies):	STS; AATS					
CPT Code:	33268					
Sample Size:	850	**Resp N:**	93			
Description of Sample:	Random sample of 850 US self-identified cardiac surgeons					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**15.00**	25.00	190.00
Survey RVW:	2.50	5.15	**8.75**	16.00	35.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	11.00	**20.00**	60.00	296.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	33268	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32507	ZZZ	3.00	**RUC Time**

CPT Descriptor Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34714	ZZZ	5.25	**RUC Time**

CPT Descriptor Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
32506	090	3.00	**RUC Time**

CPT Descriptor Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 12.9 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 10.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 33268	Top Key Reference CPT Code: 32507	2nd Key Reference CPT Code: 34714
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	30.00	52.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**30.00**	**52.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	25%	25%	25%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	42%	33%
Physical effort required	25%	58%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	25%	58%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	60%	40%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	30%	40%	30%
Physical effort required	20%	50%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	60%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 5 includes 3 new codes that represent surgical exclusion of the left atrial appendage (LAA). Surgical exclusion of the left atrial appendage is integral to and should not be separately reported with the Maze (33254–33259, 33265-33266) or the surgical mitral valve repair or replacement procedures (33420, 33422, 33425, 33426, 33427, 33430). There is an existing code for percutaneous LAA closure, 33440 *Percutaneous transcatheter closure of the left atrial appendage with*

endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation. The three new codes represent new technology and surgical techniques that may be used to treat atrial fibrillation at the time of another surgical procedure (other than Maze or mitral valve repair or replacement) that involves an approach via median sternotomy or thoracotomy or as a stand-alone procedure performed via median sternotomy, thoracotomy or thoracoscopy where the left atrial appendage is excluded by any method which may include excision, isolation via stapling, oversewing, ligation, plication or application of a clip.

Rationale 33268

Code 33268 is an add-on procedure, the most commonly performed of the three new codes, which represents a procedure that may be performed to treat patients with atrial fibrillation at the same time as another cardiac or thoracic procedure (other than maze or mitral valve repair or replacement) where a median sternotomy or a thoracotomy approach has been used for performance of the primary procedure and through which exclusion of the left atrial appendage is performed.

Intensity and complexity of the procedure: 93 surveys were completed by a random sample of 850 US self-identified cardiac surgeons. 12 respondents selected code 32507, *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)* as a reference code making it the 1st key reference service (KRS). That code has a lower value than the 25th percentile and the median RVWs from the survey code, with a longer intraservice and total time. In their intensity/complexity comparison, the survey respondents indicated that the survey code was identical or somewhat more complex than 32507 for all of the intensity/complexity measures except the psychological stress. For the psychological stress, 58% of the respondents indicated that the intensity/complexity of the survey code was more and 25% indicated that the physical effort required was identical to the 1st KRS code. 10 respondents selected code 34714 *Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 2nd KRS. This code has a higher value than the 25th percentile from the survey and a lower value than the median RVW from the survey with a longer intraservice and total service time. In their intensity/complexity comparison, the survey respondents indicated that the survey code was identical or somewhat more complex than 34714 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33268 (add-on open exclusion of the left atrial appendage) has a median intra-operative survey time of 20 minutes and a total time of 20 minutes. The Expert Panel felt that the 25th percentile RVW of 5.15 from the survey with 20 minutes of intra-time and total time and an IWPUT of 0.258 was too high for the procedure compared to other procedures in the RUC database. In looking at other codes with similar intra-service and total times, the Expert Panel felt code 32506 *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* with an RVW of 3.00 and an intra-service and total time of 25 minutes, which is similar to the survey code is reasonable crosswalk code to value the procedure.

For code 33268, the Expert Panel is recommending a work RVW of 3.00 with a median intra-service and total time of 20 minutes based on a crosswalk to code 32506.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999 or -22 modifier

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on a review of the 2016 Part A discharge data and vendor data, it is estimated that 6000 surgical LAA exclusions outside of Maze and mitral valve procedures are performed nationally per year in heart centers around the country. Of those, approximately 70% (4200) are performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268). Of the 1800 stand-alone procedures performed nationally per year, it is estimated that 77% (1386) are performed using the open technique (33267) and 23% (414) are performed thoracoscopically (33269).

Specialty Cardiothoracic Surgery Frequency 4200 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the surgical LAA procedures are performed in Medicare patients with an estimated 2800 add-on surgical LAA exclusions performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268), 924 stand-alone open LAA exclusions (33267) and 276 thoracoscopic LAA exclusions.

Specialty Cardiothoracic Surgery Frequency 2800 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33257

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33269 Tracking Number A3 Original Specialty Recommended RVU: **15.73**
Presented Recommended RVU: **15.73**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **14.31**

CPT Descriptor: Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 85-year-old female with persistent atrial fibrillation has undergone numerous electrophysiologic procedures in the past and was deemed a poor candidate for endovascular LAA occlusion device. Thoracoscopic LAA exclusion (eg, ligation, plication, clip) is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 6% , Overnight stay-more than 24 hours 94%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 56%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed. Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging and laboratory studies are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure including education of the patient on the expected surgcial approch and method of left atrial appendage exclusion and possible alternatives, the expected recovery, and expected outcomes, including potential complications, are reviewed with the family. The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Availability of the surgical assistant is confirmed. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. Then the surgeon positions and preps the patient after which the surgeon scrubs, gowns, and drapes the patient The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation

Description of Intra-Service Work: Under general anesthesia, the site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. The left lung is deflated. Adhesions between the lung and chest wall are freed. Care is taken to avoid decreasing venous return by careful monitoring of CO2 flow and pressure (usually kept +/< 6 mmHg) and patient's blood pressure.

The pericardium is carefully opened posterior to the phrenic nerve and the left atrial appendage is exposed. The left atrial appendage base is exposed and measured. The appendage is then clipped, stapled or ligated with transesophageal echocardiography (TEE) guidance to make sure there is no flow into the left atrial appendage. The pericardium is left open. Intercostal nerve block is performed with local anesthetic for post-operative analgesia. The left lung is expanded. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch. The patient is extubated.

Description of Post-Service Work: Perform post procedure debriefing. Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to cart. Monitor transport of patient from operating room to recovery room. Review nursing/other staff patient chart notes. Answer patient and family questions. Answer nursing/other staff questions. Write orders for following days laboratory tests, films, medications, diet, and patient activity. Discuss procedure outcome with family. Review postoperative chest X ray, arterial blood gas, mixed venous saturation blood gas, cardiac output and index and pulmonary pressure parameters, postoperative lab work including CBC, CMP. Discuss procedure outcome with referring physician. Coordinate care with other physicians. Dictate full operative note for patient's chart. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company.

Postoperative hospital work until discharge day: Assess patient’s neurological state and hemodynamics. Review the patient’s chart notes with nursing and other staff. Examine patient daily. Inspect the wound, review chest tube output volume and consistency and patient progress. Assess postoperative pain and use of analgesics. Assess respiration, character of pulmonary secretions and the patient’s ability to clear airway. Review vital signs, intake and output and laboratory results. Review chest radiograph, echocardiogram, and evaluate the cardiac monitor for rate, rhythm, and presence or absence of arrhythmia. Encourage ambulation and pulmonary physiotherapy. Monitor postoperative nutritional status. Remove pacing wires and chest tube when appropriate (usually 24 to 48 hours postoperatively). Obtain and review chest X rays after tube removal. Answer questions from the patient, family, and nursing or other staff (oral and written). Discuss the patient’s progress (orally and in writing) with the referring physician. Coordinate care with other physicians. Document evaluation, patient progress, and the care plan in the medical record.

Discharge day work: Check the final pathology, laboratory, or film reports and discuss with the patient’s family or caregiver. Check wounds. Explain wound care, dietary management, activities permitted, bathing, handling of wound, return appointment to office. Outline expectations for recovery and describe potential complications. Coordinate care with other physicians. Answer questions from the patient, family, and nursing and other staff. Write post discharge orders for laboratory tests, films, and medications. Explain new medications, home medications and homeopathic agents to ensure that additional agents are compatible or will not be used. Dictate a discharge summary. Communicate with patient’s primary care physician(s).

Postoperative office work: Review medications, and determine compliance. Review interval encounters with other care providers. Check wounds and patient progress. Remove sutures if necessary. Review post discharge laboratory tests or films. Write orders for medications. Answer questions from the patient and family. Discuss the patient’s progress (orally and in writing) with the referring physician. Coordinate the patient’s care with other physicians. Discuss progress with the patient and family. Dictate a patient progress note for the medical chart, and send letters to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	James Levett, MD; Stephen Lahey, MD; Joseph Turek, MD; Jacob Schroder, MD; Kirk Kanter, MD; Prashanath Vallabhajosyula, MD; Richard Freeman, MD					
Specialty Society(ies):	STS; AATS					
CPT Code:	33269					
Sample Size:	850	**Resp N:**	77			
Description of Sample:	Random sample of 850 US self-identified cardiac surgeons					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**2.00**	5.00	40.00
Survey RVW:	6.00	18.00	**21.50**	25.00	40.00
Pre-Service Evaluation Time:			**42.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	5.00	50.00	**65.00**	90.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**95.00**	99231x **0.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**20.00**	99224x **1.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33269	**Recommended Physician Work RVU: 14.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**42.00**	**40.00**	**2.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**65.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**95.00**	99231x **0.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**20.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32666	090	14.50	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32673	090	21.13	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
27216	090	15.73	**RUC Time**

CPT Descriptor Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 20.7 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 18.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 33269	Top Key Reference CPT Code: 32666	2nd Key Reference CPT Code: **32673**
Median Pre-Service Time	72.00	75.00	75.00
Median Intra-Service Time	65.00	75.00	150.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	95.0	75.00	115.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	23.0	39.00	39.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	20.0	0.00	0.00
Median Total Time	**343.00**	**332.00**	**447.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	31%	56%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	19%	25%	56%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	25%	69%
Physical effort required	6%	50%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	25%	75%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	50%	36%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	36%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	7%	71%	21%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	36%	64%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 5 includes 3 new codes that represent surgical exclusion of the left atrial appendage (LAA). Surgical exclusion of the left atrial appendage is integral to and should not be separately reported with the Maze (33254–33259, 33265-33266) or the surgical mitral valve repair or replacement procedures (33420, 33422, 33425, 33426, 33427, 33430). There is an existing code for percutaneous LAA closure, 33440 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left*

atrial appendage angiography, when performed, and radiological supervision and interpretation. The three new codes represent new technology and surgical techniques that may be used to treat atrial fibrillation at the time of another surgical procedure (other than Maze or mitral valve repair or replacement) that involves an approach via median sternotomy or thoracotomy or as a stand-alone procedure performed via median sternotomy, thoracotomy or thoracoscopy where the left atrial appendage is excluded by any method which may include excision, isolation via stapling, oversewing, ligation, plication or application of a clip.

Rationale 33269

Code 33269 is a 90-day global procedure that represents a stand-alone procedure to exclude the left atrial appendage thoracoscopically.

Pre-Time Package 4

Pre-Time Changes:
The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 42 minutes): For the evaluation, the Expert Panel is recommending a 2-minute increase in time over the package for a total evaluation time of 42 minutes. This is supported by the survey data with 42 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the education efforts that go into each case. The additional evaluation time of 2 minutes accounts for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure, including the planned approach, method of LAA exclusion and the associated aftercare. The surgeon reviews the preoperative echocardiogram to evaluate the preoperative flow in the LAA which will be compared to the intraoperative TEE upon LAA exclusion to ensure there is no blood flow in a LAA stump. The surgeon will explain the different methods of exclusion (excision, isolation via stapling, oversewing, ligation, plication or application of a clip) that may be used to exclude the LAA. The Expert Panel felt that adding 2 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the work for pre-service evaluation involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is typical for thoracoscopic procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent positioning the patient for a left-sided thoracoscopy.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 30 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 3-minute decrease in time over the package for a total immediate post time of 30 minutes, which is supported by the median immediate post-service time from the survey.

Intensity and complexity of the procedure: 77 surveys were completed by a random sample of 850 US self-identified cardiac surgeons. 16 respondents selected code 32666, *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* as a reference code making it the 1st key reference service (KRS). That code has a lower value than the 25th percentile and the median RVWs from the survey code, with a longer intraservice time and a shorter total time then the survey code. In their intensity/complexity comparison, the survey respondents indicated that the survey code was more or somewhat more complex than 32666 for all of the intensity/complexity measures except the physical effort required. For the physical effort required, 50% of the respondents indicated that the intensity/complexity of the survey code was identical and 44% indicated that the physical effort required was more complex than the 1st KRS code. 14 respondents selected code 32673 *Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral* as a reference code making it the 2nd KRS. This code has a higher value than the 25th percentile from the survey and a lower value than the median RVW from the survey with a longer intraservice and total service time. In their intensity/complexity

comparison, the f the survey respondents indicated that the survey code was identical or somewhat more complex than 32673 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33269 (thoracoscopic exclusion of the left atrial appendage) has a median intra-operative time of 65 minutes. 100% of the survey respondents indicated that that procedure is performed in the hospital and 94% of the respondents indicated that the patient has an overnight say of more than 24 hours. 56% of the respondents indicated that they provided a 99233 E/M visit the same day of the procedure. The survey showed a 2-day hospital LOS with one 99232 level visit and a 99238 for discharge day management services. The survey also supported one 99224 subsequent observation care visit. The Expert Panel felt that the survey accurately represented the hospital length of stay, the level of subsequent hospital visits and the level of discharge day management services. However, the Expert Panel did not agree that there was one subsequent observation care visit associated with the procedure and are not recommending that an observation care visit be added to the global period. The survey also supported one 99213 office visit after the patient is discharged from the hospital.
The Expert Panel felt that the 25th percentile RVW of 18.00 with 65 minutes of intra-time, 323 minutes of total time and an IWPUT of 0.158 was too high for the procedure compared to other procedures in the RUC database. In looking at other codes with similar intra-service and total times, the Expert Panel felt that code 27216 *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)* with an RVW of 15.73, an intra-service time of 60 minutes (5 minutes less than the survey code), a total time of 393 (70 minutes more than the survey code) and IWPUT 0.088 compared to the survey IWPUT of 0.123 is reasonable crosswalk code to value the procedure. The survey code is a more invasive procedure with a slightly higher intra-service time. Although the survey code has a shorter LOS, the in-hospital visit pattern is more complex with 99233 and 99232 level visits for the survey code compared to 99232 and 99231 level visits for the crosswalk code. The Expert Panel feels that the procedure represented by the survey code is more intense than the crosswalk code and this supports the recommended RVW even though the total time of the crosswalk code is greater than that of the survey code. This RVW also fits well with the recommended RVW, time and IWPUT compared to the open code.

For code 33269, the Expert Panel is recommending a work RVW of 15.73 with a median intra-service time of 65 minutes, a total time of 323 minutes and an IWPUT of 0.123 based on a crosswalk to code 27216. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 72 minutes. Immediate post-service time package 9b was selected with recommended decrease of 3- minutes based on the survey for a total time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 414
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on a review of the 2016 Part A discharge data and vendor data, it is estimated that 6000 surgical LAA exclusions outside of Maze and mitral valve procedures are performed nationally per year in heart centers around the country. Of those, approximately 70% (4200) are performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268). Of the 1800 stand-alone procedures performed nationally per year, it is estimated that 77% (1386) are performed using the open technique (33267) and 23% (414) are performed thoracoscopically (33269).

Specialty Cardiothoracic Surgery Frequency 414 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 276
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the surgical LAA procedures are performed in Medicare patients with an estimated 2800 add-on surgical LAA exclusions performed with cardiac or thoracic procedures other than Maze or mitral valve repair/replacement (33268), 924 stand-alone open LAA exclusions (33267) and 276 thoracoscopic LAA exclusions. .

Specialty Cardiothoracic surgery Frequency 276 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32665

SS Rec Summary

ISSUE: Exclusion of Left Atrial Appendage

TAB: 5

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	32666	90	Thoracoscopy, surgical; with th	11	0.092			14.50			332	40	20	15			75			30			1		1	1.0						1	1							
2nd REF	33030	90	Pericardiectomy, subtotal or co	9	0.074			36.00			739	40	20	3			180			45	2		2	2	1	1.0					1	1							
CURRENT					#DIV/0!						0																												
SVY	33267	90	Exclusion of left atrial appenda	73	0.118	5.00	18.50	23.15	28.46	39.00	441	45	10	15	2	60	90	110	240	30	1			2		1.0			1				1				0	0	1	3	100
REC 25th	33267	90	Exclusion of left atrial appendage, ope		0.077			18.50			401	45	10	15			90			30	1			2		1.0							1							

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	32666	90	Thoracoscopy, surgical; with th	16	0.092			14.50			332	40	20	15			75			30			1		1	1.0						1	1							
2nd REF	32673	90	Thoracoscopy, surgical; with re	14	0.081			21.13			447	40	15	20			150			30			1	1	1	1.0						1	1							
CURRENT					#DIV/0!						0																												
SVY	33269	90	Exclusion of left atrial appenda	77	0.204	6.00	18.00	21.50	25.00	40.00	343	42	15	15	5	50	65	90	240	30			1	1		1.0			1				1				0	1	5	10	100
REC	33269	90	Exclusion of left atrial appendage, tho		0.102			14.31			323	42	15	15			65			30			1	1		1.0						1								
crosswalk code	33020	90	Pericardiotomy for removal of c		0.104			14.31			321	30	10	15			60			30			1	1	1	1.0						1								

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	32507	ZZZ	Thoracotomy; with diagnostic v	12	0.100			3.00			30						30																								
2nd REF	34714	ZZZ	Open femoral artery exposure w	10	0.101			5.25			52						52																								
CURRENT					#DIV/0!						0																														
SVY	33268	ZZZ	Exclusion of left atrial appenda	93	0.438	2.50	5.15	8.75	16.00	35.00	20				2	11	20	60	296																		0	6	15	20	190
REC	33268	ZZZ	Exclusion of left atrial appendage, ope		0.125			2.50			20						20																								

FACILITY DIRECT PE INPUTS **CPT CODE(S): 33267, 33269, 33268**

SPECIALTY SOCIETY(IES): STS/AATS

PRESENTER(S):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2020

CPT Code	Long Descriptor	Global Period
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	090

CPT Code	Long Descriptor	Global Period
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	090

CPT Code	Long Descriptor	Global Period
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
33267	A 75-year-old male who is status post left lung resection presents with persistent atrial fibrillation and CHADS2 (stroke risk) score of 4. Recurrent, significant GI bleeding episodes preclude anticoagulation therapy. He is deemed a poor candidate for LAA endovascular occlusion device. Because of anticipated dense adhesions within the left chest cavity, a thoracoscopic approach is contraindicated and an open approach to left atrial appendage exclusion (eg, ligation, plication, clip) is recommended.

CPT Code	Vignette
33269	An 85-year-old female with persistent atrial fibrillation has undergone numerous electrophysiologic procedures in the past and was deemed a poor candidate for endovascular LAA occlusion device. Thoracoscopic LAA exclusion (eg, ligation, plication, clip) is recommended.

CPT Code	Vignette
33268	A 50-year-old female with severe peripheral vascular disease, bicuspid aortic valve with severe stenosis but undergoes surgical aortic valve replacement and surgical LAA exclusion (eg, ligation, plication, clip).

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Expert Panel comprised of RUC Advisors and clinical experts representing settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

The reference code selected for 33267 is 33202 Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach. This code was selected as the reference code because it represents a cardiac procedure that requires clinical staff time, supplies and equipment that are similar to the survey code.
The reference code selected for code 33269 is 32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral. This code was selected as the reference code because it represents a thoracoscopic procedure that requires clinical staff time, supplies and equipment that are similar to the survey code.
Survey respondents selected 32666 as the 1st KRS for both 33267 and 33269. 33030 Pericardiectomy, subtotal or complete; without cardiopulmonary bypass was the 2nd KRS selected for 33267. The Expert Panel felt that 33202 is a better practice expense reference code for 33267 then either of the KRS codes because it is a cardiac procedure that also allows for multiple approaches with similar practice expense inputs. Code 33030 had more clinical staff time and different equipment and supplies then those required by 33267 and as such the Expert Panel felt that it was not a good reference code for the practice expense.

3. Is this code(s) typically reported with an E/M service?

No, codes 33267 and 33269 will not typically be billed with an E/M service

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

The clinical staff pre-service work includes completion of pre-service diagnostic and referral forms, for the procedure. Coordination of pre-surgery services and diagnostic tests, which may include chest x-rays, CT Scan, MRI, aortogram and TEE and any laboratory studies if avaiable. The clinical staff must also coordinate with the other specialists that will be needed to diagnose and perform the procedure, this will include, at a minimum coordination with neurology, anesthesia, assistant surgeon, the ICU, cardiology for the TEE, and perfusion. The clinical staff will schedule the operating room and ensure that all necessary equipment, including for cardiopulmonary bypass. Clinical staff will also provide education to the patient on the procedure, including the possibility of using cardiopulmonary bypass, the planned surgical approach or alternative approaches based on findings once the procedure is initiated, the planned method of left atrial appendage (LAA) exclusion the expected post-operative course and obtain consent from the patient. The clinical staff will also complete any pre-procedure phone calls to patient verifying time pre op instruction and verify all pre-operative prescriptions medications to take/not take .

   b. Service period (includes pre, intra and post):

The procedure includes a several day hospital stay with a 99238 discharge day management service with 12 minutes of clinical staff time allocated to standards for assisting in discharge day management, which may include coordination of post-operative prescriptions, appointments, coordination with other physicians.

   c. Post-service period:

There is one post-operative E/M visit in the post-service period. The clinical staff work includes the standard activities involved in any post-operative E/M visit including ensuring the appropriate supplies are available in the room, rooming the patient, gowning, reviewing current medications/allergies in EHR, obtaining vital signs, assisting with wound care, coordination of care, and cleaning of the room.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**2.1122**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (suture & staple)	**SA053**	**pack**		**5.95**
kit, staple removal		kit	1	
kit, suture removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF023 – Table, exam - office visits
EF014 – Light, surgical – office visits

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

FACILITY DIRECT PE INPUTS **CPT CODE(S): 33267, 33269, 33268**

SPECIALTY SOCIETY(IES): STS/AATS

PRESENTER(S):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The majority of offices of our specialty utilize RN's or advance practice providers (PA's or NP's) because of the complexity of triaging outpatient care for cardiac surgery patients. Since CMS does not recognize PAs or NPs as clinical staff, the RN level has been traditionally accepted. This is a long-standing standard and is consistent in the family of cardiothoracic surgery codes that are not typically performed by multiple specialties. Codes 33267, 33268 and 33269 are all performed by cardiothoracic surgeons and would not be considered a multi-specialty procedure.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	H	L	N	R	S
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**	**RECOMMENDED**	**REFERENCE CODE**	**RECOMMENDED**	**RECOMMENDED**
2						**33202**	**33267**	**32666**	**33269**	**33268**
3		***RUC Collaboration Website***								
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 5 Specialty: STS, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Insertion of electrodes to outer layer of heart, open procedure	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)
5		**LOCATION**				**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**				**90**	**90**	**90**	**90**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 64.77**	**$ 64.42**	**$ 82.21**	**$ 64.42**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L051A	RN	0.51	**108.0**	**108.0**	**135.0**	**108.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51	**60.0**	**60.0**	**60.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A	RN	0.51	**12.0**	**12.0**	**12.0**	**12.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51	**36.0**	**36.0**	**63.0**	**36.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 55.08**	**$ 55.08**	**$ 68.85**	**$ 55.08**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L051A	RN	0.51	5	5	5	5	
16	CA002	Coordinate pre-surgery services (including test results)	L051A	RN	0.51	20	20	20	20	
17	CA003	Schedule space and equipment in facility	L051A	RN	0.51	8	8	8	8	
18	CA004	Provide pre-service education/obtain consent	L051A	RN	0.51	20	20	20	20	
19	CA005	Complete pre-procedure phone calls and prescription	L051A	RN	0.51	7	7	7	7	
20	CA006	Confirm availability of prior images/studies	L051A	RN	0.51					
21	CA007	Review patient clinical extant information and	L051A	RN	0.51					
30		**SERVICE PERIOD**								
59		**Post-Service (of service period)**								
74	CA036	Discharge day management	L051A	RN	0.51	**12**	**12**	**12**	**12**	
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L051A	RN	0.51					
85	CA038	Coordinate post-procedure services	L051A	RN	0.51					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27					1		
89		99213 36 minutes	36			1	1	1	1	
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L051A	RN	0.51	**36.0**	**36.0**	**63.0**	**36.0**	**0.0**
99		**End: with last office visit before end of global period**								
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 8.87**	**$ 8.87**	**$ 11.95**	**$ 8.87**	**$ -**
102	SA048	pack, minimum multi-specialty visit	3.0815	pack		1	1	2	1	
103	SA053	pack, post-op incision care (suture & staple)	5.79	pack		1	1	1	1	
104										
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 0.82**	**$ 0.47**	**$ 1.41**	**$ 0.47**	**$ -**
113	EF031	table, power	6030.195	Office Visits	0.01600249	36		63		
114	EF023	table, exam	3037.9485	Office Visits	0.00675759	36	36		36.0	
115	EF014	light, surgical	2872.8985	Office Visits	0.00639046		36	63	36.0	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2020

Harvest of Upper Extremity Artery, Endoscopic and Open – Tab 6

In May 2020, the CPT Editorial Panel created CPT code 33509 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic* to describe endoscopic radial artery harvest via an endoscopic approach and CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open* was modified to only include an open approach for the upper extremity harvesting procedure.

33509 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic*
The RUC reviewed the specialty societies' recommended work RVU of the survey 25th percentile of 5.63 from 39 cardiothoracic surgeons and concurred that the survey respondents overestimated the work involved in performing this service. The RUC agreed that a direct work RVU crosswalk to CPT code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* (work RVU= 4.04, intra-service and total time of 45 minutes) was appropriate, noting that both codes involve an identical amount of physician time and work to perform. The RUC recommends interim intra-service time of 45 minutes for CPT code 33509.

The specialty societies explained the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their National Provider Identifier (NPI) number. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the January 2021 RUC meeting to include these providers who are potentially the dominant providers. **The RUC recommends an interim work RVU of 4.04 for CPT code 33509.**

35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open*
The RUC rejected the specialty societies' initial recommendation to maintain the current work RVU of 4.94 for CPT code 35600, noting that the IWPUT associated with this work RVU value would be higher than the CABG procedure itself. The RUC agreed that a direct work RVU crosswalk to CPT code 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)* (work RVU= 3.73, intra-service time of 40 minutes, total time of 42 minutes) is appropriate, noting that both codes require similar intra-service times and identical total time and an identical amount of physician work. The RUC recommends interim time of 42 minutes intra-service.

The specialty societies explained that the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would

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allow the individual who performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the next meeting to include the providers that are potentially the dominant providers. **The RUC recommends an interim work RVU of 3.73 for CPT code 35600.**

Practice Expense
CPT codes 33509 and 35600 are typically performed in the facility setting and do not have any direct practice expense inputs.

Modifier-51 Exempt Status
CPT codes 33509 and 35600 are recommended to be placed on the Modifier -51 Exempt list, as these services are performed a large majority of the time with a coronary artery bypass procedure, though typically it is a separate provider (such as an NP or PA) that is performing the harvest of upper extremity artery procedure and therefore would be reporting 33509 or 35600 as a standalone code on a separate claim.

New Technology
CPT codes 35600 and 33509 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cardiovascular System **Heart and Pericardium** **Endoscopy**				
		To report endoscopic harvesting of a vein for coronary artery bypass procedure, use 33508 in addition to the code for the associated bypass procedure. To report endoscopic harvesting of an upper extremity artery for a bypass procedure, use 33509.		
		Surgical vascular endoscopy always includes diagnostic endoscopy.		
+33508		*Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)* *(Use 33508 in conjunction with 33510-33523)* *(For open harvest of upper extremity vein procedure, use 35500)*		

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●33509	B1	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic (For open harvest of upper extremity artery, use 35600) (For bilateral procedure, report 33509 with modifier 50)	XXX	4.04 (Interim Recommendation and Resurvey for January 2021)

Heart and Pericardium
Combined Arterial-Venous Grafting for Coronary Bypass

The following codes …

To report combined arterial-venous …

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 33509 or 35600 ~~in addition to the bypass procedure~~. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see ~~*33990-3399*~~*33990, 33991, 33992, 33993, 339X1, 339X2.*

✚*33517* *Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)*

(Use 33517 in conjunction with 33533-33536)

Arterial Grafting for Coronary Artery Bypass

The following codes …

To report combined …

Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 33509 or 35600 ~~in addition to the bypass procedure~~. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see ~~*33990-3399*~~*33990, 33991, 33992, 33993, 339X1, 339X2.*

33533 *Coronary artery bypass, using arterial graft(s); single arterial graft*

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Arteries and Veins **Bypass Graft** **Other Than Vein**				
▲35600	B2	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open ~~(List separately in addition to code for primary procedure)~~ ~~(Use 35600 in conjunction with 33533–33536)~~ (For bilateral procedure, report 35600 with modifier 50) (For endoscopic approach, see 33509, 33508, 37500)	XXX ~~ZZZ~~	3.73 (Interim Recommendation and Resurvey for January 2021)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33509 Tracking Number B1 Original Specialty Recommended RVU: **5.63**
Presented Recommended RVU: **5.63**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **4.04**

CPT Descriptor: Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male presents to the emergency room with unstable angina. He has history of coronary artery bypass graft (CABG). Cardiac catheterization reveals multivessel disease requiring several grafts. He is an acceptable candidate for re-operation CABG. Saphenous vein conduit is limited because of prior CABG and only a small segment available. The left internal mammary artery was used for the previous CABG but the right internal mammary artery is available. The left radial artery in this right-handed individual is evaluated and appropriate for endoscopic harvesting and use for coronary artery bypass grafting

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: At the time of CABG procedure (reported separately), the radial artery is typically harvested simultaneously while other conduits are also being harvested. The arm is positioned on a surgical arm board, a tourniquet is placed high on the upper arm in anticipation of later inflation. The appropriate endoscopic equipment is set up and tested. A continuous nitroglycerin intravenous infusion is begun to prevent spasm of the radial artery. A 3 cm longitudinal incision is made proximal to the wrist crease over the radial artery. The radial artery is identified by dissection and clamped. Pulse oximetry on the index finger is checked to assess integrity of the arterial palmar arch and the adequacy of ulnar artery flow while the radial artery is clamped. The forearm is then wrapped tightly with an Esmark bandage distal to proximal in order to evacuate the blood. The tourniquet is then inflated to 75-100 mmHg over systolic blood pressure, not exceeding 250 mmHg total, and the Esmark bandage removed. The radial artery is dissected as a pedicle with the accompanying venae comitantes and the endoscope advanced over the anterior pedicle enough to allow insertion of the port. The trocar port is inflated and CO2 is insufflated at a pressure of 10- 12 mmHg with a flow rate of 3-5 L/min creating a working tunnel. The endoscope is advanced to perform the anterior dissection along the pedicle, taking care to secure veins on each side of the radial artery. This is performed while minimizing any contact with the artery, itself. The dissection is continued to the level of the recurrent radial artery or venous plexus in the antecubital fossa being careful to avoid all nerves and larger vessels. The endoscope is withdrawn back to the port, and then advanced posteriorly to the radial artery pedicle. The posterior arterial branches are dissected to the level of the recurrent radial or venous plexus in the antecubital fossa. The endoscope is again withdrawn to the port and then advanced laterally for similar dissection. Fasciotomy of the brachioradialis muscle is performed to enhance visualization by opening up the working tunnel using sharp dissection and applying energy from an appropriate power supply (electrocautery) to cut the tissue. Extreme caution is used to avoid untoward thermal injury to neural or vascular tissues during bracheoradialis fasciotomy. The fascia is released from the distal forearm to the mid or proximal forearm. With the fasciotomy complete, arterial branches are divided using the power source by working proximal to distal. Pulse oximetry on the thumb is rechecked. Before dividing the radial artery, a soft non-occluding clamp is placed across the dissected but still intact radial artery and palpation of the ulnar artery is performed to be certain that there is adequate blood supply to the hand. Only after adequacy of ulnar artery

flow is confirmed, is the radial artery pedicle divided, ligated and then withdrawn in a retrograde fashion externally through the port. The port is withdrawn and the radial artery is divided and ligated at the wrist area using standard technique. The tourniquet is deflated and removed. The wound is carefully inspected for hemostasis. The fascia and subcutaneous tissues at the wrist are closed in two layers using absorbable sutures, and the skin is closed by a subcuticular method using monofilament absorbable sutures. The arm is wrapped and a methylene blue marking pen is used to score the vein on its anterior surface. The radial artery is soaked and flushed with papaverine and heparinized patient blood. The entire length of the radial artery is checked while flushing it with the heparinized blood and branches are carefully clipped or tied per routine.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	James Levett, MD; Stephen Lahey, MD; Joseph Turek, MD; Jacob Schroder, MD; Kirk Kanter, MD; Prashanath Vallabhajosyula, MD; Richard Freeman, MD					
Specialty Society(ies):	STS; AATS					
CPT Code:	33509					
Sample Size:	850	**Resp N:**	39			
Description of Sample:	Random sample of 850 US self-identified cardiac surgeons					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	17.00	200.00
Survey RVW:	4.00	5.63	**7.19**	8.33	16.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	30.00	**45.00**	60.00	95.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	33509	**Recommended Physician Work RVU: 4.04**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34716	ZZZ	7.19	**RUC Time**

CPT Descriptor Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33987	ZZZ	4.04	**RUC Time**

CPT Descriptor Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
61642	ZZZ	8.66	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 28.2 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 17.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 33509	Top Key Reference CPT Code: 34716	2nd Key Reference CPT Code: **33987**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	72.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**72.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	27%	55%	18%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	18%	73%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	9%	27%	64%
Physical effort required	0%	55%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	45%	55%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	57%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	43%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	57%	43%
Physical effort required	0%	71%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	29%	57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 6 includes 2 codes that represent harvest of an upper extremity artery, typically the radial artery, that is used as an arterial conduit for coronary artery bypass grafting (CABG). Code 35600 is for harvest of an upper extremity artery using an open technique and the new code 33509 is for harvest of an upper extremity artery using an endoscopic technique. Endoscopic harvest of the upper extremity represents a new technology that is currently reported using the unlisted cardiac surgery code (33999), the unlisted vascular surgery code (37799) or the unlisted vascular endoscopy code (37501).

The radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure and in patients where the intrathoracic arteries have already been used and/or the patient has limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent emerging studies appear to indicate that use of radial-artery grafts for coronary-artery bypass grafting (CABG) may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

The existing code 35600, was originally developed as an add-on code since the radial artery is typically only harvested for use in conjunction with an arterial CABG procedure. Over the years, in order to streamline CABG procedures, the radial artery conduit is typically harvested simultaneously while other conduits are also being harvested. The radial artery harvest may be performed by the surgeon performing the CABG procedure or an assistant at surgery, who may be another physician, a physician assistant (PA) or a nurse practitioner (NP). The individual harvesting the radial artery may be the 1st assistant at surgery, however more typically, it is an MD or APP that specializes in harvesting the peripheral arterial and venous conduits for the CABG procedures. Since the procedure has evolved in this manner, the specialty societies felt that it would be more appropriate to have an XXX global period assigned to the upper extremity artery harvest procedures even though the procedures are almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536). Assigning this global period to the procedures allows the individual that performs the procedure to report it under their NPI, which will allow for appropriate tracking and reimbursement for the radial artery harvest procedures. Any preoperative and postoperative care associated with the radial artery harvest is typically subsumed in the global of the CABG procedure with the primary surgeon providing any associated pre and post-operative care related to the upper extremity artery harvest, including postoperative care of the surgical excision site. Based on these factors, the two upper extremity radial artery harvest codes were assigned an XXX global period, but were surveyed as ZZZ global procedures accounting for only the intra-operative time associated with the procedures. Since the procedures account for the intra-operative time only, there are no direct practice expense inputs for the procedures.

33509

Intensity and complexity of the procedure: 39 surveys were completed by a random pool of 850 US self-identified cardiac surgeons. 11 respondents selected code 34716 *Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 1st key reference service (KRS). That code has a higher value, and a longer intraservice and total time then the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code was identical or somewhat more complex than 34716 for all of the intensity/complexity measures. 7 respondents selected code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* as a reference code making it the 2nd KRS. This code has a lower value with the same intraservice and total service time as the survey code. The respondents ranged in their intensity/complexity comparison saying that the survey code is identical to or somewhat more complex than 33987 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33509 (endoscopic upper extremity artery harvest) shows that the median intra-operative time is 45 minutes. The 25th percentile RVW from the survey was 5.63 and the median RVW from the survey was 7.19. The Expert Panel reviewed the survey data and are recommending the 25th percentile RVW of 5.63 and the median intra-service time of 45 minutes and an IWPUT of 0.125. The 1st KRS has a longer intraservice time and higher RVW than the survey code with an IWPUT of 0.100. The 2nd KRS has a slightly lower RVW and the same intraservice time as the survey code with and IWPUT of 0.090. The expert panel felt that the 25th percentile RVW of 5.63 for the survey codes is representative of the increased intensity over the open code and the 2nd KRS. The higher intensity/complexity of the survey code is related to the increased mental effort and judgement and psychological stress related to the procedure. The 2nd KRS represents a procedure where an artery is exposed and a graft is sewn onto the exposed artery to create a conduit to facilitate ECMO. Upon the conclusion of the ECMO, the graft is resected and the arterial exposure is oversewn. The survey code represents a procedure where a segment of the radial artery is harvested. This requires careful consideration to avoid injury of the surrounding neural and vascular tissues. In addition, there are numerous arterial branches that must be identified and clipped to achieve hemostasis after the artery is harvested. Identification of the small arterial branches is more difficult using the endoscope with indirect video then it is for the open radial artery harvest procedure. The arterial branches are much easier to identify in the open radial artery harvest procedure 35600 since it is performed under direct visualization and a harmonic scalpel is frequently used to seal the branches while harvesting. This reduces the need to clip vessels after removing the artery from the arm as is required in the endoscopic technique 33509. The same considerations are not required for either of the KRS codes since there is no extensive arterial mobilization, dissection or resection involved in those procedures.

While the intraservice time for 33509 is only 3 minutes longer than that of 35600 (45 minutes vs 42 minutes), the time spent on wound closure of the open procedure, that has a much larger incision and operative field, is significantly longer than that required to close the small “endoscopic” incision. This, therefore, means that the time made up by having a smaller incision to close is offset by the significantly longer time to dissect, mobilize, and resect the radial artery endoscopically. This combination of circumstances

contributes to the increased intensity /complexity of the endoscopic upper extremity artery harvest procedure compared to both KRS codes and the open upper extremity artery harvest code (35600).

The Expert Panel is recommending the 25th percentile work RVW of 5.63, with a median intra-service time of 45 minutes, and total time of 45 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is valued as an add-on code, but it is desiganged as an XXX global because the procedure is typically performed by an NP or PA (typically from the same practice). The upper extremity artery is harvested by the NP/PA simultaneously with the surgeon performs the sternal approach. There may be another MD/PA/NP that acts as a 1st assistnat at surgery for the rest of the case. The follow-up care for the entire procedure, including the post-op care for the upper extremity artery harvest, is provided by the surgeon.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

25th CPT	Desc	global	work rvu	pre time	intra time	post time	Tot tim
33533	CABG 1 artery	090	33.75	95	158	429	682
33530	Reop CABG	ZZZ	10.13		70	42.4	112.4
33518	CABG 2 Vein	ZZZ	7.93		50	62.6	112.6
33508	EVH	ZZZ	0.31		10		10
33509	Endo UEAH	XXX	5.63		45		45
Total			57.75	95	333	534	962

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999, 37501 or 37799

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2834
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

It is estimated that 2/3 of the total CABG procedures per year are performed for Medicare patients, so the estimated number of radial artery harvest procedures peformed natinally is 6501. Of those, 3666 will be performed using an open technique and 2834 of them will be perfromed endoscopically

Specialty Cardiothoracic Surgery Frequency 2834 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,890
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

The estimated number of radial artery harvest procedures peformed for Medicare is 4334. Of those, 2444 will be performed using an open technique and 1890 of them will be perfromed endoscopically.

Specialty cardiothoracic surgery Frequency 1890 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-CABG

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 35600

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:35600 Tracking Number B2 Original Specialty Recommended RVU: **4.94**
Presented Recommended RVU: **4.94**
Global Period: XXX Current Work RVU: **4.94** RUC Recommended RVU: **3.73**

CPT Descriptor: Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male presents to the emergency room with unstable angina. He has history of CABG. Cardiac catheterization reveals multivessel disease requiring several grafts. He is an acceptable candidate for re-operation CABG. Saphenous vein conduit is limited because of prior CABG and only a small segment available. The right internal mammary artery is available, the left radial artery in this right-handed individual is evaluated and appropriate for open harvesting and use for coronary artery bypass grafting.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: At the time of CABG procedure (reported separately), the radial artery is typically harvested simultaneously while other conduits are also being harvested. A continuous intravenous nitroglycerin infusion is begun to prevent spasm of the radial artery. The radial artery is harvested simultaneously by making a curvilinear incision at the edge of the hairline of the left forearm following the brachioradialis muscle lateral to the biceps tendon and down to a midway point between the tendon of the flexor carpi radialis muscle and the radial styloid at the wrist crease. Hemostasis is obtained using a Bovie needle coagulator or a harmonic scalpel and dissection continues being careful to avoid nerves and larger vessels. The fascia between the bellies of the brachioradialis and flexor carpi radialis muscle is then divided. The radial artery is visualized and dissected beginning at the middle of the forearm proximally with the venous vascular pedicle kept intact. The vasa vasorum of the radial artery are then divided posteriorly using the harmonic scalpel or silk sutures proximally and metallic clips distally. As the dissection approaches the wrist, there are usually numerous small vessels that required meticulous identification and separation. Pulse oximetry on the thumb is rechecked. Before dividing the radial artery, a soft non-occluding clamp is placed across the dissected but still intact radial artery and palpation of the ulnar artery is performed to be certain that there is adequate blood supply to the hand. Only after adequacy of ulnar artery flow is confirmed, is the radial artery pedicle ligated and divided. The wound is inspected for hemostasis and the artery is ligated and divided. The fascia and subcutaneous tissues are closed in two layers using absorbable sutures, and the skin is closed by a subcuticular method using monofilament absorbable sutures. The arm is wrapped and a methylene blue marking pen is used to score the vein on its anterior surface. The radial artery is soaked and flushed with papaverine and heparinized patient blood. The entire length of the radial artery is checked while flushing it with the heparinized blood and branches are carefully clipped or tied per routine.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	James Levett, MD; Stephen Lahey, MD; Joseph Turek, MD; Jacob Schroder, MD; Kirk Kanter, MD; Prashanath Vallabhajosyula, MD; Richard Freeman, MD					
Specialty Society(ies):	STS; AATS					
CPT Code:	35600					
Sample Size:	850	**Resp N:**	44			
Description of Sample:	Random sample of 850 US self-identified cardiac surgeons					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	10.00	100.00
Survey RVW:	3.00	5.00	**7.00**	8.00	14.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	30.00	**42.00**	56.25	95.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	35600	**Recommended Physician Work RVU: 3.73**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**42.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34716	ZZZ	7.19	**RUC Time**

CPT Descriptor Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33987	ZZZ	4.04	**RUC Time**

CPT Descriptor Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
	090	4.25	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 18.1 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 15.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 35600	Top Key Reference CPT Code: 34716	2nd Key Reference CPT Code: 33987
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	42.00	72.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**42.00**	**72.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	38%	50%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	50%	38%
Physical effort required	13%	38%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	57%	43%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	57%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	29%	57%
Physical effort required	14%	57%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	29%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 6 includes 2 codes that represent harvest of an upper extremity artery, typically the radial artery, that is used as an arterial conduit for coronary artery bypass grafting (CABG). Code 35600 is for harvest of an upper extremity artery using an open technique and the new code 33509 is for harvest of an upper extremity artery using an endoscopic technique. Endoscopic harvest of the upper extremity represents a new technology that is currently reported using the unlisted cardiac surgery code (33999), the unlisted vascular surgery code (37799) or the unlisted vascular endoscopy code (37501).

The radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure and in patients where the intrathoracic arteries have already been used and/or the patient has limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent emerging studies appear to indicate that use of radial-artery grafts for coronary-artery bypass grafting (CABG) may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

The existing code 35600, was originally developed as an add-on code since the radial artery is typically only harvested for use in conjunction with an arterial CABG procedure. Over the years, in order to streamline CABG procedures, the radial artery conduit is typically harvested simultaneously while other conduits are also being harvested. The radial artery harvest may be performed by the surgeon performing the CABG procedure or an assistant at surgery, who may be another physician, a physician assistant (PA) or a nurse practitioner (NP). The individual harvesting the radial artery may be the 1st assistant at surgery, however more typically, it is an MD or APP that specializes in harvesting the peripheral arterial and venous conduits for the CABG procedures. Since the procedure has evolved in this manner, the specialty societies felt that it would be more appropriate to have an XXX global period assigned to the upper extremity artery harvest procedures even though the procedures are almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536). Assigning this global period to the procedures allows the individual that performs the procedure to report it under their NPI, which will allow for appropriate tracking and reimbursement for the radial artery harvest procedures. Any preoperative and postoperative care associated with the radial artery harvest is typically subsumed in the global of the CABG procedure with the primary surgeon providing any associated pre and post-operative care related to the upper extremity artery harvest, including postoperative care of the surgical excision site. Based on these factors, the two upper extremity radial artery harvest codes were assigned an XXX global period, but were surveyed as ZZZ global procedures accounting for only the intra-operative time associated with the procedures. Since the procedures account for the intra-operative time only, there are no direct practice expense inputs for the procedures.

35600

Intensity and complexity of the procedure: 44 surveys were completed by a random pool of 850 US self-identified cardiac surgeons. 8 respondents selected code 34716 *Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 1st key reference service (KRS). That code has a higher value, and a longer intraservice and total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code was identical or somewhat more complex than 34716 for all of the intensity/complexity measures. 7 respondents selected code 33987 *(Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* as a reference code making it the 2nd KRS. This code has a lower value with a slightly longer intraservice and total service time then the survey code. The respondents ranged in their intensity/complexity comparison saying that the survey code is identical to or somewhat more complex than 33987 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 35600 (open upper extremity artery harvest) shows that the median intra-operative time is 42 minutes. The current intra-service time for this procedure is 40 minutes. The current RVW for the code is 4.94. The 25th percentile RVW from the survey was 5.00 and the median RVW from the survey was 7.00. The Expert Panel reviewed the data recognizing that there was a 2 minute increase in intra-work time from the current time, but determined that there is no compelling evidence to support an increase in the RVW.

The Expert Panel is recommending the current work RVW of 4.94, with a median intra-service time of 42 minutes, and total time 42 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) This procedure is valued as an add-on code, but it is desiganged as an XXX global because the procedure is typically performed by an NP or PA (typically from the same practice). The upper extremity artery is harvested by the NP/PA simultaneously with the surgeon performs the sternal approach. There may be another MD/PA/NP that acts as a 1st assistnat at surgery for the rest of the case. The follow-up care for the entire procedure, including the post-op care for the upper extremity artery harvest, is provided by the surgeon.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT	Desc	global	work rvu	pre time	intra time	post time	Tot tim
33533	CABG 1 artery	090	33.75	95	158	429	682
33530	Reop CABG	ZZZ	10.13		70	42.4	112.4
33518	CABG 2 Vein	ZZZ	7.93		50	62.6	112.6
33508	EVH	ZZZ	0.31		10		10
35600	ORAH	XXX	4.94		45		42
Total			57.06	95	330	534	959

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35600

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3366
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

It is estimated that 2/3 of the total CABG procedures per year are performed for Medicare patients, so the estimated number of radial artery harvest procedures peformed natinally is 6501. Of those, 3666 will be performed using an open technique and 2834 of them will be perfromed endoscopically.

Specialty Cardiothoracic Surgery Frequency 3366 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,444
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

The estimated number of radial artery harvest procedures peformed for Medicare is 4334. Of those, 2444 will be performed using an open technique and 1890 of them will be perfromed endoscopically.

Specialty Cardiothoracic Surgery Frequency 2444 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-CABG

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 35600

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Harvest of Upper Extremity Artery

TAB: 6

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	34716	ZZZ	Open axillary/subclavian artery (	11	0.100			7.19			72						72																			
2nd REF	33987	ZZZ	Arterial exposure with creation (	7	0.090			4.04			45						45																			
SVY	33509	XXX	Harvest of upper extremity arter	39	0.160	4.00	5.63	7.19	8.33	16.00	45				5	30	45	60	95													0	0	5	17	200
INTERIM REC	33509	XXX	Harvest of upper extremity artery, 1 se		0.090			4.04			45						45																			
REC crosswalk	33987	ZZZ	Arterial exposure with creation of graft		0.090			4.04			45						45																			

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	34716	ZZZ	Open axillary/subclavian artery (	8	0.100			7.19			72						72																			
2nd REF	33987	ZZZ	Arterial exposure with creation (	7	0.090			4.04			45						45																			
CURRENT	35600	ZZZ	Harvest of upper extremity arter		0.124			4.94			40						40																			
SVY	35600	XXX	Harvest of upper extremity arter	44	0.167	3.00	5.00	7.00	8.00	14.00	42				5	30	42	56	95													0	1	5	10	100
INTERIM REC	35600	XXX	Harvest of upper extremity artery, 1 se		0.089			3.73			42						42																			
REC crosswalk	37222	ZZZ	Revascularization, endovascular, oper		0.092			3.73			42	1					40			1																

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 6 Practice Expense

Dear Dr. Manaker:

Tab 6 on the October 2020 RUC agenda addresses two XXX global codes for open and endoscopic upper extremity artery harvest that were valued as add-on codes. These two codes are typically only performed with arterial CABG procedures. Any pre and postoperative work associated with these procedures are accounted for in the work/ practice expense of the arterial CABG procedures. Both procedures are provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 5.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Julie Painter at jpainter@physiciancoding.com if you have any questions.

Sincerely,

James M. Levett, MD
STS RUC Advisor

Stephen J. Lahey, MD
AATS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2020

Per-Oral Endoscopic Myotomy (POEM) – Tab 7

In May 2020, the CPT Editorial Panel created new code 43497 *Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])* to describe a Per-Oral Endoscopic Myotomy (POEM), which involves the visualization and dissection of the esophageal muscle layers via an endoscope to treat esophageal motility disorders such as achalasia. This procedure accomplishes a comparable myotomy to what traditional open and laparoscopic myotomy (Heller) accomplishes. POEM utilizes an endoscope and specially designed dissecting, cutting, and cauterizing instruments to create a long submucosal tunnel beginning in the mid-esophagus and extending several centimeters into the cardia.

43497 ***Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])***
The RUC reviewed the survey results from 119 physicians and determined that the survey 25th percentile work RVU of 15.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time and 50 minutes immediate post-service time, 0.5-99238 discharge visit, and 2-99213 office visits. The RUC discussed the addition of 20 minutes of immediate post-service time to the initial value of 30 minutes of immediate post-service time, for a final recommendation of 50 minutes of immediate post-service time. The societies explained that it is typical for the performing physician to check in on the patient following the procedure; however, given CMS rules prohibiting an observation visit during hospital stays of less than 24 hours (as would be the case for CPT code 43497), listing such a visit would be improper. Therefore, the societies included this observation time in the immediate post-service time.

The RUC compared CPT code 43497 to the top two key reference services: CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU = 22.10 and 150 minutes intra-service time) and CPT code 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and 60 minutes intra-service time). The RUC noted 43279 requires more physician time and work to perform, yet similar intensity, thus is appropriately valued more than CPT code 43497. CPT code 43180 requires much less physician time, work and intensity, thus is appropriately valued less than CPT code 43497. Additionally, 74% of the survey respondents that selected key reference code 43180 indicated overall, 43497 was more intense and complex to perform than 43180.

For additional support the RUC referenced MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00- and 90-minutes intra-service time) and 60500 *Parathyroidectomy or exploration of parathyroid(s)* (work RVU = 15.60 and 120 minutes intra-service time). **The RUC recommends a work RVU of 15.50 for CPT code 43497.**

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Practice Expense
The Practice Expense Subcommittee reviewed the standard 90-day global inputs and determined that the standard exam table is typical for postoperative office visits. Thus, EF023 *table, exam* was added to the equipment inputs and EF031 *table, power* was removed. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT code 43497 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery				
Respiratory System				
Lungs and Pleura				
Thoracoscopy (Video-assisted thoracic surgery [VATS])				
32650		*Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)*		
…				
32665		*with esophagomyotomy (Heller type)*		
		(Do not report 32665 in conjunction with 43497)		
		(For exploratory thoracoscopy, and exploratory thoracoscopy with biopsy, see 32601-32609)		
Digestive System				
Esophagus				
Endoscopy				
Esophagoscopy				
43191		*Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)*		
		(Do not report 43191 in conjunction with 43192, 43193, 43194, 43195, 43196, 43197, 43198, 43210, 43497)		
		(For diagnostic transnasal esophagoscopy, see 43197, 43198)		
		(For diagnostic flexible transoral esophagoscopy, use 43200)		

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43197	*Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (Do not report 43197 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43198, 43200-43232, 43235-43259, 43266, 43270, 43497, 92511)
43200	*Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (Do not report 43200 in conjunction with 43197, 43198, 43201-43232, 43497) *(For diagnostic rigid transoral esophagoscopy, use 43191)* *(For diagnostic flexible transnasal esophagoscopy, use 43197)* *(For diagnostic flexible esophagogastroduodenoscopy, use 43235)*
Esophagogastroduodenoscopy	
43235	*Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (Do not report 43235 in conjunction with 43197, 43198, 43210, 43236-43259, 43266, 43270, 43497, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379)

●43497	C1	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM]) (Do not report 43497 in conjunction with 32665, 43191, 43197, 43200, 43235)	090	15.50

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43497 Tracking Number Original Specialty Recommended RVU: **15.50**
Presented Recommended RVU: **15.50**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **15.50**

CPT Descriptor: Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male presents with progressive dysphagia for solids and liquids. Testing has confirmed achalasia. The patient is referred for per-oral endoscopic myotomy.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 1%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 5% , Overnight stay-less than 24 hours 52% , Overnight stay-more than 24 hours 41%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Description of Pre-Service Work:
1. Review symptoms, history and preadmission work-up with particular attention to use of a systematic symptoms inventory, imaging reports (esophagram, CT), relevant diagnostic tests (EKG, esophageal manometry, prior endoscopy) and laboratory studies especially as they relate to coagulation status, CBC and basic metabolic panel.
2. Review patient's allergies and medications noting usage of antiplatelets or anticoagulants. Determine need for timing of pre-procedure antibiotics, steroids, or contrast allergy prophylaxis. Perform a pre-procedural examination including vitals, BMI, airway assessment, cardiopulmonary assessment and abdominal examination.
3. Review Achalasia type, prior interventions history and likely benefit from POEM based on evidence. Counsel patient accordingly to set realistic expectations including the need for secondary interventions. Document pre-procedural history and physical. Review the risks, benefits alternatives and potential complications of the procedure with the patient and family. Review the logistics of the planned procedure and the post-operative management. Document informed consent.
4. Review length and type of anesthesia with the anesthesiologist and discuss need for aspiration precaution measures.
5. Plan technical aspects of the procedure. Determine length of myotomy based on pre-procedural work-up.
6. Verify that all required instruments and supplies are available including endoscopic tools.
7. Position patient on the procedure table. Position endoscopic, imaging, electrocautery and monitoring equipment to provide access for the procedure. Apply appropriate protective attire and shielding to all in the suite including the patient. Perform a pre-procedure time out.

Description of Intra-Service Work:
1. Place a bite-block in the patient's mouth. Confirm with anesthesiology that adequate level of anesthesia is in place to begin intubation of the esophagus.
2. Insert a flexible upper endoscope through the mouth into the oropharynx and into the esophagus to assess for esophageal anatomy, retained food, infections (candidiasis) and degree of esophageal dilation/tortuosity, removing and reinserting the scope. Meticulous attention to suctioning and removing solid and liquid debris and secretions from the esophagus to allow complete visualization of the esophageal mucosa and anatomy. Advance endoscope through the lower esophageal sphincter into the proximal stomach. Insufflate the stomach with CO2. Perform an examination of the entire stomach in the forward and retroflexed position. Advance the endoscope through the pylorus into the duodenal bulb. Perform circumferential inspection of the duodenum after insufflation. Once initial examination confirms that there are no contraindications to proceeding, it is optional to lavage esophagus with antibiotics and/or place an esophageal overtube.

3. During this detailed endoscopic examination, careful measurements of critical landmarks are recorded (Teeth/overtube, Squamocolumnar junction, proximal gastric folds). Observe esophageal motility and mucosa and make final adjustments to planned endpoints and length of myotomy as appropriate. Instillation of water into the esophageal lumen to determine anterior vs posterior wall is done, since approach may differ in each case.
4. Once initial examination and landmarks noted, and anterior vs posterior approach determined, remove the endoscope and fit and securely fix the endoscope with a clear cap.
5. Reinsert the cap fitted endoscope into the esophagus and position the endoscope in the esophageal lumen at the anticipated proximal end of the myotomy and perform a submucosal injection with appropriate lifting solution using an injection needle. After an adequate fluid cushion is achieved, create a mucosal incision using the electrocautery dissection knife selected at the appropriate energy settings, to create a submucosal "entry tunnel" for the endoscope. Incision should be several centimeters proximal to planned proximal myotomy. Once the esophageal submucosal space has been entered, careful dissection of the layers of submucosal tissue begins to further expand the submucosal tunnel and expose the inner circular esophageal muscle below it. Meticulous hemostasis of submucosal vessels as encountered during creation of the tunnel is essential and may require alternative instruments, settings and interventions.
6. Extend the tunnel distally until the tunnel has reached 1.5-3 cm onto the gastric cardia below the GE junction. Continuous monitoring of the patient's vital signs and physical examination of the chest and abdomen should be performed to assess presence and impact of extraluminal CO2 extravasation. Once the submucosal tunnel creation is complete and its adequacy documented, incision and division of the circular muscle fibers is performed extending the full length of the myotomy. Once the myotomy is complete, repeat endoscopy is performed to evaluate the adequacy of the myotomy and patency of the GE junction. The esophageal mucosa is carefully examined to rule out any mucosal injury. The mucosal defect at the entry point of the submucosal tunnel is then closed using endoclips. Careful inspection of the incision site is performed to assure adequate closure and hemostasis. After suctioning to deflate the stomach and esophagus the endoscope is withdrawn.

Description of Post-Service Work:
Hospital: Monitor patient during reversal of anesthesia with particular attention to hypercapnia issues and aspiration risk. Reassess for crepitus and pneumoperitoneum. Monitor transport of patient from operating area to recovery room. Complete post-procedure orders. Discuss postoperative recovery with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write or dictate an operative note and complete final operative documentation. Forward procedure report to referring physicians. Write orders for transferring to hospital inpatient floor and discuss ongoing care with floor team including physicians and nurses. Discuss plan for monitoring, barium esophagram, antibiotics, post myotomy diet, monitoring and discharge criteria. Examine patient including vitals, cardiopulmonary exam and abdominal exam daily while admitted. Review pain and treat appropriately. Answer patient, family, nursing questions. Once patient is taking adequate nutrition, has adequate pain control with oral analgesics and has a normal esophagram or no physical contraindications, consider discharge. Discuss orders for follow-up visits, labs, medications and studies prior to discharge. Complete all appropriate medical records including day of discharge progress notes, discharge summary, discharge instructions.

Clinic: Examine and obtain history from patient. Pay specific attention to pain, swallowing function, and symptoms of acid reflux. Discuss post-operative testing which may include esophagram, esophageal manometry, pH testing, and/or endoscopy with impedance planimetry. Arrange for return visits to monitor progress and review follow-up testing. Educate patients regarding the long-term, natural history of achalasia and the need for long term follow-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020
Presenter(s):	AATS: Stephen Lahey, MD ACG: R. Bruce Cameron, MD AGA: Shivan Mehta, MD; Patricia Garcia, MD ASGE: Seth A. Gross, MD; Vivek Kaul, MD SAGES: Ketan Sheth, MD STS: James Levett, MD; Francis Nichols, MD
Specialty Society(ies):	American Association for Thoracic Surgery, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of American Gastrointestinal and Endoscopic Surgeons, Society of Thoracic Surgeons
CPT Code:	43497
Sample Size:	2264 **Resp N:** 119
Description of Sample:	ACG, AGA and ASGE sent the survey to a self-identified subset of 188 ASGE physician members of a special interest group who perform advanced endoscopy procedures, including POEM, as approved by the Research Subcommittee. SAGES sent the survey to an applicable subset of 176 of the society's U.S. Membership based on characteristics including subspecialty certification and inclusion in an established specialty society member section. AATS and STS sent the survey to 1900 self-identified general thoracic surgeons.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**7.00**	20.00	109.00
Survey RVW:	5.00	15.50	**22.10**	24.03	39.00
Pre-Service Evaluation Time:			**47.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	30.00	77.00	**120.00**	120.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**40.00**	99224x **0.00** 99225x **1.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	43497	**Recommended Physician Work RVU: 15.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**50.00**	**30.00**	**20.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43279	090	21.10	**RUC Time**

CPT Descriptor Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43180	090	9.03	**RUC Time**

CPT Descriptor Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.00	**RUC Time**	24,587

CPT Descriptor 1 Mastectomy, simple, complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60500	090	15.60	**RUC Time**	18,399

CPT Descriptor 2 Parathyroidectomy or exploration of parathyroid(s);

Other Reference CPT Code	Global	Work RVU	Time Source

0.00

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 86 **% of respondents:** 72.2 **%**

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 12.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 43497	**Top Key Reference CPT Code:** 43279	**2nd Key Reference CPT Code:** **43180**
Median Pre-Service Time	46.00	60.00	60.00
Median Intra-Service Time	120.00	150.00	60.00
Median Immediate Post-service Time	50.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	98.00	38.00
Median Discharge Day Management Time	19.0	20.00	0.00
Median Office Visit Time	46.0	46.00	23.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**281.00**	**404.00**	**201.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	34%	51%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	68%	32%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	26%	73%
Physical effort required	4%	42%	55%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	33%	65%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	27%	67%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	47%	53%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	7%	60%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	47%	53%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The AATS, ACG, AGA, ASGE, SAGES and STS conducted a survey of new CPT code 43497 (*Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])*) for the October 2020 RUC meeting. Our multi-specialty consensus panel reviewed the survey data for code 43497, comparing the data and work RVUs (wRVUs) to the current data for similar 90-day global codes that were recently approved by the RUC. The consensus panel agreed with the overall survey data.

43497 – Discussion and Recommendation

Code 43497 is a new code approved by the CPT Editorial Panel at its May 2020 CPT meeting.
For this survey, AATS, ACG, AGA, ASGE, SAGES and STS conducted a survey and received 119 responses.

43497 Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])

We recommend a **wRVU of 15.50**. This value is equal to the 25th percentile of the combined survey data.

Pre-time Package 3 (*Straightforward Patient/Difficult Procedure*) is appropriate for 43497 with a reduction of 7 minutes of positioning time to reflect the Package 3 positioning time of 3 minutes rather than the survey time of 10 minutes and 5 minutes of scrub, dress, wait time to reflect the Package 3 scrub, dress, wait time of 10 minutes rather than the survey time of 15 minutes.

Pre-service evaluation time: 33 minutes
Pre-service positioning time: 3 minutes
Pre-service scrub, dress, wait time: 10 minutes

Post-time Package 9A (*General Anesthesia or Complex Regional Block/ Straightforward Procedure*) of 30 minutes is appropriate with 20 minutes added. CMS has a policy that they will not allow inpatient visits for a service that typically has an outpatient facility status. However, per the CMS 23-hour stay policy, physicians are not allowed to include an inpatient visit, but instead should add the intra-service time of that visit to the immediate post-op time. Therefore, the immediate post-op time is 50 minutes, which is the sum of 30 minutes for time in recovery until discharge to surgical floor plus 20 minutes, which is the intra-service time for 99232.

Key Reference Services

Two reference services were selected more often than others: 43279 and 43180. However, code 43279 (*Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed*) was selected most often (86/119).

Discussion of Intra-service Time

Attachment A contains an analysis of POEM studies regarding intra-service time. We found the median intra-service time of 120 minutes from the RUC survey data to be consistent with studies that conforms to the RUC definition of intra-service time.

Comparison to Other RUC-Reviewed Codes with Similar Time and Post-Operative Visits:

CPT Code	Long Desc	Glob	Work RVU	Pre time	Intra Time	Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Util
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	090	14.08	51	120	30	266	RUC	2016-01	OBSTETRICS/ GYNECOLOGY	0.0825		8
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	090	14.39	56	110	30	261	RUC	2014-04	OBSTETRICS/ GYNECOLOGY	0.0918		34
19303	Mastectomy, simple, complete	090	15.00	58	90	30	283	RUC	2016-04	GENERAL	0.1018	YES	24587
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	090	15.00	56	120	30	271	RUC	2017-01	OBSTETRICS/ GYNECOLOGY	0.0892		4370
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	090	15.00	56	90	30	241	RUC	2014-04	OBSTETRICS/ GYNECOLOGY	0.119		22432
434XX	**Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy**	**090**	**15.50**	**47**	**120**	**30**	**261**				**0.095**		
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	090	15.60	56	120	30	271	RUC	2014-04	OBSTETRICS/ GYNECOLOGY	0.0942		83
60500	Parathyroidectomy or exploration of parathyroid(s);	090	15.60	72	120	40	313	RUC - CMS Revised	2010-10	GENERAL SURGERY	0.086	YES	18399
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	090	15.68	58	120	30	305	RUC	2017-01	PLASTIC AND RECONSTRUCTIVE SURGERY	0.0865		5657
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	090	22.10	80	150	30	404	RUC	2008-04	GENERAL SURGERY	0.097		829

CPT Code	Long Desc	99204	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency				2						0.5			
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;				2						0.5			
19303	Mastectomy, simple, complete				2	1					0.5			
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair				2						0.5			
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)				2						0.5			
434XX	**Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy**				**2**						**0.5**			
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)				2						0.5			
60500	Parathyroidectomy or exploration of parathyroid(s);			1	2						0.5			
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)			2	2						0.5			
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed				2			2	2		1			

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43499

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty General surgery How often? Sometimes

Specialty Gastroenterology How often? Sometimes

Specialty Thoracic surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 540
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. POEM is performed more commonly in the non-Medicare population. We estimate that it is performed 70% in the commercial patient population (540) and 30% in the Medicare population (230)

Specialty Gastroenterology Frequency 351 Percentage 65.00 %

Specialty General surgery Frequency 135 Percentage 25.00 %

Specialty Thoracic surgery Frequency 54 Percentage 10.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 230
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 20% of 43499 = ~230 Medicare volume

Specialty Gastroenterology Frequency 150 Percentage 65.21 %

Specialty General surgery Frequency 58 Percentage 25.21 %

Specialty Thoracic surgery Frequency 24 Percentage 10.43 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43279

SS Rec Summary

ISSUE: 43497 POEM

TAB: 7

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	Pre Pkg	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	Post Pkg	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	43279	090	Laparoscopy, surgical, esophagomyoto		0.097			22.10			404	4	40	20	20			150			30					1	1	1.0				2							
2nd REF	43180	090	Esophagoscopy, rigid, transoral with di		0.086			9.03			201	4	40	10	10			60			20							1.0				1							
NEW	43497	090	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])								0																												
All Data	43497	090	Lower esophageal myotomy, tra	119	0.129	5.00	15.50	22.10	24.03	39.00	341		47	10	10	30	77	120	120	360	30					1		1.0				2			0	1	7	20	109
GI	43497	090	Lower esophageal myotomy, tra	57	0.123	11.00	21.00	22.10	25.00	39.00	379		65	10	15	40	90	118	120	210	30					1		1.0			1	1			0	7	12	30	109
SAGES	43497	090	Lower esophageal myotomy, tra	16	0.137	5.00	16.63	22.10	25.00	27.10	307		43	10	10	30	64	120	151	360	20						1	1.0				2			0	1	4	11	40
AATS/STS	43497	090	Lower esophageal myotomy, tra	46	0.080	9.00	12.00	16.00	22.10	35.00	329		45	10	10	45	75	120	120	180	20					1		1.0				2			0	0	1	7	45
REC	43497	090	Lower esophageal myotomy, transoral (		0.091			15.50			281	3	33	3	10			120			50	9a						0.5				2							

FACILITY DIRECT PE INPUTS **CPT CODE(S):**43497

SPECIALTY SOCIETY(IES): AATS, ACG, AGA, ASGE, SAGES, STS

PRESENTER(S): Stephen Lahey, MD (AATS), R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth A. Gross, MD (ASGE) Vivek Kaul, MD (ASGE), Ketan Sheth, MD (SAGES), James Levett MD (STS), Francis Nichols, MD (STS)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
43497	A 48-year-old male presents with progressive dysphagia for solids and liquids. Testing has confirmed achalasia. The patient is referred for per-oral endoscopic myotomy.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The AATS, ACG, AGA, ASGE, SAGES, and STS convened an RVS expert panel of the surveying specialty societies to review practice expense data for code 43497. The panel included both sub-specialists and generalists from within the specialties of a variety of settings across the United States. They also received input from practice managers and clinical staff familiar with the direct expense inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   43279, Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   We are not recommending more minutes than the PE Subcommittee standards

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   NA – 43497 is a new code

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   NA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms = 5 minutes Coordinate pre-surgery services (including test results) = 20 minutes Schedule space and equipment in facility = 8 minutes Provide pre-service education/obtain consent = 20 minutes Complete pre-procedure phone calls and prescription = 7 minutes

   b. Service period (includes pre, intra and post):

NA

   c. Post-service period:

Discharge day management = 6 minutes

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

NA

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

NA

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

NA

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Pack, minimum multi-specialty visit - SA048; unit price = $2.11 paper, exam table = 7 feet gloves, non-sterile = 2 pair gown, patient = 1 item pillowcase = 1 item cover, thermometer probe = 1 item

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

NA

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam light = office visits Power table = office visits

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

NA

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

NA

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	C	D	E	F
1	**RUC Practice Expense Spreadsheet**					
2						
3		***RUC Collaboration Website***				
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 7 Specialty: AATS, ACG, AGA, ASGE, SAGES, STS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**
5		**LOCATION**				
6		**GLOBAL PERIOD**		**090**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				
8		**TOTAL CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				
13		**PRE-SERVICE PERIOD**				
14		**Start: Following visit when decision for surgery/procedure made**				
15	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37
16	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37
17	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37
18	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37
19	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37
20	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37
21	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)		L037D	RN/LPN/MTA	0.37
23				L037D	RN/LPN/MTA	0.37
26		*Other activity: please include short clinical description here and type new in column A*		L037D	RN/LPN/MTA	0.37
29		**End: When patient enters office/facility for surgery/procedure**				
30		**SERVICE PERIOD**				
31		**Start: When patient enters office/facility for surgery/procedure:**				
32		**Pre-Service (of service period)**				
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	Standard time for this activity is 3 minutes.	L037D	RN/LPN/MTA	0.37
34	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37
35	CA011	Provide education/obtain consent	Include only the additional education/consent activities not	L037D	RN/LPN/MTA	0.37
36	CA012	Review requisition, assess for special needs		L037D	RN/LPN/MTA	0.37
37	CA013	Prepare room, equipment and supplies	2 minute standard	L037D	RN/LPN/MTA	0.37
38	CA014	Confirm order, protocol exam	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37
39	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set up in the non facility	L037D	RN/LPN/MTA	0.37
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2 minute standard	L037D	RN/LPN/MTA	0.37
41	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37
42				L037D	RN/LPN/MTA	0.37
45		*Other activity: please include short clinical description here and type new in column A*		L037D	RN/LPN/MTA	0.37
48		**Intra-service (of service period)**				
49	CA018	Assist physician of other qualified healthcare professional---directly related	100% of physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37
50	CA019	Assist physician of other qualified healthcare professional---directly related	67% of physician or other qualified healthcare professional	L037D	RN/LPN/MTA	0.37
51	CA020	Assist physician of other qualified healthcare professional---directly related	other% of physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37
52	CA021	Perform procedure/service---NOT directly related to physician work time		L037D	RN/LPN/MTA	0.37
55				L037D	RN/LPN/MTA	0.37
56		*Other activity: please include short clinical description here and type new in column A*		L037D	RN/LPN/MTA	0.37
59		**Post-Service (of service period)**				
60	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following procedure, the standard is 15	L037D	RN/LPN/MTA	0.37
61	CA023	Monitor patient following procedure/service, no multitasking		L037D	RN/LPN/MTA	0.37
62	CA024	Clean room/equipment by clinical staff	3 minute standard	L037D	RN/LPN/MTA	0.37
63	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37
64	CA026	Clean surgical instrument package	Standard for cleaning instruments	L037D	RN/LPN/MTA	0.37
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions		L037D	RN/LPN/MTA	0.37
66	CA028	Review/read post-procedure x-ray, lab and pathology reports		L037D	RN/LPN/MTA	0.37
67	CA029	Check dressings, catheters, wounds	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose report	Baseline time for this activity is 2 minute. For use in	L037D	RN/LPN/MTA	0.37
69	CA031	Review examination with interpreting MD/DO	Standard time for this activity is 2 minute. For use in	L037D	RN/LPN/MTA	0.37
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	Standard time for this activity is 1 minute. For use in	L037D	RN/LPN/MTA	0.37
71	CA033	Perform regulatory mandated quality assurance activity (service period)		L037D	RN/LPN/MTA	0.37
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ESC file, etc.)		L037D	RN/LPN/MTA	0.37
73	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37
74	CA036	Discharge day management	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	0.37
75				L037D	RN/LPN/MTA	0.37
78		*Other activity: please include short clinical description here and type new in column A*		L037D	RN/LPN/MTA	0.37
81		**End: Patient leaves office/facility**				
82		**POST-SERVICE PERIOD**				
83		**Start: Patient leaves office/facility**				
84	CA037	Conduct patient communications	Phone calls/emails/texts are in 3 minute increments	L037D	RN/LPN/MTA	0.37
85	CA038	Coordinate post-procedure services		L037D	RN/LPN/MTA	0.37
86		***Office visits: List Number and Level of Office Visits***		**MINUTES**		
87		99211 16 minutes		16		
88		99212 27 minutes		27		
89		99213 36 minutes		36		
90		99214 53 minutes		53		
91		99215 63 minutes		63		
92	CA039	Post-operative visits (total time)		L037D	RN/LPN/MTA	0.37
93				L037D	RN/LPN/MTA	0.37
96		*Other activity: please include short clinical description here and type new in column A*		L037D	RN/LPN/MTA	0.37
99		**End: with last office visit before end of global period**				

	A	B	C	D	E	F
1	**RUC Practice Expense Spreadsheet**					
2						
3		***RUC Collaboration Website***				
4	**Clinical Activity Code**	**Meeting Date: 10/2020** **Revision Date (if applicable):** **Tab: 7** **Specialty: AATS, ACG, AGA, ASGE, SAGES, STS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**
5		**LOCATION**				
6		**GLOBAL PERIOD**		**090**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				
8		**TOTAL CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37
100	**Supply Code**	**MEDICAL SUPPLIES**		**PRICE**	**UNIT**	
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				
102	SA048	pack, minimum multi-specialty visit		3.0815	pack	
103	SA054	pack, post-op incision care (suture)		4.7635	pack	
104						
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*	*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice in column B, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*			
109						
110	**Equipment Code**	**EQUIPMENT**		**Purchase Price**	**Equipment Formula**	**Cost Per Minute**
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				
112	EQ168	light, exam		1431.5035	Office Visits	0.003798819
113	EF031	table, power		6030.195	Office Visits	0.016002488
114	EF023	table, exam		3037.9485	Office Visits	0.006757594
115						
116						
117						
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*	*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice in column B, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*			

	A	B	G	H	I	J
1	**RUC Practice Expense Spreadsheet**		**REFERENCE CODE**		**RECOMMENDED**	
2			**43279**		**43497**	
3		***RUC Collaboration Website***	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed		Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	
4	**Clinical Activity Code**	**Meeting Date: 10/2020** **Revision Date (if applicable):** **Tab: 7** **Specialty: AATS, ACG, AGA, ASGE, SAGES, STS**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 65.63**	**$ -**	**$ 57.98**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**144.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**72.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 53.28**	**$ -**	**$ 51.06**
13		**PRE-SERVICE PERIOD**				
14		**Start: Following visit when decision for surgery/procedure made**				
15	CA001	Complete pre-service diagnostic and referral forms		5		5
16	CA002	Coordinate pre-surgery services (including test results)		20		20
17	CA003	Schedule space and equipment in facility		8		8
18	CA004	Provide pre-service education/obtain consent		20		20
19	CA005	Complete pre-procedure phone calls and prescription		7		7
20	CA006	Confirm availability of prior images/studies				
21	CA007	Review patient clinical extant information and questionnaire				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)				
23						
26		*Other activity: please include short clinical description here and type new in column A*				
29		**End: When patient enters office/facility for surgery/procedure**				
30		**SERVICE PERIOD**				
31		**Start: When patient enters office/facility for surgery/procedure:**				
32		**Pre-Service (of service period)**				
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available				
34	CA010	Obtain vital signs				
35	CA011	Provide education/obtain consent				
36	CA012	Review requisition, assess for special needs				
37	CA013	Prepare room, equipment and supplies				
38	CA014	Confirm order, protocol exam				
39	CA015	Setup scope (nonfacility setting only)				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient				
41	CA017	Sedate/apply anesthesia				
42						
45		*Other activity: please include short clinical description here and type new in column A*				
48		**Intra-service (of service period)**				
49	CA018	Assist physician of other qualified healthcare professional---directly related				
50	CA019	Assist physician of other qualified healthcare professional---directly related				
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other%)				
52	CA021	Perform procedure/service---NOT directly related to physician work time				
55						
56		*Other activity: please include short clinical description here and type new in column A*				
59		**Post-Service (of service period)**				
60	CA022	Monitor patient following procedure/service, multitasking 1:4				
61	CA023	Monitor patient following procedure/service, no multitasking				
62	CA024	Clean room/equipment by clinical staff				
63	CA025	Clean scope				
64	CA026	Clean surgical instrument package				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions				
66	CA028	Review/read post-procedure x-ray, lab and pathology reports				
67	CA029	Check dressings, catheters, wounds				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose report				
69	CA031	Review examination with interpreting MD/DO				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue				
71	CA033	Perform regulatory mandated quality assurance activity (service period)				
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)				
73	CA035	Review home care instructions, coordinate visits/prescriptions				
74	CA036	Discharge day management	**n/a**	**12**	**n/a**	**6**
75						
78		*Other activity: please include short clinical description here and type new in column A*				
81		**End: Patient leaves office/facility**				
82		**POST-SERVICE PERIOD**				
83		**Start: Patient leaves office/facility**				
84	CA037	Conduct patient communications				
85	CA038	Coordinate post-procedure services				
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes				
88		99212 27 minutes				
89		99213 36 minutes		2		2
90		99214 53 minutes				
91		99215 63 minutes				
92	CA039	Post-operative visits (total time)	**0.0**	**72.0**	**0.0**	**72.0**
93						
96		*Other activity: please include short clinical description here and type new in column A*				
99		**End: with last office visit before end of global period**				

	A	B	G	H	I	J
1	**RUC Practice Expense Spreadsheet**		**REFERENCE CODE**		**RECOMMENDED**	
2			**43279**		**43497**	
3		***RUC Collaboration Website***	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed		Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	
4	**Clinical Activity Code**	**Meeting Date: 10/2020** **Revision Date (if applicable):** **Tab: 7** **Specialty: AATS, ACG, AGA, ASGE, SAGES, STS**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 65.63**	**$ -**	**$ 57.98**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**144.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**72.0**
100	**Supply Code**	**MEDICAL SUPPLIES**				
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 10.93**	**$ -**	**$ 6.16**
102	SA048	pack, minimum multi-specialty visit		2		2
103	SA054	pack, post-op incision care (suture)		1		
104						
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*				
109						
110	**Equipment Code**	**EQUIPMENT**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ 1.43**	**$ -**	**$ 0.76**
112	EQ168	light, exam		72		72
113	EF031	table, power		72		**0**
114	EF023	table, exam				**72**
115						
116						
117						
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*				

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000

October 2020

Retinal Detachment Prophylaxis – Tab 8

CPT code 67145 was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC agreed with the specialty societies and recommended that CPT code 67145 as well as its parent code 67141 be referred to CPT for a descriptor and global period change. The codes were edited to remove the reference to "1 or more sessions" so that the services may be valued as a 010-day procedure versus the current 090-day global. At the May 2020 CPT Editorial Panel meeting, the Panel approved revision of the two codes to remove "1 or more sessions" from the descriptors and deletion of the Eye and Ocular Adnexa Prophylaxis guidelines.

67141 ***Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy***
CPT code 67141 describes cryotherapy of a retinal tear typically in an adult without the presence of a retinal detachment and is typically performed in a non-facility setting with local anesthesia. The RUC reviewed the survey results from 58 ophthalmologists and retina specialists and determined that a work RVU of 2.53 accurately reflects the physician work necessary for this service. Acknowledging that this falls considerably below the survey 25th percentile and below any RVU indicated by the survey respondents, the RUC determined that a direct work RVU crosswalk to CPT code 32552 *Removal of indwelling tunneled pleural catheter with cuff* (work RVU = 2.53, 15 minutes intra-service time and 82 minutes total time) would be appropriate and supportive of the valuation.

The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 15 minutes intra-service time, 5 minutes immediate post-service time and two 99213 office visits. The RUC acknowledged that the median survey intra-service time of 15 minutes is a substantial reduction compared to the current value, however, CPT code 67141 is Harvard valued and thus has never been surveyed and reviewed by the RUC. The RUC reduced the pre-service evaluation time from the pre-service package time of 17 minutes to 5 minutes to account for overlap of work with the same-day Evaluation and Management (E/M) visit. It is typical for the patient to be seen by a provider (ophthalmologist or optometrist) first then referred to a retina specialist. Most patients are referred for flashers and floaters not for a tear, and it is during the E/M visit that the tear is ascertained, treatment is recommended and ultimately performed. In addition, the pre-service positioning time was reduced from the median survey time of 5 minutes to 1 minute (package time). The pre-service scrub/dress/wait time of 5 minutes was supported by the survey and includes administration of the topical and subconjunctival anesthesia and checking the probe to ensure adequate freezing. The survey immediate post-service time of 5 minutes to monitor and instruct the patient on postoperative care, prepare an operative report, discuss symptoms of a retinal detachment and contact the referring physician is recommended.

The RUC supports the survey result of two 99213 postoperative visits, a decrease from the current number of three 99213 visits. Both visits, typically 1 day and approximately 1 week after the procedure respectively, entail a complete dilated examination to assess early response to

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therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches with an associated loss of central vision. Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure (separately reported) to prevent progression is necessary, as delay of only one day may lead to macular detachment, which is associated with a significantly poorer visual outcome. Therefore, the entire peripheral retina must be examined the day after the treatment and again within another week.

CPT code 67141 has changed from a 090-day global to a 010-day global procedure and was surveyed as such. However, there are no 15-minute 010-day global procedures with two 99213 postoperative visits. As a result, there were no 010-day global codes valued in the past 10 years with an intra-service time of 15 minutes and similar total times that were eligible for crosswalk, nor were there any with a high enough work value to result in a positive IWPUT. Including codes valued up to 15 years ago, the RUC recommends CPT code 32552 as the direct work value crosswalk code. For further support, the RUC compared CPT code 67141 to the top key reference code 67227 *Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy* (work RVU = 3.50, 11 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and noted that the overall intensity and complexity for the survey code is higher than for the reference code as justified by the shorter intra-service time which is half that of the reference code.

Finally, the RUC referenced MPC codes 11443 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm* (work RVU = 2.34, 20 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU = 2.62, 15 minutes pre-service time, 25 minutes intra-service time and 5 minutes immediate post-service time) for additional support. The RUC concluded that CPT code 67141 should be valued based on a direct work RVU crosswalk to CPT code 32552 which falls below the survey lowest response and is appropriately bracketed by the multi-specialty points of comparison codes. **The RUC recommends a work RVU of 2.53 for CPT code 67141.**

67145 *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation*
The two codes in this family, CPT codes 67141 and 67145, describe two different methods of treating the same pathology. CPT code 67145 describes laser photocoagulation of a retinal tear typically in an adult without the presence of a retinal detachment. It is typically performed in a non-facility with local anesthesia. The RUC reviewed the survey results from 66 ophthalmologists and retina specialists and determined that a work RVU of 2.53 accurately reflects the physician work necessary for this service. Acknowledging that this falls considerably below the survey 25th percentile and below the lowest survey response, the RUC determined that a direct work RVU crosswalk to CPT code 32552 *Removal of indwelling tunneled pleural catheter with cuff* (work RVU = 2.53, 15 minutes intra-service time and 82 minutes total time) would be appropriate and supportive of the valuation.

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The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 3 minutes of pre-service scrub/dress/wait time, 16 minutes intra-service time, 5 minutes immediate post-service time and two 99213 office visits. CPT code 67145 is Harvard valued and thus has never been surveyed and reviewed by the RUC and therefore times are not valid for comparison. As with the parent code, the RUC decreased the pre-service evaluation time to 5 minutes given concerns with overlap of work with the same day E/M visit. The RUC also noted that performance of both procedures on the same day would be extremely uncommon and there is currently a CCI edit precluding reporting of both procedures together.

The RUC supports the survey result of two 99213 postoperative visits, a decrease from the current number of three 99213 visits. Both visits, typically 1 day and approximately 1 week after the procedure, entail a complete dilated examination to assess early response to therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches. Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure to prevent progression is necessary, as delay of only a day may lead to macular detachment, which is associated with a significantly poorer visual outcome. Therefore, the entire peripheral retina must be examined the day after the treatment and again within another week.

Both codes in the family changed from 090-day to 010-day global periods. As with CPT code 67141, there are no recent 15- or 16-minute 010-day global procedures with two postoperative visits, making it impossible to find a crosswalk with a similar intra-service time and a work value resulting in a positive IWPUT. Going back to 2008, there was support for a value of 2.53 RVUs from CPT code 32552 as a crosswalk code. This is identical to the recommendation for CPT code 67141 as the amount of physician work of the two procedures is essentially the same.

The RUC compared CPT code 67145 to the top key reference code 67228 *Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation* (work RVU = 4.39, 23 minutes pre-service time, 25 minutes intra-service time and 10 minutes immediate post-service time) and noted that the overall intensity and complexity for the survey code is higher and the intra-service time is ten minutes less than for the reference code. To further justify a work value of 2.53, the RUC also referenced key MPC codes 11443 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm* (work RVU = 2.34, 20 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU = 2.62, 15 minutes pre-service time, 25 minutes intra-service time and 5 minutes immediate post-service time) and noted that these multi-specialty points of comparison codes appropriately bracket the survey code.

The RUC concluded that CPT code 67145 should be valued based on a direct work RVU crosswalk to CPT code 32552 which falls below the lowest survey response. **The RUC recommends a work RVU of 2.53 for CPT code 67145.**

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Practice Expense
The Practice Expense Subcommittee accepted the spreadsheet for CPT codes 67141 and 67145 as submitted, including reductions for changing from 090-day to 010-day global period and eliminating any overlap with the ophthalmology office visits. No modifications were made. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Office Visits Included in Codes with a Surgical Global Period
The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. However, the Centers for Medicare & Medicaid Services (CMS) proposes not to apply the office visit increases to the visits bundled into global surgery payment. An example of why this policy is flawed was raised during discussion of CPT code 67141. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes are being valued too low considering that office visits for the surgical global period are not going to change. The 99213-office visit in 2021 will be valued at 1.30 RVUs, therefore, the two office visits will be valued higher than this code. It is disadvantageous to the eye surgeons and an example of the why the policy from CMS is flawed. The Agency implies that the physician work for office visits are not the same when performed in a surgical global period. As stated in the RUC comment letter to CMS on the CY 2021 Proposed Rule, **The RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the office visit increases to the office visits included in surgical global payment, as it has done historically.**

Do Not Use to Validate for Physician Work
The RUC agreed that CPT codes 67141 and 67145 should be labeled in the RUC database with a flag that they should not be used to validate physician work. These services are valued below the lowest survey response and would not be appropriate to compare the relativity for other codes particularly noting the absence of eligible crosswalk codes with 010-day global and two 99213 visits as supported by the survey.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Eye and Ocular Adnexa** **Posterior Segment** **Retina or Choroid** **Prophylaxis** ~~Codes 67141, 67145 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.~~ ~~Repetitive services. The services listed below are often performed in multiple sessions or groups of sessions. The methods of reporting vary.~~ ~~The following descriptors are intended to include all sessions in a defined treatment period.~~				
▲67141	D1	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage~~, 1 or more sessions~~; cryotherapy, diathermy	010 ~~090~~	2.53
▲67145	D2	photocoagulation ~~(laser or xenon arc)~~	010 ~~090~~	2.53

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67141 Tracking Number D1 Original Specialty Recommended RVU: **2.53**
Presented Recommended RVU: **2.53**
Global Period: 010 Current Work RVU: **6.15** RUC Recommended RVU: **2.53**

CPT Descriptor: Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male with a retinal tear with a vitreous hemorrhage, but no retinal detachment, has cryotherapy to the retina around the tear.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 3% , In the ASC 9%, In the office 88%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The patient's record is reviewed. The preoperative retinal drawing and diagnostic testing are reviewed. The procedure is discussed with the patient and informed consent obtained. The referring physician is contacted to confirm the presence of a tear and the treatment plan. Preoperative orders for medication and additional pupillary dilation are entered. In the treatment room, a time-out is performed to identify and mark the correct eye. The patient is positioned on the treatment table or the treatment chair is reclined and elevated to the proper height. Topical anesthesia and subconjunctival lidocaine are administered to the eye. The cryoprobe attachment and settings are checked and the probe is tested to ensure adequate temperature during the freeze. The patient's head is positioned.

Description of Intra-Service Work: A lid speculum in placed in the eye. The retina is re-examined to localize the retinal tear and lattice degeneration. Lubrication is placed on the ocular surface, and the cryopexy probe is applied directly to the sclera overlying the retinal tear. Multiple transcleral freezes are placed with the cryopexy probe to surround the retinal tear and associated lattice degeneration while monitoring the freezes with the indirect ophthalmoscope. The patient's head is repositioned as needed throughout the treatment. The lid speculum is removed. A topical ointment is applied, and a patch is placed over the eye.

Description of Post-Service Work: Postoperative orders are entered and a procedure note is created. The procedure and post-procedure instructions are reviewed with the patient and family including topical medications to reduce post-procedure discomfort. Post-procedure restrictions are discussed with the patient. The referring physician is contacted to confirm that treatment was completed and the plan for follow-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO), John T. Thompson, MD (ASRS)					
Specialty Society(ies):	AAO, ASRS					
CPT Code:	67141					
Sample Size:	737	**Resp N:**	58			
Description of Sample:	Random sample of US practicing ophthalmologists from AAO and ASRS					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	2.00	**5.00**	12.00	75.00	
Survey RVW:	3.10	3.50	**4.18**	5.00	17.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	5.00	15.00	**15.00**	24.00	40.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**57.50**	99211x **0.00** 12x **0.00** 13x **2.50** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	67141	**Recommended Physician Work RVU: 2.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**17.00**	**-12.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	46.00	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67227	010	3.50	**RUC Time**

CPT Descriptor Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67228	010	4.39	**RUC Time**

CPT Descriptor Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11443	010	2.34	**RUC Time**	8,316

CPT Descriptor 1 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11642	010	2.62	**RUC Time**	89,442

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
32552	010	2.53	**RUC Time**

CPT Descriptor Removal of indwelling tunneled pleural catheter with cuff

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 24 **% of respondents:** 41.3 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 67141	Top Key Reference CPT Code: 67227	2nd Key Reference CPT Code: **67228**
Median Pre-Service Time	11.00	11.00	23.00
Median Intra-Service Time	15.00	30.00	25.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	19.00	0.00
Median Office Visit Time	46.0	23.00	23.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**77.00**	**93.00**	**81.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	21%	54%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	46%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	29%	67%
Physical effort required	8%	58%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	25%	75%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	64%	36%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	21%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	7%	93%
Physical effort required	0%	15%	85%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67141, *prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy,* is in a family with CPT 67145, *prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation,* which was identified as a potentially misvalued code by a screen for Harvard-valued codes with utilization over 30,000. CPT 67141 has never been surveyed and reviewed by the RUC. It describes cryotherapy of a retinal tear typically in an adult without the presence

of a retinal detachment. It is typically performed in a non-facility under local anesthesia including topical proparacaine and subconjunctival lidocaine.

The specialty believed that these two codes, both of which were 090-day globals, were better described as 010-day globals. The CPT editorial panel agreed that a 010-day global period was appropriate and accepted changes to the descriptors. The codes were surveyed as 010-day globals.

The two codes in this family, CPT 67141 and 67145, describe two different methods of treating the same pathology. Performance of both procedures on the same day would be extremely uncommon. There is currently a CCI edit precluding reporting of both procedures together.

A random survey of AAO and American Society of Retina Specialists (ASRS) members included 58 respondents, 98% of whom found the vignette typical. The median WRVU was 4.18 and the 25th percentile was 3.50. Median IST was 15 minutes. The current value of the code is 6.15 as a 090-day global. The primary reference service, chosen by 41%, was CPT 67227, *Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy* (RUC 2015) with a WRVU of 3.50 and an IST of 30 minutes. Overall intensity and complexity for the surveyed code was higher than for the reference code, as were all of the submeasures except physical effort, where the majority ranked them identical. The second reference service, chosen by 24%, was CPT 67228, *Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation* (RUC 2015), with 4.39 WRVU and 25 minutes IST. Overall intensity and complexity and each of the submeasures were ranked higher for the surveyed code than the second reference service.

The expert panel of the AAO and ASRS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The median survey IST of 15 minutes was a substantial reduction compared to the current value. The procedure has not changed in 25 years, but survey times often decrease in comparison to Harvard times.

The panel supports the survey result of two level-3 postop visits, a decrease from the current number of three level-3 visits. Both visits, typically 1 day and approximately 1 week after the procedure, entail a complete dilated examination to assess early response to therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches with an associated loss of central vision.

Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure to prevent progression is necessary, as delay of only a day may lead to macular detachment, which is associated with a significantly poorer visual outcome. This is why the entire peripheral retina must be examined the day after the treatment and again within another week.

We chose pre-service package 6. We reduced pre-service evaluation time from the package time of 17 minutes to 7 minutes to account for a same day E/M visit. These 7 minutes are necessary for the following tasks, corresponding to specific items in the pre-service evaluation package:

- 3 minutes to “Communicate with patient and/or family (Discuss procedure/obtain consent):” The typical patient is not expecting a surgical procedure to be performed the same day on an urgent basis. Explaining the need for the procedure and obtaining consent is not part of the same-day office visit. Because of the blinding nature of the disease if left untreated and the potential for vision loss from the treatment itself, this consent takes time to obtain.

- 1 minute to "Prepare for Procedure (Check labs, plan, assess risks, review procedure):" Although some of this is part of the same-day office visit, time is required to enter orders specifically associated with the treatment into the EHR. This is not part of a same-day office visit.
- 1 minute to "Communicate with other professionals:" A call to the referring physician is made to convey the findings of a tear and the plan to perform treatment. The package time is 2 minutes. We reduced this to 1 minute because a brief call to the referring physician would be part of a same-day office visit when no tear is found. The time in addition to an office visit is required when a tear is found and treatment intended to communicate the treatment plan to the referring physician.
- 1 minute to "Check/set-up room, supplies and equipment:" This time is needed to attach or check the attachment of the cryo-probe and check the cryo-probe machine settings. It is not part of a same-day office visit.
- 1 minute to "Check/prepare patient readiness (gown, prep, drape, mark):" This time is needed to perform a time out and mark the eye and is not part of an office visit.

We reduced the pre-service positioning time from the median survey time of 5 minutes to 1 minute (package time) and used the pre-service scrub, dress, and wait time of 5 minutes as supported by our survey. During this time topical and subconjunctival anesthesia is administered and the probe is checked to ensure adequate freezing. We used the survey immediate post-service time of 5 minutes to monitor and instruct the patient on postoperative care, prepare an operative report, discuss symptoms of a retinal detachment and contact the referring physician. This results in a total time of 79 minutes.

There are no 15-minute 010-day global procedures with two level 3 postop visits. As a result, there are no 010-day global codes valued in the past 10 years with an IST of 15 minutes and similar total times that are eligible for crosswalk, nor are there any with a high enough work value to result in a positive IWPUT. Including codes valued up to 15 years ago, we find some support from CPT 32552, *Removal of indwelling tunneled pleural catheter with cuff* (RUC 2008) with 2.53 WRVU, an IST of 15 minutes, and a total time of 82 minutes.

For CPT 67141, we recommend a work value of 2.53 WRVU, considerably below the 25th percentile and below the survey minimum response, with times of 13/15/5 minutes and a total time of 79 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Billed with an office visit.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	92002	5	15	5	25.0	0.88	XXX	1.25%
5.	92004	5	25	10	40.0	1.82	XXX	10.00%

6.	92012	5	15	5	25.0	0.92	XXX	7.50%
7.	92014	5	24	8	37.0	1.42	XXX	18.75%
8.	99204	5	30	10	45.0	2.43	XXX	25.00%
9.	99205	7	45	15	67.0	3.17	XXX	6.25%
10.	99213	3	15	5	23.0	0.97	XXX	1.25%
11.	99214	5	25	10	40.0	1.50	XXX	3.75%
12.	99215	5	35	15	55.0	2.11	XXX	1.25%
13.								Total: 75%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3750
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation.

Specialty Ophthalmology Frequency 3750 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,395
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 1395 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:

Treatment of retinal lesions

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67141

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67145 Tracking Number D2 Original Specialty Recommended RVU: **2.53**
Presented Recommended RVU: **2.53**
Global Period: 010 Current Work RVU: **6.32** RUC Recommended RVU: **2.53**

CPT Descriptor: Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female with a retinal tear without a retinal detachment has photocoagulation of the retina around the tear.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 3%, In the office 97%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The patient's record is reviewed. The preoperative retinal drawing and diagnostic testing are reviewed. The procedure is discussed with the patient and informed consent obtained. The referring physician is contacted to confirm the presence of a tear and the treatment plan. Preoperative orders for medication and additional pupillary dilation are entered. In the treatment room, a time-out is performed to identify and mark the correct eye. Topical anesthesia is administered to the eye. The chair is reclined, and the patient is positioned for treatment. The laser is turned on and the laser indirect ophthalmoscope headband/interpupillary distance are adjusted by the physician. The laser duration, spot size, and power settings are set to be appropriate for the procedure.

Description of Intra-Service Work: The retina is re-examined to localize the tear and determine the extent of the treatment. The indirect ophthalmoscope laser delivery system is used to apply multiple rows of laser photocoagulation surrounding the retinal tear using scleral depression. The patient's head and eye are repositioned during the treatment to visualize the entire extent of the pathology and ensure that it is completely surrounded.

Description of Post-Service Work: Postoperative orders are entered and a procedure note is created. The procedure and post-procedure instructions are reviewed with the patient and family. Post-procedure restrictions and the symptoms of a retinal detachment requiring an urgent return visit are discussed with the patient. The referring physician is contacted to confirm that treatment was completed and the plan for follow-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); John T. Thompson, MD (ASRS)					
Specialty Society(ies):	AAO, ASRS					
CPT Code:	67145					
Sample Size:	737	**Resp N:**	66			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO and ASRS					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	10.00	25.00	**43.00**	62.00	270.00	
Survey RVW:	3.00	3.43	**4.45**	5.00	17.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**3.00**			
Intra-Service Time:	7.00	15.00	**16.00**	22.00	45.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	67145	**Recommended Physician Work RVU: 2.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**17.00**	**-12.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**3.00**	**5.00**	**-2.00**
Intra-Service Time:		**16.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67228	010	4.39	**RUC Time**

CPT Descriptor Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67105	010	3.39	**RUC Time**

CPT Descriptor Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11443	010	2.34	**RUC Time**	8,316

CPT Descriptor 1 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11642	010	2.62	**RUC Time**	89,442

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
32552	010	2.53	**RUC Time**

CPT Descriptor Removal of indwelling tunneled pleural catheter with cuff

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 34 **% of respondents:** 51.5 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 27.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 67145	Top Key Reference CPT Code: 67228	2nd Key Reference CPT Code: **67105**
Median Pre-Service Time	9.00	23.00	11.00
Median Intra-Service Time	16.00	25.00	30.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	46.0	23.00	46.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**76.00**	**81.00**	**97.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	12%	56%	32%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	29%	68%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	12%	88%
Physical effort required	0%	55%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	12%	88%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	50%	17%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	50%	17%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	78%	11%
Physical effort required	17%	67%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	56%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67145, *prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation,* was identified as a potentially misvalued code by a screen for Harvard-valued codes with utilization over 30,0000. It has never been surveyed and reviewed by the RUC. It describes laser photocoagulation of a retinal tear typically in an adult without the presence of a retinal detachment. It is typically performed in a non-facility under local anesthesia. While the code is currently a 090-day global, the

specialty believed that it was better described as a 010-day global procedure. The CPT editorial panel agreed that a 010-day global period was appropriate and accepted changes to the descriptors. The code was surveyed as 010-day global.

The two codes in this family, CPT 67141 and 67145, describe two different methods of treating the same pathology. Performance of both procedures on the same day would be extremely uncommon. There is currently a CCI edit precluding reporting of both procedures together.

A random survey of AAO and American Society of Retina Specialists (ASRS) members included 66 respondents, 97% of whom found the vignette typical. The median WRVU was 4.45 and the 25th percentile was 3.43. Median IST was 16 minutes. The current value of the code is 6.32 as a 090-day global.

The primary reference service, chosen by 52%, was CPT 67228, *Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation* (RUC April 2015) with a WRVU of 4.39 and an IST of 25 minutes. The overall intensity and complexity for the surveyed code was higher than the reference code. The mental effort/judgment, technical skill, and psychological stress submeasures were also substantially higher, while the majority ranked physical effort identical to the reference code. The secondary reference service, chosen by 27%, was CPT 67105, *Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation* (RUC 2015) with 3.39 WRVU and an IST of 30 minutes. The majority ranked the surveyed code identical to the reference code on overall intensity and complexity and each of the submeasures.

The expert panel of the AAO and ASRS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The median survey IST of 16 minutes was a substantial reduction compared to the current value. The procedure has not changed in 25 years, but survey times often decrease in comparison to Harvard times.

The panel supports the survey result of two level-3 postop visits, a decrease from the current number of three level-3 visits. Both visits, typically 1 day and approximately 1 week after the procedure, entail a complete dilated examination to assess early response to therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches.

Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure to prevent progression is necessary, as delay of only a day may lead to macular detachment, which is associated with a significantly poorer visual outcome. This is why the entire peripheral retina must be examined the day after the treatment and again within another week.

We chose pre-service package 6. We reduced pre-service evaluation time from the package time of 17 minutes to 7 minutes to account for a same day E/M visit. These 7 minutes are necessary for the following tasks, corresponding to specific items in the pre-service evaluation package:

- 3 minutes to “Communicate with patient and/or family (Discuss procedure/obtain consent):” The typical patient is not expecting a surgical procedure to be performed the same day on an urgent basis. Explaining the need for the procedure and obtaining consent is not part of the same-day office visit.
- 1 minute to “Prepare for Procedure (Check labs, plan, assess risks, review procedure):” Although some of this is part of the same-day office visit, time is required to enter orders associated with the treatment into the EHR. This is not part of a same-day office visit.
- 1 minute to “Communicate with other professionals:” A call to the referring physician is made to convey the findings of a tear and the plan to perform treatment. The package time is 2 minutes. We reduced this to 1 minute because a brief call to the referring physician would be part of a same-day

office visit when no tear is found. The time in addition to an office visit is required when a tear is found and treatment intended to communicate the treatment plan to the referring physician.

- 1 minute to "Check/set-up room, supplies and equipment:" This time is needed to turn on and adjust the laser power, spot size, and duration settings and adjust the laser indirect ophthalmoscope headband and interpupillary distance settings. It is not part of a same-day office visit.
- 1 minute to "Check/prepare patient readiness (gown, prep, drape, mark):" This time is needed to perform a time out and mark the eye and is not part of an office visit.

We reduced the pre-service positioning time from the median survey time of 5 minutes to 1 minute (package time) and used the survey pre-service scrub, dress, and wait time of 3 minutes. During this time topical anesthesia is applied and the laser power is titrated to achieve the appropriate level of burn. We used the survey immediate post-service time of 5 minutes to monitor and instruct the patient on postoperative care, prepare an operative report, discuss symptoms of a retinal detachment and contact the referring physician. The total time is 78 minutes.

As with CPT 67141, there are no 15- or 16-minute 10-day global procedures with two postoperative visits, making it impossible to find a crosswalk with a similar IST and a work value resulting in a positive IWPUT. Going back further, we find support for a value of 2.53 WRVU from CPT 32552, *Removal of indwelling tunneled pleural catheter with cuff* (RUC October 2008) with 2.53 WRVU, an IST of 15 minutes, and a total time of 82 minutes. This is identical to the recommendation for CPT 67141 as the physician work of the two procedures is essentially the same.

For CPT 67145, we recommend a work value of 2.53 WRVU, considerably below the 25th percentile and below the survey minimum, with times of 11/16/5 minutes and a total time of 78 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Billed with an office visit.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	92002	5	15	5	25.0	0.88	XXX	0.13%
5.	92004	5	25	10	40.0	1.82	XXX	9.16%
6.	92012	5	15	5	25.0	0.92	XXX	4.78%
7.	92014	5	24	8	37.0	1.42	XXX	19.26%
8.	99203	4	20	5	29.0	1.42	XXX	0.47%
9.	99204	5	30	10	45.0	2.43	XXX	18.99%
10.	99205	7	45	15	67.0	3.17	XXX	3.57%
11.	99212	2	10	4	16	0.48	XXX	0.13%
12.	99213	3	15	5	23.0	0.97	XXX	1.95%

13.	99214	5	25	10	40.0	1.50	XXX	5.39%
14.	99215	5	35	15	55.0	2.11	XXX	2.02%
15.								Total: 65.85%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 83800
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation.

Specialty Ophthalmology Frequency 83800 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
31,865 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 31865 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Treatment of retinal lesions

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67145

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Retinal Detachment Prophylaxis

TAB: 8

67141

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11
1st REF	67227	10	Destruction of extensive or progressive retinopathy (eg,	24	0.050			3.50			93	5	1	5			30			10						0.5				1		
2nd REF	67228	10	Treatment of extensive or progressive retinopathy (eg, d	14	0.110			4.39			81	17	1	5			25			10										1		
CURRENT	67141	90	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy	Hvd	0.075			6.15			139	28					32			10										3		
SVY	67141	10	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy	58	0.084	3.10	3.50	4.18	5.00	17.00	97.5	10	5	5	5	15	15	24	40	5									2.5		
XWALK	32552	10	Removal of indwelling tunneled pleural catheter with cuff		0.052			2.53			82	13	1	6			15			12						0.5				1		
REC	67141	10	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy		0.020			2.53			77	5	1	5			15			5										2		

67145

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11
1st REF	67228	10	Treatment of extensive or progressive retinopathy (eg, d	34	0.110			4.39			81	17	1	5			25			10										1		
2nd REF	67105	10	Repair of retinal detachment, including drainage of subr	18	0.035			3.39			97	5	1	5			30			10										2		

FACILITY DIRECT PE INPUTS **CPT CODE(S):__67141__**
SPECIALTY SOCIETY(IES):_AAO, ASRS___
PRESENTER(S):_David Glasser, Ankoor Shah, John Thompson_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67141	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy	010 ~~090~~

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
67141	A 66-year-old male with a retinal tear with a vitreous hemorrhage, but no retinal detachment, has cryotherapy to the retina around the tear.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment. Moreover an informal survey of 40 ophthalmologists that perform this procedure was taken to more accurately determine changes to PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?

Yes

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Although a 10-day Global typically has no pre-service time with a same day E/M, we wanted to outline why there is significant pre-service work performed regardless. Patients are typical referred for "floaters" in their vision. During the E/M a retinal tear is identified. At this point the clinical vignette of "A 66yo M with retinal tear" begins the actual procedure for treatment of retinal tear. Since the procedure is not planned, the staff is required to perform all of the activities below despite the fact that an E/M was performed the same day. Even when done in the facility setting this is still typically performed on the same day. Line CA001 – The staff get appropriate insurance approval for the new indicated procedure for treatment of retinal tear. This approval is not obtained in advance of the E/M visit since the majority of patients with "floaters" don't have tears. Once the E/M has confirmed the presence of a tear is this process initiated. 5 minutes which is the standard time is included. Line CA004 – After a diagnosis of retinal tear is made through the E/M, the patient is then educated on the immediate need for the procedure as well as to obtain consent. As a practical matter, this process takes time as the patient is suddenly given a diagnosis that requires immediate treatment to prevent blindness. Moreover, the procedure itself carries a risk of vision loss which all must be explained to the patient as is separate from the same day E/M. 7 minutes which is the standard time is included. Line CA005 – The staff typically will typically call/help make arrangements as the patient who initially came for an exam, is now leaving with a procedure that limits the patients ability to drive home. Additional calls are made for prescriptions for topical drops and pain medications as needed. 3 minutes which is the standard time is included.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

Line CA039 – Standard inputs for technician time for 2 level-3 postoperative visits (based on the survey) are included.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Postop Visits & Cleaning Supplies:
Line SA082 Ophthalmology pack with dilation – *Reduced from 3 to 2* –The two remaining packs are to account for use on the postoperative visits where the success of the cryopexy and/or progression to retinal detachment is evaluated.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment.

Line EL005 Lane, Eye Exam – Time included reflects postoperative visits based on the survey results.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list

of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):__67141_**
SPECIALTY SOCIETY(IES):_AAO, ASRS_
PRESENTER(S):_David Glasser, Ankoor Shah, John Thompson___

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67141	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy	010 ~~090~~

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
67141	A 66-year-old male with a retinal tear with a vitreous hemorrhage, but no retinal detachment, has cryotherapy to the retina around the tear.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment. Moreover an informal survey of 40 ophthalmologists that perform this procedure was taken to more accurately determine changes to PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Yes.
Yes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Ophthalmology (~100%)
Non-facility Performance (83%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Although a 10-day Global typically has no pre-service time with a same day E/M, we wanted to outline why there is significant pre-service work performed regardless. Patients are typical referred for "floaters" in their vision. During the E/M a retinal tear is identified. At this point the clinical vignette of "A 66yo M with retinal tear" begins the actual procedure for treatment of retinal tear. Since the procedure is not planned, the staff is required to perform all of the activities below despite the fact that an E/M was performed the same day.

Line CA001 – The staff get appropriate insurance approval for the new indicated procedure for treatment of retinal tear. This approval is not obtained in advance of the E/M visit since the majority of patients with "floaters" don't have tears. Once the E/M has confirmed the presence of a tear is this process initiated. 5 minutes which is the standard time is included.
Line CA004 – After a diagnosis of retinal tear is made through the E/M, the patient is then educated on the immediate need for the procedure as well as to obtain consent. As a practical matter, this process takes time as the patient is suddenly given a diagnosis that requires immediate treatment to prevent blindness. Moreover, the procedure itself carries a risk of vision loss which all must be explained to the patient as is separate from the same day E/M. 7 minutes which is the standard time is included.
Line CA005 – The staff typically will typically call/help make arrangements as the patient who initially came for an exam, is now leaving with a procedure that limits the patients ability to drive home. Additional calls are made for prescriptions for topical drops and pain medications as needed. 3 minutes which is the standard time is included.

    b. Service period (includes pre, intra and post):

Standard input times used for pre and post activities. Survey times used for intra-service activities.

Pre: (Standard Inputs)
Line CA013: The cryo machine, probe, cover, and sterile equipment are brought into the exam room and setup.
Line CA016: The patient is tilted back, the chair elevated to an appropriate height.
Line CA017: Multiple rounds of topical drops are placed several seconds apart which are supplemental

and prior to the topical anesthesia and subconjunctival lidocaine injections performed by the physician.

Intra: (Survey Input)
Line CA018: The technician remains in the room 100% of the time the physician is performing the service. During that time, they will reapply lubrication to the eye, facilitate in repositioning the patient, lubricate to loosen the cryoprobe after each freeze, and make adjustments to the gas valve on the cryoprobe as needed.

Post: (Standard Inputs)
Line CA024 – The technician will clean the probe, disconnect tubing, turn off the gas valve, and release the excess nitrogen in the tubing to prevent line freeze.
Line CA026 – The technician will scrub and clean the cryo probe, cover, and sterile tray of instruments (lid spec, scleral depressor, etc). These will be repackaged and sterilized.
Line CA029 – The technician check the dressing to ensure complete closure, no hemorrhaging, and ensure adequate fit to prevent corneal abrasion from loosened dressings.

c. Post-service period:

Line CA039 – Standard inputs for technician time for 2 level-3 postoperative visits (based on the survey) are included.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

The technician remains in the room 100% of the time the physician is performing the service. Since the physician is holding a lens in one hand and a cryoprobe in the other throughout the procedure, the technician acts as the 3rd hand throughout the procedure. During that time, they will reapply lubrication to the eye, facilitate in repositioning the patient, lubricate to loosen the cryoprobe after each freeze, and make adjustments to the gas valve on the cryoprobe as needed.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Postop Visits & Cleaning Supplies:
Line SA082 Ophthalmology pack with dilation – *Reduced from 4 to 2* **–** The decrease accounts for 1 less pack due to conversion from 90-day to 10-day global. One additional pack was removed to eliminate duplication since it is now typically performed with an E/M. The two remaining packs are to account for use on the postoperative visits where the success of the cryopexy and/or progression to retinal detachment is evaluated.
Line SA043 Pack, cleaning surgical instruments – *Added 1 Unit* - This is required to clean off conjunctival eye tissue off the probe and other surgical instruments and prepare for resterilization prior to the next use. This was utilized even before this review but omitted in error.

Sterility Related Supplies: No Changes from Prior Review
Line SB001 Cap, Surgical – *2 Units* – One for physician and technician as this is a sterile procedure
Line SB024 Gloves, sterile – *2 Units* – One for physician and technician as this is a sterile procedure
Line SB027 Gown, staff impervious – *2 Units* – One for physician and technician as this is a sterile procedure
Line SB039 Shoe Covers, Surgical – *2 Units* – One for physician and technician as this is a sterile procedure

Anesthesia Supplies: Changes reflect change in anesthesia patterns away from retrobulbar blocks to use of topical with subconjunctival lidocaine.
Line SC029 Needle, 18-27G – *Added 1* – Used as a fill needle to draw up Lidocaine
Line SC031 Needle, 30G – *1 Unit* – Used to inject subconjunctival Lidocaine
Line SC052 Syringe, 1ml – *1 Unit* – Used to inject subconjunctival Lidocaine
Line SC057 Syringe, 5-6ml – *Removed* – Retrobulbar block is no longer typically used.
Line SC081 Needle, Retrobulbar – *Removed* – Retrobulbar block is no longer typically used.
Line SH047 Lidocaine1%-2% - *Reduced 5ml to 1ml* – This volume is more typical for subconjunctival block for this procedure
Line SH058 Proparacaine 0.5% Oph – *Added 1ml* – Used for topical anesthesia prior to subconjunctival block

Lubrication Supplies:
Line SH037 Goniosol 2.5% Ophth – *Added 1 ml* – Used to lubricate the eye throughout the procedure

Dressing Supplies: Dressings were also previously used prior to this review but omitted in error
Line SG043 Dressing, Eye pad – *Added 1 Unit* – Patch placed over the eye post procedure
Line SJ007 Bacitracin Ointment (0.9gm) – *Added 1 Unit* – Placed in eye prior to placing patch
Line SG078 Tape, Surgical Occlusive – *9 inches* – Three 3-inch ribbons placed over the patch to secure

corners and central aspect of the patch
Line SH 075 Water, Sterile Inj – *Added 10ml* – Flush is performed to remove the goniosol prior to antibiotic ointment and patch placement

Antiseptic Supplies:
Line SJ041 Povidone Soln – *1 ml* - Placed in the eye prior to procedure for sterility

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment.

Line EL005 Lane, Eye Exam – Time included reflects time room occupied for the procedure as well as postoperative visits based on the survey results.
Line EQ096 Cryosurgical Probe, Retina – Time included is for the entire procedure as well as the time needed to clean the surgical equipment before next use
Line EQ095 Cryosurgery System, Ophthalmic – Time included is for the entire procedure as the time needed.
Line EQ137 Instrument Pack, Basic ($500-1499) - Time included is for the entire procedure as well as the time needed to clean the surgical equipment before next use.

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

This code was converted from a 90-day global to a 10-day global. Supply changes reflect the loss of 1 post op visit to 2 post op visits during the 10-day period.

The significant changes in supplies also reflect the transition to topical plus subconjunctival lidocaine as the typical form of anesthesia vs the prior use of retrobulbar blocks for this procedure.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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FACILITY DIRECT PE INPUTS **CPT CODE(S):__67145__**
SPECIALTY SOCIETY(IES):_AAO, ASRS___
PRESENTER(S):_David Glasser, Ankoor Shah, John Thompson_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation	010 ~~090~~

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
67145	A 72-year-old female with a retinal tear without a retinal detachment has photocoagulation of the retina around the tear.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment. Moreover an informal survey of 40 ophthalmologists that perform this procedure was taken to more accurately determine changes to PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?

Yes

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Although a 10-day Global typically has no pre-service time with a same day E/M, we wanted to outline why there is significant pre-service work performed regardless. Patients are typical referred for "floaters" in their vision. During the E/M a retinal tear is identified. At this point the clinical vignette of "A 66yo M with retinal tear" begins the actual procedure for treatment of retinal tear. Since the procedure is not planned, the staff is required to perform all of the activities below despite the fact that an E/M was performed the same day. Even when done in the facility setting this is still typically performed on the same day. Line CA001 – The staff get appropriate insurance approval for the new indicated procedure for treatment of retinal tear. This approval is not obtained in advance of the E/M visit since the majority of patients with "floaters" don't have tears. Once the E/M has confirmed the presence of a tear is this process initiated. 5 minutes which is the standard time is included. Line CA004 – After a diagnosis of retinal tear is made through the E/M, the patient is then educated on the immediate need for the procedure as well as to obtain consent. As a practical matter, this process takes time as the patient is suddenly given a diagnosis that requires immediate treatment to prevent blindness. Moreover, the procedure itself carries a risk of vision loss which all must be explained to the patient as is separate from the same day E/M. 7 minutes which is the standard time is included. Line CA005 – The staff typically will typically call/help make arrangements as the patient who initially came for an exam, is now leaving with a procedure that limits the patients ability to drive home. Additional calls are made for prescriptions for topical drops and pain medications as needed. 3 minutes which is the standard time is included.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

Line CA039 – Standard inputs for technician time for 2 level-3 postoperative visits (based on the survey) are included.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Postop Visits:
Line SA082 Ophthalmology pack with dilation – *Reduced from 3 to 2* –The two remaining packs are to account for use on the postoperative visits where the success of the laser retinopexy and/or progression to retinal detachment is evaluated.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

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    a. If yes, please explain how the computer is used for this service(s).
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N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

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17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

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N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):__67145_**
SPECIALTY SOCIETY(IES):_AAO, ASRS_
PRESENTER(S):_David Glasser, Ankoor Shah, John Thompson___

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation	010 ~~090~~

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
67145	A 72-year-old female with a retinal tear without a retinal detachment has photocoagulation of the retina around the tear.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment. Moreover an informal survey of 40 ophthalmologists that perform this procedure was taken to more accurately determine changes to PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Yes.
Yes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Ophthalmology (~100%)
Non-facility Performance (87%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Although a 10-day Global typically has no pre-service time with a same day E/M, we wanted to outline why there is significant pre-service work performed regardless. Patients are typical referred for "floaters" in their vision. During the E/M a retinal tear is identified. At this point the clinical vignette of "A 66yo M with retinal tear" begins the actual procedure for treatment of retinal tear. Since the procedure is not planned, the staff is required to perform all of the activities below despite the fact that an E/M was performed the same day.

Line CA001 – The staff get appropriate insurance approval for the new indicated procedure for treatment of retinal tear. This approval is not obtained in advance of the E/M visit since the majority of patients with "floaters" don't have tears. Once the E/M has confirmed the presence of a tear is this process initiated. 5 minutes which is the standard time is included.
Line CA004 – After a diagnosis of retinal tear is made through the E/M, the patient is then educated on the immediate need for the procedure as well as to obtain consent. As a practical matter, this process takes time as the patient is suddenly given a diagnosis that requires immediate treatment to prevent blindness. Moreover, the procedure itself carries a risk of vision loss which all must be explained to the patient as is separate from the same day E/M. 7 minutes which is the standard time is included.
Line CA005 – The staff typically will typically call/help make arrangements as the patient who initially came for an exam, is now leaving with a procedure that limits the patients ability to drive home. Additional calls are made for prescriptions for topical drops and pain medications as needed. 3 minutes which is the standard time is included.

   b. Service period (includes pre, intra and post):

Standard input times used for pre and post activities. Survey times used for intra-service activities.

Pre: (Standard Inputs)
Line CA013: The indirect laser head piece is attached to the laser machine, the laser is turned on, and initial settings are placed.
Line CA016: The patient is tilted back, the chair elevated to an appropriate height.
Line CA017: Multiple rounds of topical drops are placed several seconds apart which are supplemental and prior to the final round of topical anesthesia applied by the physician.

Intra: (Survey Input)

Line CA018: The technician remains in the room 100% of the time the physician is performing the service. During that time, they will reapply lubrication to the eye, provide additional topical anesthesia, facilitate in repositioning the patient, and make adjustments to the laser settings as needed.

Post: (Standard Inputs)
Line CA024 – The technician will clean the room, disconnect the indirect laser attachment, turn off the laser.

c. Post-service period:

Line CA039 – Standard inputs for technician time for 2 level-3 postoperative visits (based on the survey) are included.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

The technician remains in the room 100% of the time the physician is performing the service. Since the physician is holding a lens in one hand and a scleral depressor in the other throughout the procedure, the technician acts as the 3rd hand throughout the procedure. During that time, they will reapply lubrication to the eye, facilitate in repositioning the patient, provide additional topical anesthesia, and make adjustments to the laser settings as needed.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Postop Visits:
Line SA082 Ophthalmology pack with dilation – *Reduced from 4 to 2* – The decrease accounts for 1 less pack due to conversion from 90-day to 10-day global. One additional pack was removed to eliminate duplication since it is now typically performed with an E/M. The two remaining packs are to account for use on the postoperative visits where the success of the laser retinopexy and/or progression to retinal detachment is evaluated.

Anesthesia Supplies: Changes reflect change in anesthesia patterns away from subconjunctival blocks to use of topical proparacaine.
Line SC031 Needle, 30G – *Removed 1 Unit* – No longer typically used
Line SC052 Syringe, 1ml – *Removed 1 Unit* – No longer typically used
Line SH047 Lidocaine1%-2% - *Removed 5 ml*– No longer typically used
Line SH058 Proparacaine 0.5% Oph – *Added 1ml* – Used for topical anesthesia.

Lubrication Supplies:
Line SH037 Goniosol 2.5% Ophth – *Added 1 ml* – Used to lubricate the eye throughout the procedure
Line SH 075 Water, Sterile Inj – *Added 10ml* – Flush is performed to remove the goniosol

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment.

Line EL005 Lane, Eye Exam – Time included reflects time room occupied for the procedure as well as postoperative visits based on the survey results.
Line EQ159 Laser, Argon-Kripton – *Added* – This device was added as informal surveys performed demonstrated that the indirect laser is more typical than slit lamp laser. Additionally the time included is for the entire procedure as well as the time needed to clean the room before next use.
Line EQ158 Laser, Argon (w/Slit-lamp Adapter) – *Removed* – No longer the typical laser used.
Line EQ230 Slit Lamp, dedicated laser use – No longer typical.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

This code was converted from a 90-day global to a 10-day global. Supply changes reflect the loss of 1 post op visit to 2 post op visits during the 10-day period.

The changes in supplies also reflect the shift from subconjunctival lidocaine to topical anesthesia.

The changes in the equipment reflect the shift towards indirect laser rather than slit lamp laser.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**CPT Code 67141**		**CPT Code 67141**		**CPT Code 67145**		**CPT Code 67145**	
3		***RUC Collaboration Website***				Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage;		Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage;		Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage;		Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage;	
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 8 Specialty: Ophthalmology**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**010**	**010**	**090**	**090**	**010**	**010**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 115.42**	**$ 85.31**	**$ 82.98**	**$ 47.37**	**$ 109.90**	**$ 87.59**	**$ 65.98**	**$ 47.37**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**196.0**	**168.0**	**122.0**	**87.0**	**189.0**	**174.0**	**112.0**	**87.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**35.0**	**60.0**	**15.0**	**15.0**	**35.0**	**60.0**	**15.0**	**15.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**53.0**	**0.0**	**35.0**	**0.0**	**46.0**	**6.0**	**25.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**108.0**	**108.0**	**72.0**	**72.0**	**108.0**	**108.0**	**72.0**	**72.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 74.48**	**$ 63.84**	**$ 46.36**	**$ 33.06**	**$ 71.82**	**$ 66.12**	**$ 42.56**	**$ 33.06**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery/procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CST	0.38	5	5	5	5	5	5	5	5
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CST	0.38	10	20	0	0	10	20	0	0
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST	0.38		8				8		
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	0.38	10	20	7	7	10	20	7	7
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CST	0.38	10	7	3	3	10	7	3	3
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CST	0.38								
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CST	0.38								
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CST	0.38								
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037C	Orthoptist	0.37								
24			L038A	COMT/COT/RN/CST	0.38								
27		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38								
30		**End: When patient enters office/facility for surgery/procedure**											
31		**SERVICE PERIOD**											
32		**Start: When patient enters office/facility for surgery/procedure:**											
33		**Pre-Service (of service period)**											
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L038A	COMT/COT/RN/CST	0.38	3				3			
35	CA010	Obtain vital signs	L038A	COMT/COT/RN/CST	0.38	3				3			
36	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CST	0.38								
37	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CST	0.38	2				2			
38	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CST	0.38	3		2		3		2	
39	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CST	0.38								
40	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CST	0.38								
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CST	0.38	2		2		2		2	
42	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CST	0.38			2				2	
43			L038A	COMT/COT/RN/CST	0.38								
46		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38								
49		**Intra-service (of service period)**											
50	CA018	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CST	0.38	32		15		25		16	
51	CA019	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CST	0.38								
52	CA020	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CST	0.38								
53	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CST	0.38						6		
56			L038A	COMT/COT/RN/CST	0.38								
57		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38								
60		**Post-Service (of service period)**											
61	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CST	0.38								
62	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CST	0.38								
63	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CST	0.38	3		3		3		3	
64	CA025	Clean scope	L038A	COMT/COT/RN/CST	0.38								
65	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CST	0.38			10					
66	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CST	0.38								
67	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CST	0.38								
68	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CST	0.38	5		1		5			
69	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L038A	COMT/COT/RN/CST	0.38								
70	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CST	0.38								
71	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L038A	COMT/COT/RN/CST	0.38								
72	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CST	0.38								

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4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 8 Specialty: Ophthalmology**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**010**	**010**	**090**	**090**	**010**	**010**
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10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**53.0**	**0.0**	**35.0**	**0.0**	**46.0**	**6.0**	**25.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**108.0**	**108.0**	**72.0**	**72.0**	**108.0**	**108.0**	**72.0**	**72.0**
73	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs,	L038A	COMT/COT/RN/CST	0.38								
74	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CST	0.38								
75	CA036	Discharge day management	L038A	COMT/COT/RN/CST	0.38	**n/a**		**n/a**		**n/a**		**n/a**	
76			L038A	COMT/COT/RN/CST	0.38								
79		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38								
82		**End: Patient leaves office/facility**											
83		**POST-SERVICE PERIOD**											
84		**Start: Patient leaves office/facility**											
85	CA037	Conduct patient communications	L038A	COMT/COT/RN/CST	0.38								
86	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CST	0.38								
87	CA038	Coordinate post-procedure services	L037C	Orthoptist	0.37								
88		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes	16										
90		99212 27 minutes	27										
91		99213 36 minutes	36			3	3	2	2	3	3	2	2
92		99214 53 minutes	53										
93		99215 63 minutes	63										
94	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CST	0.38	**108.0**	**108.0**	**72.0**	**72.0**	**108.0**	**108.0**	**72.0**	**72.0**
95			L038A	COMT/COT/RN/CST	0.38								
98		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38								
101		**End: with last office visit before end of global period**											

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9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**35.0**	**60.0**	**15.0**	**15.0**	**35.0**	**60.0**	**15.0**	**15.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**53.0**	**0.0**	**35.0**	**0.0**	**46.0**	**6.0**	**25.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**108.0**	**108.0**	**72.0**	**72.0**	**108.0**	**108.0**	**72.0**	**72.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 20.37**	**$ 8.86**	**$ 24.39**	**$ 5.91**	**$ 12.75**	**$ 8.86**	**$ 8.11**	**$ 5.91**
104	SA082	pack, ophthalmology visit (w-dilation)	2.9535	pack		4	3	2	2	4	3	2	2
105	SA043	pack, cleaning, surgical instruments	8.9745	pack				1					
106	SB001	cap, surgical	0.6745	item		2		2					
107	SB024	gloves, sterile	0.875	pair		2		2					
108	SB027	gown, staff, impervious	1.186	item		2		2					
109	SB039	shoe covers, surgical	0.219	pair		2		2					
110	SC029	needle, 18-27g	0.0645	item				1					
111	SC031	needle, 30g	0.442	item		1		1		1			
112	SC052	syringe 1ml	0.2	item		1		1		1			
113	SC057	syringe 5-6ml	0.14	item		1							
114	SC081	needle, retrobulbar (Atkinson)	1.4875	item		1							
115	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0475	ml		5		1		5			
116	SH058	proparacaine 0.5% ophth (Ophthaine, Alcaine)	1.194	ml				1				1	
117	SH037	Goniosol 2.5% ophth	0.61	ml				1		0		1	
118	SG043	dressing, eye pad (Opticlude)	0.334	item				1					
119	SJ007	bacitracin oint (0.9gm uou)	0.1105	item				1					
120	SG078	tape, surgical occlusive 1in (Blenderm)	0.007	inch				9					
121	SH075	water, sterile inj	0.0395	ml				10				10	
122	SJ041	povidone soln (Betadine)	0.137	ml		1		1					
123		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*											
125	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
126		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 20.57**	**$ 12.61**	**$ 12.23**	**$ 8.41**	**$ 25.32**	**$ 12.61**	**$ 15.32**	**$ 8.41**
127	EL005	lane, exam (oph)	37169.005	Default	0.116737051	161	108	97.0	72.0	154	108	97.0	72.0
128	EQ096	cryosurgical probe, retina	2652.8335	Default	0.00856237	53	0	25	0				
129	EQ095	cryosurgery system, ophthalmic	7746.473	Default	0.025002764	53	0	25	0				
130	EQ137	instrument pack, basic ($500-$1499)	500	Default	0.002323783			31					
131	EQ158	laser, argon (w-slit lamp adapter)	32900	Default	0.127491684					46		25	
132	EQ230	slit lamp (Haag-Streit), dedicated to laser use	12125.4835	Default	0.032177717					46		25	
133		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*											

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000*

October 2020

Orthoptic Training – Tab 9

This service was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC recommended that CPT code 92065 be referred to CPT May 2020 for a descriptor edit and possible creation of separate codes. This service, with an amorphous "and/or" connector, could be two different codes given their different patient populations and techniques used for the treatment. At the May 2020 CPT Editorial Panel meeting, the Panel approved revision of the code to remove "and/or pleoptic" and "with continuing medical direction and evaluation" from the descriptor.

At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes to delineate when the training is provided directly by the provider and when it is provided by a technician under the supervision of the provider. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for CPT 2023. **The RUC recommends CPT code 92065 be referred to CPT.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Ophthalmology Special Ophthalmological Services				
▲92065	E1	Orthoptic ~~and/or pleoptic~~ training~~, with continuing medical direction and evaluation~~	XXX	Refer to CPT February 2021

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AMERICAN ACADEMY™
OF OPHTHALMOLOGY

20 F Street NW
Suite 400
Washington DC
20001-6701

P.O. Box 7424
San Francisco, CA
94120-7424

T: +1 202.737.6662
www.aao.org

October 9, 2020

Peter Smith, M.D., Chair
AMA Specialty Society Relative Value Update Committee
American Medical Association
330 North Wabash Ave., Suite 39300
Chicago IL 60611-5885

Dear Dr. Smith,

The American Academy of Ophthalmology is writing to indicate our intent, based on both pre-facilitation advisory and RUC agreement, to submit an application to the AMA CPT Editorial Panel for the February 2021 meeting for CPT 92065 Orthoptic training. During review and analysis of the survey undertaken with the American Optometric Association, we became aware that this service is delivered in two different ways. Because of this, it is necessary to create two codes in order to break out when the training is provided directly by the provider and when it is provided by clinical staff under the supervision of the provider. Doing so will ensure more accurate valuation of both practice expense and work associated with this service.

We appreciate the RUC's support for this request during the October 2020 consideration of this issue (Tab 9). If you have any questions or need additional information please contact Kayla Amodeo, PhD, AAO Health Policy Director via email to kamodeo@aao.org.

Sincerely,

David B. Glasser, M.D.
RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2020

Cardiac Catheterization for Congenital Defects – Tab 10

In May 2020, the CPT Editorial Panel replaced a family of four cardiac catheterization codes with five new codes to describe cardiac catheterization for congenital cardiac defect(s). In addition, the Panel replaced two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population and a change in technology. The specialty societies noted and the RUC agreed that the vast majority of diagnostic catheter studies were performed in children who were healthier with simpler cardiac defects when the previous code structure was last valued in 1997; children with more significant cardiac defects had no treatment options, so catheterization was not warranted. Over the past 23 years, as result of improvements in both technique and technology, the specialty has evolved and now performs a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures, and the typical patient is now a more complex patient requiring more pathology. The specialties noted that one of the whitepapers that they provided by Nicholson et al. confirms that these procedures were unable to be previously accomplished on the current typical patient with earlier technology/techniques. The specialties provided additional literature to further demonstrate the changes in congenital catheterization over the past two decades.

The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

93593 ***Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections***
The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 3.99 for CPT code 93593. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent and the post-procedure work includes additional time to explain the pathology of the child to the parent.

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Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which also adds post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The specialty noted and the RUC agreed that the existing codes for cardiac catheterization for congenital heart disease have inappropriately low IWPUTs that are not in line with the other cardiac catheterization codes that are for patients without congenital heart disease (codes 93452-93461).

The RUC and the specialty societies discussed how deleted code 93530 was previously the only "right heart only" catheterization code designed to capture all possible pathologies for patients with congenital heart disease. This work is now being segmented into 93593 for patients with simple defects, defined in CPT as having normal native connections, and 93594 for the more complex patients with abnormal native connections. The RUC concurred that this change in code structure is one of several reasons why comparing the 1997 physician times for 93530 to both 93593 and 93594 is precarious at best. The RUC also noted that when deleted code 93530 was last evaluated by the RUC and CMS in 1997, both the RUC and CMS evaluated physician time with much less rigor and the valuation process has greatly evolved and become more refined. Correspondingly, deleted code 93530 has an inappropriately low IWPUT of 0.0206, which implies that the 1997 times are overstated relative to the current work RVU. Separately, the RUC also noted that 0.25 work RVUs and 10 minutes of pre-service time were systematically removed from the deleted code in 2017 when moderate sedation was unbundled from all services following the deletion of CPT Appendix G. As 93530 is typically performed on an infant under *general anesthesia*, the specialty noted and the RUC agreed that including 93530 in the moderate sedation unbundling initiative was inappropriate, and had an unwarranted downward effect on the work RVUs currently credited to the code. Furthermore, the times captured in surveys in 1997 only reflected a small number of specialists who had adequate experience to provide reliable information on the procedure, a reflection of the nascent nature of the specialty 23 years ago.

To justify a value of 3.99, the RUC compared the survey code to CPT code 49422 *Removal of tunneled intraperitoneal catheter* (work RVU= 4.00, intra-service time of 45 minutes, total time of 111 minutes) and noted that both services involve an identical amount of intra-service time and a similar overall amount of physician work. The RUC also compared the survey code to MPC code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes, total time of 116 minutes) and noted that both services involve identical intra-service time and the survey code at 3.99 would be appropriately valued to this reference service. **The RUC recommends a work RVU of 3.99 for CPT code 93593.**

93594 ***Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections***

The RUC reviewed the survey results from 45 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 6.10 for CPT code 93594. The RUC recommends 46 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 60 minutes of intra-service time and 48 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent and the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into

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national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC and the specialty societies discussed how deleted code 93530 was previously the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. This work is now being segmented into 93593 for patients with simple defects, defined in CPT as having normal native connections, and 93594 for the more complex patients with abnormal native connections. The RUC concurred that this change in code structure is one of several reasons why comparing the 1997 physician times for 93530 to both 93593 and 93594 is precarious at best. The RUC also noted that when deleted code 93530 was last evaluated by the RUC and CMS in 1997, both the RUC and CMS evaluated physician time with much less rigor and the valuation process has greatly evolved and become more refined. Correspondingly, deleted code 93530 has an inappropriately low IWPUT of 0.0206, which implies that the 1997 times are overstated relative to the current work RVU. Separately, the RUC also noted that 0.25 work RVUs and 10 minutes of pre-service time were systematically removed from the deleted code in 2017 when moderate sedation was unbundled from all services following the deletion of CPT Appendix G. As 93530 is typically performed on an infant under *general anesthesia*, the specialty noted and the RUC agreed that including 93530 in the moderate sedation unbundling initiative was inappropriate, and had an unwarranted downward effect on the work RVUs currently credited to the code. Furthermore, the times captured in surveys in 1997 only reflected a small number of specialists who had adequate experience to provide reliable information on the procedure, a reflection of the nascent nature of the specialty 23 years ago.

To justify a value of 6.10, the RUC compared the survey code to CPT code 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* (work RVU= 6.29, intra-service time of 60 minutes, total time of 111 minutes) and noted that both services involve identical intra-service time and a similar overall amount of physician work. The RUC also compared the survey code to CPT code 20245 *Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)* (work RVU=6.00, intra-service time of 60 minutes, total time of 160 minutes) and noted that although both services have identical intra-service time, the survey code involves 10 more minutes of total time, supporting the somewhat higher work value. **The RUC recommends a work RVU of 6.10 for CPT code 93594.**

93595 ***Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections***

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 6.00 for CPT code 93595. The RUC recommends 46 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 48 minutes of intra-service time and 46 minutes of immediate post-service time. The specialty societies noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

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CPT code 93595 describes a left heart catheterization procedure in patients with congenital heart and vascular defects. In addition to left heart obstructive lesions such as aortic valve stenosis and coarctation of the aorta, a left heart catheterization is often needed for evaluation of patients with pulmonary blood flow originating from the aorta; those with major aorto-pulmonary collateral arteries or, major aortopulmonary collateral arteries (MAPCAs), for example. Such patients typically have numerous vascular connections from the aorta to supply the pulmonary blood flow in a secondary vascular tree, either in addition to, or as replacement for the native pulmonary arterial tree. These procedures require a significantly greater level of diagnostic evaluation, catheter and wire manipulation, and angiography to identify each vessel for surgical planning than previously afforded with the non-congenital diagnostic codes.

The RUC noted that 93595 is typically somewhat more intense to perform than 93594, justifying a somewhat higher assigned physician work intensity. For 93595, the physician typically accesses the femoral artery after which all of them connect to the aorta; there is no variability with this for the most part. For a normal connection patient, it will be straightforward. Risk of arterial catheterization is always high due to risks of stroke, bleeding into the brain for infants on heparin, femoral artery injury for infants. For an abnormal connection patient, things get more complicated because doctors are now also talking about crossing arterial shunts or the PDA to evaluate the pulmonary arteries, or evaluating other vascular structures like MAPCAs, which can be multiple. Although the overall structures evaluated are still fewer than from a right heart catheterization (93594), when assessing the pulmonary arteries across shunts or a PDA, this is not typically well tolerated. These shunts are 3 or 3.5mm in diameter with a catheter being ~1.5mm, the procedure involves blocking roughly 50 percent or more of the entire blood flow to the lungs. Due to this, the physician work intensity is very high.

To justify a value of 6.00, the RUC compared the survey code to CPT code 93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU=5.99, intra-service time of 45 minutes, total time of 113 minutes) and noted that the survey code involves similar intra-service time and more total time, and similar amount of physician work. The RUC also compared the survey code to CPT code 37248 *Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein* (work RVU= 6.00, intra-service time of 50 minutes, total time of 109 minutes) and noted that the survey code involves similar intra-service time and more total time, and a similar total amount of physician work. **The RUC recommends a work RVU of 6.00 for CPT code 93595.**

93596 ***Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections***

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 7.91 for CPT code 93596. The RUC recommends 50 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 60 minutes of intra-service time and 53 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details

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into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

To justify a value of 7.91 the RUC compared the survey code to CPT code 93461 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization…* (work RVU=7.85, intra-service time of 60 minutes, total time of 143 minutes) and noted both services involve identical intra-service times whereas the survey code involves more total time. The RUC also compared the survey code to CPT code 52356 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU= 8.00, intra-service time of 60 minutes, total time of 133 minutes) and noted both services involve identical intra-service times and a similar overall amount of physician work. **The RUC recommends a work RVU of 7.91 for CPT code 93596.**

93597 ***Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections***
The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the current work RVU of 9.99 for CPT code 93597. The RUC recommends 55 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 83 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

To justify a value of 9.99, the RUC compared the survey code to CPT code 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU= 9.85, intra-service time of 68 minutes, total time of 127 minutes) and noted that, although the survey code involves more intra-service and total time, that is offset by it being somewhat less intense to perform. The RUC agreed both services should be valued similarly. **The RUC recommends a work RVU of 9.99 for CPT code 93597.**

+93598 ***Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends 20 minutes of intra-service time. The RUC reviewed the survey 25th percentile work RVU of 2.00 and agreed that this value overstates the amount of physician work involved. The RUC agreed that a direct work value crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service time= 20 min) is appropriate, as both services involve an identical amount of physician work and time and therefore, should be valued the same. The RUC also compared the survey code to CPT code 20931 *Allograft, structural, for spine surgery only*

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(List separately in addition to code for primary procedure) (work RVU= 1.81, intra-service time of 20 minutes) and noted that both services involve identical intra-service times, though the survey code is slightly less intense to perform. **The RUC recommends a work RVU of 1.75 for CPT code 93598.**

Practice Expense
These services are facility-only and have no direct practice inputs. **The RUC recommends no direct practice inputs for CPT codes 93593-93598.**

New Technology/New Service
The RUC recommends that 93593-93598 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Critical Care Services** *Critical care is…* *Providing medical care…* *Inpatient critical care…* *Services for a…* *Critical care and…* For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (~~93561, 9356~~93598), chest X rays (71045, 71046), pulse oximetry (94760, 94761, 94762), blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data); gastric intubation (43752, 43753); temporary transcutaneous pacing (92953); ventilatory management (94002-94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed that are not included in this listing should be reported separately. Facilities may report the above services separately. **…**				
99291		***Critical care, evaluation and management*** *of the critically ill or critically injured patient; first 30-74 minutes*		
99292		*each additional 30 minutes (List separately in addition to code for primary service)*		

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(Use 99292 in conjunction with 99291)

---------- ***Coding Tip*** ----------

Services Included in Critical Care Services

For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (~~93561, 9356~~93598), chest X rays (71045, 71046), pulse oximetry (94760, 94761, 94762), blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data); gastric intubation (43752, 43753); temporary transcutaneous pacing (92953); ventilatory management (94002-94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed that are not listed above should be reported separately. Facilities may report the above services separately

CPT Coding Guideline, Critical Care

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services

Pediatric Critical Care Patient Transport

Codes 99466, 99467…

Codes 99485, 99486…

For the definition…

The non-face-to-face direction…

Emergency department services…

The following services are included when performed during the pediatric patient transport by the physician providing critical care and may not be reported separately: routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry), the interpretation of cardiac output measurements (~~9356~~93598), chest X rays (71045, 71046), pulse oximetry (94760, 94761, 94762), blood gases and information data stored in computers (eg, ECGs, blood pressures, hematologic data), gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilatory management 94002, 94003, 94660, 94662), and vascular access procedures (36000, 36400, 36405, 36406, 36415, 36591, 36600). Any services performed which are not listed above should be reported separately. **…**

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Surgery
Cardiovascular System
Heart and Pericardium
Pacemaker or Implantable Defibrillator

A pacemaker system…

A single chamber…

A leadless cardiac…

Right heart catheterization (93451, 93453, 93456, 93457, 93460, 93461~~, 93530, 93531, 93532, 93533~~) may not be reported in conjunction with leadless pacemaker insertion and removal codes 33274, 33275 unless complete right heart catheterization is performed for an indication distinct from the leadless pacemaker procedure.

#33275 *Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed*

(Do not report 33274, 33275 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93596, 93597, 9359893530, 93531, 93532, 93533, unless complete right heart catheterization is performed for indications distinct from the leadless pacemaker procedure)

Implantable Hemodynamic Monitors

33289 *Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed*

(Do not report 33289 in conjunction with 36013, 36014, 36015, 75741, 75743, 75746, 76000, 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93596, 93597, 9359893530, 93531, 93532, 93533, 93568)

Heart (Including Valves) and Great Vessels

33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation*

(Do not report 33340 in conjunction with 93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597, 93598~~93531, 93532, 93533,~~ unless catheterization of the left ventricle is performed by a non-transseptal approach for indications distinct from the left atrial appendage closure procedure)

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(Do not report 33340 in conjunction with 93451, 93453, 93456, 93460, 93461, 93593, 93594, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~, unless complete right heart catheterization is performed for indications distinct from the left atrial appendage closure procedure)

Cardiac Valves
Mitral Valve

Codes 33418 and…

Codes 33418 and…

Angiography, radiological supervision…

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~) should **not** be used with 33418, 33419 to report:

1. Contrast injections, angiography, road-mapping, and/ or fluoroscopic guidance for the transcatheter mitral valve repair (TMVR),

2. Left ventricular angiography to assess mitral regurgitation for guidance of TMVR, or

3. Right and left heart catheterization for hemodynamic measurements before, during, and after TMVR for guidance of TMVR.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) may be reported with 33418, 33419, representing separate and distinct services from TMVR, if:

1. No prior study is available, and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. There is inadequate visualization of the anatomy and/or pathology, or

   b. The patient's condition with respect to the clinical indication has changed since the prior study, or

   c. There is a clinical change during the procedure that requires new evaluation.

Other cardiac catheterization…

For same session…

Diagnostic coronary angiography…

Percutaneous coronary interventional…

When transcatheter ventricular…

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When cardiopulmonary bypass…

33418 Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

Pulmonary Valve

Code 33477 is…

Code 33477 includes…

Code 33477 includes all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 33477 in conjunction with 76000, 93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~, 93563, 93566, 93567, 93568 for angiography intrinsic to the procedure.

Code 33477 includes,,,

Codes 92997, 92998…

Diagnostic right heart catheterization and diagnostic coronary angiography codes (93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~, 93563, 93566, 93567, 93568) should **not** be used with 33477 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,

2. Pulmonary conduit angiography for guidance of TPVI, or

3. Right heart catheterization for hemodynamic measurements before, during, and after TPVI for guidance of TPVI.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~), diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564), and diagnostic pulmonary angiography code (93568) may be reported with 33477, representing separate and distinct services from TPVI, if:

1. No prior study is available, and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. There is inadequate visualization of the anatomy and/or pathology, or

   b. The patient's condition with respect to the clinical indication has changed since the prior study, or

   c. There is a clinical change during the procedure that requires new evaluation.

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Other cardiac catheterization…

For same session…

Diagnostic coronary angiography…

Percutaneous coronary interventional…

Percutaneous pulmonary artery…

When transcatheter ventricular…

When cardiopulmonary bypass…

33470 *Valvotomy, pulmonary valve, closed heart; transventricular*

Arteries and Veins
Vascular Injection Procedures
Intra-Arterial-Intra-Aortic

36215 *Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family*

…

✚*36218* *additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)*

(Use 36218 in conjunction with 36216, 36217, 36225, 36226)

(For angiography, see 36222-36228, 75600-75774)

(For transluminal balloon angioplasty [except lower extremity artery[ies] for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit], see 37246, 37247)

(For transcatheter therapies, see 37200, 37211, 37213, 37214, 37236, 37237, 37238, 37239, 37241, 37242, 37243, 37244, 61624, 61626)

(When ~~coronary artery,~~ arterial ~~conduit~~ [eg, internal mammary, inferior epigastric or free ~~radical~~ radial artery] or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization, injection procedure, and imaging supervision code[s] [93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, ~~93530-93533,~~ 93593, 93594, 93595, 93596, 93597, 93564] in the **Medicine** section. When internal mammary artery angiography only is performed without a concomitant cardiac catheterization, use 36216 or 36217 as appropriate)

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Radiology
Diagnostic Radiology (Diagnostic Imaging)
Vascular Procedures
Aorta and Arteries

✚*75774* *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)*

(For cardiac catheterization procedures, see 93452-93462, 93593, 93594, 93595, 93596, 93597~~93531-93533~~, 93563-93568)

Medicine
Cardiovascular
Cardiac Catheterization

Cardiac catheterization is a diagnostic medical procedure which includes introduction, positioning and repositioning, when necessary, of catheter(s), within the vascular system, recording of intracardiac and/or intravascular pressure(s), and final evaluation and report of procedure. There are two code families for cardiac catheterization: one for congenital heart disease and one for all other conditions. For cardiac catherization for congenital heart defects (93593, 93594, 93595, 93596, 93597, 93598), see the **Medicine/Cardiovascular/Cardiac Catheterization for Congenital Heart Defects** subsection. The following guidelines apply to cardiac catheterization performed for indications other than the evaluation of congenital heart defects. ~~Anomalous coronary arteries, patent foramen ovale, mitral valve prolapse, and bicuspid aortic valve are to be reported with 93451-93464, 93566-93568.~~

Right ~~h~~Heart ~~c~~Catheterization: for indications other than the evaluation of congenital heart defects (93453, 93456, 93457, 93460, 93461) includes catheter placement in one or more right-sided cardiac chamber(s) or structures (ie, the right atrium, right ventricle, pulmonary artery, pulmonary wedge), obtaining blood samples for measurement of blood gases, and cardiac output measurements (Fick or other method), when performed. For placement of a flow directed catheter (eg, Swan-Ganz) performed for hemodynamic monitoring purposes not in conjunction with other catheterization services, use 93503. Do not report 93503 in conjunction with other diagnostic cardiac catheterization codes. Right heart catheterization does not include right ventricular or right atrial angiography (93566). ~~Left heart catheterization involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and included left ventricular injection(s) when performed. Do not report 93503 in conjunction with other diagnostic cardiac catheterization codes. When right heart catheterization is performed in conjunction with other cardiac catheterization services, report 93453, 93456, 93457, 93460, or 93461.~~

For right heart catheterization as part of catheterization to evaluate congenital heart defects, see 93593, 93594, 93596, 93597, 93598. For reporting purposes, when the morphologic left ventricle is in a subpulmonic position (eg, certain cases of transposition of the great arteries) due to congenital heart disease, catheter placement with hemodynamic assessment in this structure~~s~~ during right heart catheterization is considered part of that procedure, and does not constitute left heart catheterization. When the subpulmonic ventricle also connects to the aorta (eg, double outlet right ventricle), catheter placement with hemodynamic assessment of this ventricle during right heart catheterization is considered part of that procedure, while catheter placement with hemodynamic assessment of that same ventricle from the arterial approach is considered left heart catheterization. Report the appropriate code for right and left heart catheterization if catheter placement with hemodynamic assessment of the

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double outlet ventricle is performed both during the right heart catheterization and separately from the arterial approach. Right heart catheterization for congenital heart defects does not typically involve thermodilution cardiac output assessments. When thermodilution cardiac output is performed in this setting it may be separately reported using 93598). ~~When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 93653, 93654. Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involve selective engagement of the origins of the graft(s) for the purpose of bypass angiography. It is typically performed only in conjunction with coronary angiography of native vessels.~~

Left Heart Catheterization: for indications other than congenital heart defects (93452, 93453, 93458, 93459, 93460, 93461) involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and includes left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed. For reporting purposes, when the morphologic right ventricle is in a systemic (subaortic) position due to congenital heart disease (eg, certain cases of transposition of the great arteries), catheter placement with hemodynamic assessment of the subaortic ventricle performed during left heart catheterization is considered part of the procedure and does not constitute right heart catheterization. If additional catheterization of right heart structures (eg, atrium, pulmonary artery) is performed at the same setting, report the appropriate code for right and left heart catheterization. When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 93596, 93597. For left heart catheterization services for the evaluation of congenital heart defects, see 93595, 93596, 93597, 93565.

***Catheter Placement and Injection Procedures*:** For a listing of the injection procedures included in specific cardiac catheterization procedures, please refer to the tables on pages (X-X).

Cardiac catheterization (93451-93461), other than for the evaluation of congenital heart defects, includes: a) all roadmapping angiography in order to place the catheters; b) any injections for angiography of the left ventricle, left atrium, native coronary arteries or bypass grafts listed as inherent to the procedure in the cardiac catheterization table located on pages X-X; and c) imaging supervision, interpretation, and report. Do not report 93563, 93464, 93565 in conjunction with 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461. The cardiac catheterization codes do not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by other specific procedure code(s).

Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involves selective engagement of the origins of the graft(s) for the purpose of bypass angiography. Bypass graft angiography is typically performed only in conjunction with coronary angiography of native vessels.

~~The cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s), imaging supervision, interpretation, and report for imaging typically performed. Codes for left heart catheterization (93452, 93453, 93458-93461), other than those for congenital heart disease, include intraprocedural injection(s) for left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed.~~ Codes for ~~coronary~~ catheter placement(s) in native coronary arteries (93454-93461) and bypass graft(s) (93455,

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93457, 93459, 93461) ~~, other than those for congenital heart disease,~~ include intraprocedural injection(s) for coronary/bypass graft angiography, imaging supervision, and interpretation, except when these catheter placements are performed during cardiac catheterization for the evaluation of congenital heart defects. ~~Codes for catheter placement(s) in bypass graft(s) (93455, 93457, 93459, 93461), other than those for congenital heart disease, include intraprocedural injection(s) for bypass graft angiography, imaging supervision, and interpretation.~~ Do not report 93563-93565 in conjunction with 93452-93461.

For right ventricular or right atrial angiography performed in conjunction with right heart catheterization for noncongenital heart disease (93451, 93453, 93456, 93457, 93460, 93461) or for the evaluation of congenital heart defects (93593, 93594, 93596, 93597), use 93566. For reporting purposes, angiography of the morphologic right ventricle or morphologic right atrium is reported with 93566, whether these structures are in the standard prepulmonic position or in a systemic (subaortic) position. Left heart catheterization performed for noncongenital heart disease (93452, 93453, 93458, 93459, 93460, 93461) includes left ventriculography, when performed. For reporting purposes, angiography of the morphologic left ventricle or morphologic left atrium is reported with 93565, whether these structures are in the standard systemic (subaortic) position or in a prepulmonic position. Do not report 93565 with 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461. For cardiac catheterization performed for the evaluation of congenital heart defects, left ventriculography is separately reported with 93565. For both congenital and noncongenital cardiac catheterization, supravalvular aortography is reported with 93567. For both congenital and noncongenital cardiac catheterization, pulmonary angiography is reported with 93568 plus the appropriate right heart catheterization code.

When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital heart disease (93593, 93594, 93595, 93596, 93597), see 93563, 93564, 93565, 93566, 93567, 93568. Injection procedures 93563, 93564, 93565, 93566, 93567, 93568 represent separate identifiable services and may be reported in conjunction with one another when appropriate. Codes 93563, 93564, 93565, 93566, 93567, 93568 include imaging supervision, interpretation, and report.

For angiography of noncoronary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.

~~For cardiac catheterization for congenital cardiac anomalies, see 93530-93533. When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital anomalies, see 93563-93568~~

~~Cardiac catheterization (93451-93461) includes all roadmapping angiography in order to place the catheters, including any injections and imaging supervision, interpretation, and report. It does not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by other specific procedure code(s). For right ventricular or right atrial angiography performed in conjunction with cardiac catheterization for congenital or noncongenital heart disease (93451-93461, 93530-93533), use 93566. For aortography, use 93567. For pulmonary angiography, use 93568. For angiography of noncoronary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section~~.

Adjunctive Hemodynamic Assessments: ~~W~~when cardiac catheterization is combined with pharmacologic agent administration with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, use 93463 in conjunction with 93451-93453, 93456-93461, 93593, 93594, 93595, 93596, 93597. Do not report 93463 for intracoronary administration of pharmacologic agents during percutaneous

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coronary interventional procedures, during intracoronary assessment of coronary pressure, flow or resistance, or during intracoronary imaging procedures. Do not report 93463 in conjunction with 92920-92944, 92975, 92977.

When cardiac catheterization is combined with exercise (eg, walking or arm or leg ergometry protocol) with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, report 93464 in conjunction with 93451-93453, 93456-93461, ~~and~~93593, 93594, 93595, 93596, 9359793530-93533.

~~Please see the cardiac catheterization table located on page 684.~~

93451 *Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed*

(Do not report 93451 in conjunction with 33289, 93453, 93456, 93457, 93460, 93461, *0X06T)*

(Do not report 93451 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for diagnostic right heart catheterization procedures intrinsic to the valve repair or annulus reconstruction procedure)

Illustration caption:

~~**Right Heart Catheterization—Infant**~~
~~Catheter is advanced retrograde through the arterial system to the ascending aorta; pressures are measured in the aortic root; the catheter is manipulated using fluoroscopic guidance into the ostium of a coronary artery, arterial bypass conduit, or venous coronary bypass graft.~~

Illustration deleted

93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed*

(Do not report 93453 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for diagnostic left and right heart catheterization procedures intrinsic to the valve repair or annulus reconstruction procedure)

93454 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation*

(Do not report 93454 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)

93455 *with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography*

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	(Do not report 93455 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)
93456	*with right heart catheterization*
	(Do not report 93456 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for diagnostic coronary angiography or right heart catheterization procedures intrinsic to the valve repair or annulus reconstruction procedure)
93460	*with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed*
	(Do not report 93460 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for diagnostic coronary angiography or left and right heart catheterization procedures intrinsic to the valve repair or annulus reconstruction procedure)
93461	*with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography*
	(Do not report 93461 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for diagnostic coronary angiography or left and right heart catheterization procedures intrinsic to the valve repair or annulus reconstruction procedure)
✚*93462*	*Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)*
	(Use 93462 in conjunction with 33477, 93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597, 93582, 93653, 93654)
	(Use 93462 in conjunction with 93590, 93591 for transapical puncture performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)
	(Use 93462 in conjunction with 93581 for transseptal or transapical puncture performed for percutaneous transcatheter closure of ventricular septal defect)
	(Do not report 93462 in conjunction with 93590 for transeptal puncture through intact septum performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)
	(Do not report 93462 in conjunction with 93656)
	(Do not report 93462 in conjunction with 33418, 0345T, 0544T unless transapical puncture is performed)
✚*93463*	*Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)*

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		(Use 93463 in conjunction with 33477, 93451-93453, 93456-93461, 93593, 93594, 93595, 93596, 9359793530, 93531, 93532, 93533, 93580, 93581, 93582) *(Report 93463 only once per catheterization procedure)* *(Do not report 93463 for pharmacologic agent administration in conjunction with coronary interventional procedure 92920-92944, 92975, 92977)*		
✚	*93464*	*Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)* (Use 93464 in conjunction with 33477, 93451-93453, 93456-93461, 93593, 93594, 93595, 93596, 9359793530-93533) *(Report 93464 only once per catheterization procedure)* *(For pharmacologic agent administration, use 93463) (For bundle of His recording, use 93600)* (For bundle of His recording, use 93600)		
D	93530	-	Right heart catheterization, for congenital cardiac anomalies (93530 has been deleted. To report, see 93593, 93594)	000	N/A (2020 work RVU = 3.97)
D	93531	-	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	000	N/A (2020 work RVU = 8.34)
D	93532	-	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	N/A (2020 work RVU = 9.99)
D	93533	-	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies (93531, 93532, 93533 have been deleted. To report, see 93462, 93596, 93597)	000	N/A (2020 work RVU = 6.69)
Injection Procedures					

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~~All injection codes include radiological supervision, interpretation, and report. Cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s) for imaging typically performed during these (see Cardiac Catheterization above). Do not report 93563-93565 in conjunction with 93452-93461. When injection procedures for right ventricular, right atrial, aortic, or pulmonary angiography are performed in conjunction with cardiac catheterization, these services are reported separately (93566-93568). When right ventricular or right atrial angiography is performed at the time of heart catheterization, use 93566 with the appropriate catheterization code (93451, 93453, 93456, 93457, 93460, or 93461. Use 93567 when supravalvular ascending aortography is performed at the time of heart catheterization. Use 93568 with the appropriate right heart catheterization code when pulmonary angiography is performed. Separately reported injection procedures do not include introduction of catheters but do include repositioning of catheters when necessary and use of automatic power injectors, when performed.~~

~~When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital cardiac anomalies (93530-93533), see 93563-93568. Injection procedure codes 93563-93568 include imaging supervision, interpretation, and report.~~

~~Injection procedures 93563-93568 represent separate identifiable services and may be coded in conjunction with one another when appropriate. The technical details of angiography, supervision of imaging and processing, interpretation, and report are included.~~

~~**D**93561~~	-	~~Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)~~	ZZZ	N/A (2020 work RVU = 0.95)
~~**D**93562~~	-	~~subsequent measurement of cardiac output~~ ~~(Do not report 93561, 93562 in conjunction with 93451-93462, 93582)~~ (Codes 93561, 93562 have been deleted) (For cardiac output measurement[s], thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects, use 93598) *(For radioisotope method of cardiac output, see 78472, 78473, or 78481)*	ZZZ	N/A (2020 work RVU = 0.77)

~~**+**~~*93563*	*Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization, including catheter placement(s) when performed (List separately in addition to code for primary procedure)*
~~**+**~~*93564*	*for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart*

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catheterization, , including catheter placement(s) when performed (List separately in addition to code for primary procedure)

(Do not report 93563, 93564 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)

✚*93565* *for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)*

(Do not report 93563-93565 in conjunction with 93452-93461)

(Use 93563-93565 in conjunction with 93593, 93594, 93595, 93596, 93597~~93530-93533~~)

✚*93566* *for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)*

(Use 93566 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93582~~93530-93533~~)

(Do not report 93566 in conjunction with 33274 for right ventriculography performed during leadless pacemaker insertion)

(Do not report 93566 in conjunction with 0545T for right ventricular or right atrial angiography procedures intrinsic to the annulus reconstruction procedure)

✚*93567* *for supravalvular aortography (List separately in addition to code for primary procedure)*

(Use 93567 in conjunction with 93451-93461, 93593, 93594, 93595, 93596, 93597~~93530-93533~~)

(For non-supravalvular thoracic aortography or abdominal aortography performed at the time of cardiac catheterization, use the appropriate radiological supervision and interpretation codes [36221, 75600-75630])

✚*93568* *for pulmonary angiography (List separately in addition to code for primary procedure)*

(Use 93568 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93595, 93596, 93597~~93530-93533~~, 93580, 93581, 93582, 93583)

✚*93571* *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)*

(Use 93571 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564, 93593, 93594, 93595, 93596, 93597)

(Do not report 93571 in conjunction with 0523T)

✚*93572* *each additional vessel (List separately in addition to code for primary procedure)*

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(For unlisted cardiac catheterization procedure, use 93799)

(Use 93572 in conjunction with 93571)

(Intravascular distal coronary blood flow velocity measurements include all Doppler transducer manipulations and repositioning within the specific vessel being examined, during coronary angiography or therapeutic intervention [eg, angioplasty])

(For unlisted cardiac catheterization procedure, use 93799) (Do not report 93572 in conjunction with 0523T)

Repair of Structural Heart Defect

93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan* fenestration, atrial septal defect) with implant

(Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms. Codes 93451-93453, 9345~~6~~5, 93457, 93458, 93459, 93460, ~~-~~93461, 93593, 93594, 93595, 93596, 93597, 9359893530-93533, 9356~~4-~~, 93566 should not be reported separately in addition to code 93580)

(For other cardiac angiographic procedures performed at the time of transcatheter atrial septal defect closure, see 93563, 93564, 93567, 93568, as appropriate)

93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant*

(Percutaneous transcatheter closure of ventricular septal defect includes a right heart catheterization procedure. Code 93581 includes injection of contrast for atrial and ventricular angiograms. Codes 93451-93453, 9345~~6~~5, 93457, 93458, 93459, 93460, ~~-~~93461, 93593, 93594, 93595, 93596, 93597, 9359893530-93533, 9356~~4-~~, 93566 should not be reported separately in addition to code 93581)

(For other cardiac angiographic procedures performed at the time of transcatheter closure of ventricular septal defect, see 93563, 93564, 93567, 93568, as appropriate)

(For echocardiographic services performed in addition to 93580, 93581, see 93303-93317, 93662 as appropriate)

93582 *Percutaneous transcatheter closure of patent ductus arteriosus*

(93582 includes congenital right and left heart catheterization, catheter placement in the aorta, and aortic arch angiography, when performed)

(Do not report 93582 in conjunction with 36013, 36014, 36200, 75600, 75605, 93451-93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 9359893530, 93531, 93532, 93533, 93567)

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	(For other cardiac angiographic procedures performed at the time of transcatheter PDA closure, see 93563, 93564, 93565, 93566, 93568 as appropriate)
	~~(For left heart catheterization by transseptal puncture through intact septum or by transapical puncture performed at the time of transcatheter PDA closure, use 93462)~~
	(For repair of patent ductus arteriosus by ligation, see 33820, 33822, 33824)
	(For intracardiac echocardiographic services performed at the time of transcatheter PDA closure, use 93662. Other echocardiographic services provided by a separate individual are reported using the appropriate echocardiography service codes, 93315, 93316, 93317)
93583	*Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed*
	(93583 includes insertion of temporary pacemaker, when performed, and left heart catheterization)
	(Do not report 93583 in conjunction with 33210, 93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 9359793531, ~~93532, 93533~~, 93565)
	(93583 includes left anterior descending coronary angiography for the purpose of roadmapping to guide the intervention. Do not report 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563 for coronary angiography performed during alcohol septal ablation for the purpose of roadmapping, guidance of the intervention, vessel measurement, and completion angiography)
	(Diagnostic cardiac catheterization procedures may be separately reportable when no prior catheter-based diagnostic study of the treatment zone is available, the prior diagnostic study is inadequate, or the patient's condition with respect to the clinical indication has changed since the prior study or during the intervention. Use the appropriate codes from 93451, 93454, 93455, 93456, 93457, 93593, 93594, 9359893530, 93563, 93564, 93566, 93567, 93568)
	(Do not report 93583 in conjunction with 33210, 33211)
	(Do not report 93463 for the injection of alcohol for this procedure)
	(For intracardiac echocardiographic services performed at the time of alcohol septal ablation, use 93662)
	(Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography services codes, 93312, 93313, 93314, 93315, 93316, 93317)
	(For surgical ventriculomyotomy [-myectomy] for idiopathic hypertrophic subaortic stenosis, use 33416)
Transcatheter Closure of Paravalvular Leak	

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Codes 93590, 93591…

Codes 93590 and 93591…

Code 93590 includes transseptal puncture, and left heart catheterization/left ventriculography (93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597~~93531, 93532, 93533~~, 93565), when performed. Transapical left heart catheterization (93462) may be reported separately, when performed.

Code 93591 includes, when performed, supravalvular aortography (93567), left heart catheterization/left ventriculography (93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597~~93531, 93532, 93533~~, 93565). Transapical left heart catheterization (93462) may be reported separately, when performed.

Diagnostic right heart catheterization codes (93451, 93456, 93457, 93593, 93594, 93598~~93530~~) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93563, 93564) may be reported with 93590, 93591, representing separate and distinct services from PVL closure, if:

1. No prior study is available and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. there is inadequate visualization of the anatomy and/or pathology, or

   b. the patient's condition with respect to the clinical indication has changed since the prior study, or

   c. there is a clinical change during the procedure that requires new evaluation.

Other cardiac catheterization…

For same session…

93590 Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

Cardiac Catheterization for Congenital Heart Defects

Cardiac catheterization for the evaluation of congenital heart defect(s) is reported with 93593, 93594, 93595, 93596, 93597, 93598. Cardiac catheterization services for anomalous coronary arteries arising from the aorta or off of other coronary arteries, patent foramen ovale, mitral valve prolapse, and bicuspid aortic valve, in the absence of other congenital heart defects, are reported with 93451-93464, 93566, 93567, 93568. However, when these conditions exist in conjunction with other congenital heart defects, 93593, 93594, 93595, 93596, 93597 may be reported. Evaluation of anomalous coronary arteries arising from the pulmonary arterial system is reported with the congenital catheterization codes.

Right Heart Catheterization: for congenital heart defects (93593, 93594, 93596, 93597) includes catheter placement in one or more right-sided cardiac chamber(s) or structures (ie, the right atrium, right ventricle, pulmonary artery, pulmonary wedge), obtaining blood samples for measurement of blood gases, and Fick cardiac output measurements, when performed. While the morphologic right atrium and morphologic

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right ventricle are typically the right heart structures supplying blood flow to the pulmonary artery, in congenital heart disease the subpulmonic ventricle may be a morphologic left ventricle and the subpulmonic atrium may be a morphologic left atrium. For reporting purposes, when the morphologic left ventricle or left atrium is in a subpulmonic position due to congenital heart disease, catheter placement in either of these structures is considered part of right heart catheterization and does not constitute left heart catheterization. Right heart catheterization for congenital cardiac anomalies does not typically involve thermodilution cardiac output assessments. When thermodilution cardiac output is performed in this setting, it may be separately reported using add-on code 93598. Right heart catheterization does not include right ventricular or right atrial angiography. When right ventricular or right atrial angiography is performed, use 93566. For reporting purposes, angiography of the morphologic right ventricle or morphologic right atrium is reported with 93566, whether these structures are in the standard pre-pulmonic position or in a systemic (subaortic) position. For placement of a flow directed catheter (eg, Swan-Ganz) performed for hemodynamic monitoring purposes not in conjunction with other catheterization services, use 93503. Do not report 93503 in conjunction with 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93595, 93596, 93597.

Right heart catheterization for congenital heart defects may be performed in patients with normal or abnormal connections. The terms *normal* and *abnormal* native connections are used to define the variations in the anatomic connections from the great veins to the atria, atria to the ventricles, and ventricles to the great arteries. This designation as normal or abnormal is used to determine the appropriate code to report right heart catheterization services in congenital heart disease.

Normal native connections exist when the pathway of blood flow follows the expected course through the right and left heart chambers and great vessels (ie, superior vena cava/inferior vena cava to right atrium, then right ventricle, then pulmonary arteries for the right heart; left atrium to left ventricle, then aorta for the left heart). Examples of congenital heart defects with normal connections would include acyanotic defects such as isolated atrial septal defect, ventricular septal defect, or patent ductus arteriosus. Services including right heart catheterization for congenital cardiac anomalies with normal connections are reported with 93593, 93596.

Abnormal native connections exist when there are alternative connections for the pathway of blood flow through the heart and great vessels. Abnormal connections are typically present in patients with cyanotic congenital heart defects, any variation of single ventricle anatomy (eg, hypoplastic right or left heart, double outlet right ventricle), unbalanced atrioventricular canal (endocardial cushion) defect, transposition of the great arteries, valvular atresia, tetralogy of Fallot with or without major aortopulmonary collateral arteries (MAPCAs), total anomalous pulmonary veins, truncus arteriosus, and any lesions with heterotaxia and/or dextrocardia. Examples of right heart catheterization through abnormal connections include accessing the pulmonary arteries via surgical shunts, accessing the pulmonary circulation from the aorta via MAPCAs, or accessing isolated pulmonary arteries through a patent ductus arteriosus. Other examples would include right heart catheterization through cavopulmonary anastomoses, Fontan conduits, atrial switch conduits [Mustard/Senning], or any variations of single ventricle anatomy/physiology. Services including right heart catheterization for congenital heart defects with abnormal connections are reported with 93594, 93597.

Left Heart Catheterization: for congenital heart defects (93595, 93596, 93597) involves catheter placement in a left-sided (systemic) cardiac chamber(s) (ventricle or atrium). The systemic chambers channel oxygenated blood to the aorta. In normal physiology the systemic chambers include the morphologic left atrium and left ventricle. In congenital heart disease, the systemic chambers may include a morphologic right atrium or morphologic right ventricle which is connected to the aorta due to transposition or other congenital anomaly. These may be termed

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subaortic chambers. For the purposes of reporting, the term left ventricle or left atrium is meant to describe the systemic (subaortic) ventricle or atrium. When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93595, 93596, 93597. Left heart catheterization for congenital heart defects does not include left ventricular/left atrial angiography when performed. Left ventriculography or left atrial angiography performed during cardiac catheterization for congenital heart defects is separately reported with 93565. For reporting purposes, angiography of the morphologic left ventricle or morphologic left atrium is reported with 93565, whether these structures are in the standard systemic (subaortic) position or in a pre-pulmonic position. For left heart catheterization only, in patients with congenital heart defects, with either normal or abnormal connections, use 93595. When combined left and right heart catheterization is performed to evaluate congenital heart defects, use 93596 for normal native connections, or 93597 for abnormal native connections.

Catheter Placement and Injection Procedures: The work of imaging guidance, including fluoroscopy and ultrasound guidance for vascular access and to guide catheter placement for hemodynamic evaluation, is included in the cardiac catheterization for congenital heart defects codes, when performed by the same operator.

For cardiac catheterization for congenital heart defects, injection procedures are separately reportable due to the marked variability in the cardiovascular anatomy encountered.

When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital heart defects, see injection procedure codes 93563, 93564, 93565, 93566, 93567, 93568, or use appropriate codes from the Radiology section and the Vascular Injection Procedures section. Codes 93563, 93564, 93565, 93566, 93567, 93568 include imaging supervision, interpretation, and report.

Injection procedures 93563, 93564, 93565, 93566, 93567, 93568 represent separate, identifiable services and may be reported in conjunction with one another when appropriate. For angiography of noncoronary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.

Angiography of the native coronary arteries or bypass grafts during cardiac catheterization for congenital heart defects is reported with 93563, 93564. Catheter placement(s) in coronary artery(ies) or bypass grafts involves selective engagement of the origins of the native coronary artery(ies) or bypass grafts for the purpose of coronary angiography.

●93593	F1	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	000	3.99
●93594	F2	abnormal native connections	000	6.10
●93595	F3	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	000	6.00

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●93596	F4	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	000	7.91
●93597	F5	abnormal native connections	000	9.99
✚●93598	F6	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure) (Use 93598 in conjunction with 93593, 93594, 93595, 93596, 93597) (Do not report 93598 in conjunction with 93451-93461) (For pharmacologic agent administration during cardiac catheterization for congenital heart defect[s], use 93463) (For physiological exercise study with cardiac catheterization for congenital heart defect[s], use 93464) (For indicator dilution studies such as thermodilution for cardiac output measurement during cardiac catheterization for congenital heart defect[s], use 93598) (For contrast injections during cardiac catheterization for congenital heart defect[s], see 93563, 93564, 93565, 93566, 93567, 93568) (For angiography or venography not described in the 90000 series code section, see appropriate codes from the Radiology and the Medicine/Vascular Injection Procedure subsection) (For transseptal or transapical access of the left atrium during cardiac catheterization for congenital heart defect[s], use 93462 in conjunction with 93595, 93596, 93597, as appropriate)	ZZZ	1.75

Category III Codes

0342T *Therapeutic apheresis with selective HDL delipidation and plasma reinfusion*

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Fluoroscopy (76000) and radiologic supervision and interpretation are inherent to the transcatheter mitral valve repair (TMVR) procedure and are not separately reportable. Diagnostic cardiac catheterization (93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~) should not be reported with transcatheter mitral valve repair (0345T) for:

- Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the transcatheter mitral valve repair (TMVR),
- Left ventricular angiography to assess mitral regurgitation, for guidance of TMVR, or
- Right and left heart catheterization for hemodynamic measurements before, during, and after TMVR for guidance of TMVR.

Diagnostic right and left heart catheterization (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~), and diagnostic coronary angiography (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) not inherent to the TMVR, may be reported with 0345T, appended with modifier 59 if:

1. No prior study is available and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. There is inadequate visualization of the anatomy and/or pathology, or

   b. The patient's condition with respect to the clinical indication has changed since the prior study, or

   c. There is a clinical change during the procedure that requires new evaluation.

Percutaneous coronary interventional…

Other cardiac catheterization...

When transcatheter ventricular…

0345T *Transcatheter mitral valve repair percutaneous approach via the coronary sinus*

…

0463T *Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day*

(Do not report 0463T in conjunction with 0451T-0462T)

(Do not report 0451T-0463T in conjunction with 36000, 36002, 36005, 36010, 36200-36228, 75600-75774, 76000, 76936, 76937, 77001, 77002, 77011, 77012, 77021, 93451-93533, 93598, ~~93561~~93563, 93564, 93565, 93566, 93567, 93568, 93571, - 93572)

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0481T *Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed*

…

Codes 0483T, 0484T…

Angiography, radiological supervision…

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~) should not be used with 0483T, 0484T to report:

1. contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the transcatheter mitral valve implantation (TMVI),

2. left ventricular angiography to assess or confirm valve positioning and function,

3. right and left heart catheterization for hemodynamic measurements before, during, and after TMVI for guidance of TMVI.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) performed at the time of TMVI may be separately reportable, if:

1. no prior study is available, and a full diagnostic study is performed, or

2. a prior study is available, but as documented in the medical record:

a. there is inadequate visualization of the anatomy and/or pathology, or

b. the patient's condition with respect to the clinical indication has changed since the prior study, or

c. there is a clinical change during the procedure that requires new evaluation.

For same session…

When cardiopulmonary bypass…

For percutaneous transcatheter…

0483T *Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed*

Wireless Cardiac Stimulation System for Left Ventricular Pacing

A wireless cardiac…

The complete system…

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Patients with a…

Code 0515T describes…

For removal of…

All catheterization and…

Do not report left heart catheterization codes (93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597~~93531, 93532, 93533~~) for delivery of a wireless cardiac stimulator electrode into the left ventricle.

0515T *Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])*

…

0543T *Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae*

(For transesophageal echocardiography image guidance, use 93355)

Codes 0544T and…

Angiography, radiological supervision…

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~, 93565, 93566) may not be used in conjunction with 0544T, 0545T to report:

1. contrast injections, angiography, road-mapping, and/or fluoroscopic guidance for the implantation and adjustment of the transcatheter mitral or tricuspid valve annulus reconstruction device, or
2. right or left ventricular angiography to assess or confirm transcatheter mitral or tricuspid valve annulus reconstruction device positioning and function, or
3. right and left heart catheterization for hemodynamic measurements before, during, and after transcatheter mitral or tricuspid valve annulus reconstruction for guidance.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) performed at the time of transcatheter mitral or tricuspid valve annulus reconstruction may be separately reportable if:

1. no prior study is available, and a full diagnostic study is performed, or

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2. a prior study is available, but as documented in the medical record:

a. there is inadequate visualization of the anatomy and/or pathology, or

b. the patient's condition with respect to the clinical indication has changed since the prior study, or

c. there is a clinical change during the procedure that requires new evaluation.

Other cardiac catheterization…

For same session…

Percutaneous coronary interventional…

When cardiopulmonary bypass…

When transcatheter ventricular…

For percutaneous transcatheter…

0544T *Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture*

(For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)

(For transcatheter mitral valve repair percutaneous approach via the coronary sinus, use 0345T)

(For transcatheter mitral valve implantation/ replacement [TMVI] with prosthetic valve percutaneous approach, use 0483T)

0545T *Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach*

(Do not report 0544T, 0545T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~, 93565, 93566 for diagnostic left and right heart catheterization procedures intrinsic to the annular repair procedure)

Tricuspid Valve Repair

Codes 0569T, 0570T…

For open tricuspid…

Angiography, radiological supervision…

Intracardiac echocardiography (93662)…

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Fluoroscopy (76000) and diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~, 93566) may **not** be used with 0569T, 0570T to report the following techniques for guidance of TTVr:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TTVr,

2. Right ventricular angiography to assess tricuspid regurgitation for guidance of TTVr, or

3. Right and left heart catheterization for hemodynamic measurements before, during, and after TTVr for guidance of TTVr.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598 ~~93530, 93531, 93532, 93533~~, 93566) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) may be reported with 0569T, 0570T, representing separate and distinct services from TTVr, if:

1. No prior study is available, and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. There is inadequate evaluation of the anatomy and/ or pathology, or

   b. The patient's condition with respect to the clinical indication has changed since the prior study, or

   c. There is a clinical change during the procedure that requires new diagnostic evaluation.

Other cardiac catheterization…

For same session…

Diagnostic coronary angiography…

Percutaneous coronary interventional…

When transcatheter ventricular…

When cardiopulmonary bypass…

0569T Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis

Modifiers
CPT Level I Modifiers

63 *Procedure Performed on Infants less than 4 kg*

Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services

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listed in the 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93593, 93594, 93595, 93596, 93597, 9359893530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory,** or **Medicine** sections (other than those identified above from the Medicine/Cardiovascular section).

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93593 Tracking Number F1 Original Specialty Recommended RVU: **3.99**
Presented Recommended RVU: **3.99**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **3.99**

CPT Descriptor: Right heart catheterization or congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone for hemodynamic evaluation; normal or abnormal native connections.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-month-old, 7 kg male with known pulmonary valve stenosis and failure to thrive is brought to the cardiac catheterization lab for evaluation. This cardiac catheterization is being requested to measure the right heart hemodynamics and severity of valvular stenosis, to determine if intervention is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR. and EKG. Determine all potential components required for the procedure are present. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential hazards, and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Set up a sterile table with all necessary sheaths and catheters, syringes, bowl with sterile heparinized flush, contrast, and any other necessary sterile equipment. Position patient. Prep, scrub, drape, and wait. Connect sterile tubing to flush system and pressure transducers and ensure the hemodynamic recording system is properly zeroed.

Description of Intra-Service Work: The vast majority of all procedures are conducted under general anesthesia. Palpate and identify the access site landmarks and administer local anesthesia. Access is obtained percutaneously, using Seldinger technique into the internal jugular, subclavian, axillary, or femoral venous systems. Ultrasound guidance for vascular access may be used depending on the vessel to be accessed and the age of the patient. Once the vessel is punctured, a guidewire is passed into the vessel. The vascular sheath is introduced into the vein, the guidewire and dilator removed, and the sheath flushed with sterile heparinized saline. A diagnostic catheter is passed through this sheath under fluoroscopic guidance. The catheter is directed from the venous system into any of the typical right heart structures including, the inferior and superior vena cavae, right atrium, right ventricle, right and left pulmonary arteries, and pulmonary capillary wedge position(s). Baseline measurements and blood sampling may be conducted in each of these chambers. Cardiac output is typically calculated using the Fick method. In patients without intra-cardiac shunting, cardiac output may be measured by thermodilution (separately reported). Positioning for angiography may occur in any of the right heart chambers or blood vessels, which includes exchanging the diagnostic catheter used for physiologic data for an angiographic catheter, and each are separately reportable. Following measurement of baseline values, pharmacological intervention may be performed (separately reported), and the measurements repeated. Following the conduct of the catherterization proper, the catheter and sheath is extracted and compression hemostasis achieved in the catheterization lab, and prior to being taken to the recovery area.

CPT Code: 93593

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. The patient is transported to the recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EHR and post procedure orders are placed for nursing care. A detailed catheterization report is documented, which includes a diagram of the congenital heart defect, description of the procedure performed, calculations and interpretations of all hemodynamic data obtained, review and interpretation of the angiograms, and listing of the findings and recommendations. All necessary data is then also entered into the appropriate national data registry, as indicated/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge instructions and follow up information prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC & AAP & SCAI					
CPT Code:	93593					
Sample Size:	676	**Resp N:**	46			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	10.00	**35.00**	60.00	250.00
Survey RVW:		2.47	2.83	**3.99**	5.00	10.55
Pre-Service Evaluation Time:				**40.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		12.00	30.00	**45.00**	60.00	120.00
Immediate Post Service-Time:	**45.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93593	**Recommended Physician Work RVU: 3.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93451	000	2.47	**RUC Time**

CPT Descriptor Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93454	000	4.54	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36475	000	5.30	**RUC Time**	109,583

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31628	000	3.55	**RUC Time**	32,291

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

Other Reference CPT Code	Global	Work RVU	Time Source
49422	000	4.00	**RUC Time**

CPT Descriptor Removal of tunneled intraperitoneal catheter

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 56.5 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 10.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93593	**Top Key Reference CPT Code:** 93451	**2nd Key Reference CPT Code:** **93454**
Median Pre-Service Time	58.00	30.00	30.00
Median Intra-Service Time	45.00	30.00	30.00
Median Immediate Post-service Time	45.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**148.00**	**90.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	46%	46%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	46%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	65%	35%
Physical effort required	0%	77%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	65%	35%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	80%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	20%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	0%	80%
Physical effort required	0%	60%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	60%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision

of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63 Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes.

These changes were recommended to address gaps in the prior codes and significant changes in the service as a result of technology evolution over the past two decades. Whereas a predominance of diagnostic catheterizations were previously performed in a healthier population of children, with simpler cardiac defects, the specialty has evolved towards performing a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures. Members felt the existing codes, created in the 1990s no longer captured the wider range of patient and procedural complexity. We explain this further in the compelling evidence discussion below and support with several pieces of literature.

The ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the first of five new codes to report cardiac catheterization for congenital heart disease.

The key reference code is 93451 for right heart catheterization. It was selected by 56% of respondents. Half of the respondents indicated that 93593 was more complex. The second reference code was 93454 for catheter placement in coronary artery. It was selected by approximately 10% of respondents. 80% of the respondents indicated that 93593 was more intense/complex overall.

Rationale - Compelling Evidence for the Family

The recommended RVUs for this family of codes would result in increased spending. As noted above and below, increasingly ill patients are treated with increasingly complex technology, which we believe supports an argument for compelling evidence. Literature from the CPT code change application explain the medical advances that have occurred in the last decade (Bergerson, et al.).

Since 1997, when to-be-deleted code 93530 was surveyed, there has been a shift in patient population and change in how these codes are billed. The typical patient is now a more complex patient with more pathology. Due to the shift in patient population, the IWPUT correctly increases with our recommendations, bringing it in line with other codes in the cardiac catherization family. We believe this also shows there are differences in RUC survey methodology from 1997 to now, and that the current codes' times and RVUs are no longer be accurate because of that evolution. Nicholson et al. explains that these procedures were unable to be previously accomplished with earlier technology/techniques. Additional literature from the code change application is attached to show the changes in congenital catheterization over the past two decades.

There are numerous reasons why the original CPT code, 93530, does not work to properly capture the work performed in 2020 and beyond. For instance, the original code was the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. Although this was somewhat appropriate in the era where right heart only catheterizations were performed mostly for simple lesions, a far broader use of right heart catheterization had since developed. This brought about a need to divide the code into two; one for those with simple defects, defined in CPT as having normal connections, and a second code for the more complex patients with abnormal connections.

Furthermore, as the specialty has evolved into a much more complex patient population, several elements of the pre- and post- service packages, simply do not suit the work performed in a children's hospital. For instance, many procedures involve off-label use of products/devices, which preclude a children's hospital from carrying sufficient inventory. Physicians must keep these products/devices at affiliated adult hospitals, and on case-by-case need, go to the parent facility and obtain the required materials, which can take a substantial amount of time. Time to discuss a patient's procedure with the parent also takes considerably more time as compared to discussing with an adult patient consenting for themselves. This same problem is further involved in the post procedure segment of work in having to explain the pathology of the child to the parent. As a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time.

Recommendation

Therefore, for code 93593 the societies recommend an RVW of 3.99 with 58 minutes preservice time, 45 minutes intraservice time from the survey median, and 45 minutes postservice time. This compares favorably with several MPC and

other codes that have identical or similar intraservice times, though each of those also have shorter total times, as shown in the summary spreadsheet.

The societies recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to diagram the congenital heart defect in the EHR (not unlike the images included in attached Cardiac Catheterization Report), speak with the family who are typically parents concerned about their infant child, and complete data submission to the registry. Package 9B with the placement of these additional minutes is presented below.

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**33**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	
Operative Note	5	+5
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+7
Written post-operative note	5	
Post-Operative Orders and Order Entry	5	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93530

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6440
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on IMPACT Registry data collected on congenital cardiac catheterizations and Medicaid claims data.

Specialty Pediatric Cardiology Frequency 6118 Percentage 95.00 %

Specialty Interventional Cardiology Frequency 322 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 287
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the Medicare data estimation reported in 2019

Specialty Interventional Cardiology Frequency 228 Percentage 79.44 %

Specialty Pediatric Interventional Cardiology Frequency 59 Percentage 20.55 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93594 Tracking Number F2 Original Specialty Recommended RVU: **6.10**
Presented Recommended RVU: **6.10**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **6.10**

CPT Descriptor: Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6-month-old, 8 kg female with pulmonary atresia status post prior surgical shunt placement, now demonstrates progressive cyanosis, failure to thrive, and worsening cardiac function. She is brought to the cardiac catheterization lab for suspected branch pulmonary artery stenosis to determine if further intervention is warranted.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT, MRI, 3D printed model, or any other pertinent studies. Determine all potential components required for the procedure are present, including discussion with industry representatives to provide any atypical supplies not kept in stock. Perform and document a complete and/or interval history and physical exam, noting any and all prior cardiovascular sugeries and interventions. Provide a description of the underlying congenital anomaly and indication for intervention, description of the procedure, and expected results to the parents of the patient, a description of potential hazards, and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Set up a sterile table with all necessary sheaths and catheters, syringes, bowl with sterile heparinized flush, contrast, and any other necessary sterile equipment. Don surgical scrubs and lead. Supervise positioning the patient to allow for multiple access sites to be prepped. Prep, scrub, drape, and wait. Connect sterile tubing to flush system and pressure transducers and ensure the hemodynamic recording system is properly zeroed.

Description of Intra-Service Work: The vast majority of all procedures are conducted under general anesthesia. Palpate and identify the access site landmarks and administer local anesthesia. Access is obtained percutaneously, using Seldinger technique into the internal jugular, subclavian, axillary, or femoral venous systems. Frequently, multiple attempts must be made because of very small vessels and/or venous thrombosis from previous studies or presence of central venous access catheters. Additional ultrasound guidance may be necessary/used due to these problems, and not additionally reportable. In rare cases, the need for hepatic venous access may be necessary due to lack of any other possible venous access, and is separately reportable. Once the vessel is punctured, a guidewire is passed into the vessel. The vascular sheath is introduced into the vein, the guidewire and dilator removed, and the sheath flushed with sterile heparinized saline. A diagnostic catheter is passed through this sheath under fluoroscopic guidance. The catheter is then directed from the venous system into any of the typical right heart structures including, the inferior and/or superior vena cavae, atria, pulmonary ventricle, right and/or left pulmonary arteries, and pulmonary capillary wedge position(s). Frequently, there are additional venous structures such as a left sided vena cava, which may have to be catheterized and evaluated selectively. These must be accessed either from an interrupted inferior vena cava, directly from the left internal jugular vein, or through the heart via the coronary sinus. Baseline measurements and blood sampling may be conducted in each of these chambers. Cardiac output is typically calculated using the Fick method. In patients without intra-cardiac shunting (eg, post complete repair),

cardiac output may be measured by thermodilution (separately reported). Positioning for angiography may occur in any of the right heart chambers or blood vessels, which includes exchanging the diagnostic catheter used for physiologic data for an angiographic catheter, and each is separately reportable. Following measurement of baseline values, pharmacological intervention (separately reported) may be performed and the measurements repeated. Following the conduct of the catherterization proper, the catheter is extracted and compression hemostasis achieved in the catheterization lab, and prior to being taken to the recovery area.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. The patient is transported to the recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed catheterization report is documented, which includes a sllightly more complex diagram of the congenital heart defect, description of the procedure performed, calculations and interpretations of all hemodynamic data obtained, review and interpretation of the angiograms, and listing of the findings and recommendations. All necessary data is then also entered into the appropriate national data registry, as indicated/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge instructions and follow up information prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC, AAP & SCAI					
CPT Code:	93594					
Sample Size:	676	**Resp N:**	45			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	2.00	20.00	**30.00**	50.00	250.00	
Survey RVW:	3.00	5.00	**6.10**	7.25	14.21	
Pre-Service Evaluation Time:			**46.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	20.00	45.00	**60.00**	70.00	180.00	
Immediate Post Service-Time:	**48.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93594	**Recommended Physician Work RVU: 6.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**46.00**	**40.00**	**6.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**48.00**	**33.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93459	000	6.35	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93451	000	2.47	**RUC Time**

CPT Descriptor Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52351	000	5.75	**RUC Time**	22,929

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37212	000	6.81	**RUC Time**	3,012

CPT Descriptor 2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

Other Reference CPT Code	Global	Work RVU	Time Source
36217	000	6.29	**RUC Time**

CPT Descriptor Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 17.7 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 93594	**Top Key Reference CPT Code:** 93459	**2nd Key Reference CPT Code:** **93451**
Median Pre-Service Time	64.00	35.00	30.00
Median Intra-Service Time	60.00	50.00	30.00
Median Immediate Post-service Time	48.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**172.00**	**115.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	37%	63%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	12%	76%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	12%	88%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	12%	63%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	12%	88%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	37%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	37%	63%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision

of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63 Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes.

These changes were recommended to address gaps in the prior codes and significant changes in the service as a result of technology evolution over the past two decades. Whereas a predominance of diagnostic catheterizations were previously performed in a healthier population of children, with simpler cardiac defects, the specialty has evolved towards performing a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures. Members felt the existing codes, created in the 1990s no longer captured the wider range of patient and procedural complexity. As a result, the ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the second of five new codes to report cardiac catheterization for congenital heart disease.

The key reference code is 93459 for catheter placement in the coronary artery. It was selected by 17% of respondents. All of the respondents indicated that 93594 was somewhat more or much more complex. The second reference code was 93451 for right heart catheterization. It was selected by approximately 18% of respondents, as well. 88% of the respondents indicated that 93594 was somewhat or much more complex.

Rationale

Since 1997, when to-be-deleted code was surveyed, there has been a shift in patient population and change in how these codes are billed. The typical patient is now a more complex patient with significantly more pathology. Due to the shift in patient population, the IWPUT increases dramatically and more correctly, in line with other codes in the cardiac catherization family. We believe this also shows there are differences in RUC survey methodology from 1997 to now, and that the current codes' times and RVUs may no longer be accurate because of that evolution.

There are numerous reasons why the original CPT code, 93530, does not work to properly capture the work performed in 2020 and beyond. For instance, the original code was the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. Although this was somewhat appropriate in the era where right heart only catheterizations were performed mostly for simple lesions, a far broader use of right heart catheterization had since developed. This brought about a need to divide the code into two; one for those with simple defects, defined in CPT as having normal connections, and a second code for the more complex patients with abnormal connections. This, second of five new codes, is for the latter and designed to capture a right heart catheterization procedure in some of the most complex congenital heart defects. Those with abnormal connections are described in CPT as having complex lesions such as heterotaxy with dextrocardia, complex single ventricle anatomy such as tricuspid valve atresia and double outlet right ventricle. Such patients often have several other congenital abnormalities which require a significant greater level of diagnostic evaluation, catheter and wire manipulation, and angiography. Additionally, as the specialty has evolved into a much more complex patient population, several elements of the pre and post service packages, simply do not suit the work performed in a children's hospital.

Furthermore, as the specialty has evolved into a much more complex patient population, several elements of the pre and post service packages, simply do not suit the work performed in a children's hospital. As previously described, there are additional reporting requirements and significant communication barriers not captured by these packages.

Recommendation

Therefore, for code 93594 the societies recommend an RVW of 6.10 with 64 minutes preservice time, 60 minutes intraservice time from the survey median, and 48 minutes postservice time. This compares favorably with multiple MPC codes and others that have identical or similar intraservice times, though each of those also have shorter total times, as shown in the summary spreadsheet.

We are recommending the complete preservice evaluation time from the survey as we believe it correctly captures additional time that is typically spent to prepare for the procedure, ensure all supplies are available, and discuss informed consent with the parents. We are recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to diagram the congenital heart defect in the EHR, speak with the family who are typically parents concerned about their infant child, and complete data submission to the registry. Package 9B with the placement of these additional minutes is presented below.

History and Exam (Performance and review of appropriate Pre-Tests)	15	
Prepare for Procedure (Check labs, plan, assess risks, review procedure)	4	+4
Communicate with patient and/or family (Discuss procedure/ obtain consent)	5	+2
Communicate with other professionals	5	
Check/set-up room, supplies and equipment	5	
Check/ prepare patient readiness (Gown, drape, prep, mark)	5	
Prepare/ review/ confirm procedure	1	
Perform/ supervise patient positioning	3	
Administer local/topical anesthesia	0	
Observe (wait anesthesia care)	15	
Dress and scrub for procedure	5	

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**33**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	
Operative Note	5	+6
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+9
Written post-operative note	5	
Post-Operative Orders and Order Entry	5	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93530

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6440
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on IMPACT Registry data collected on congenital cardiac catheterizations and Medicaid claims data.

Specialty Pediatric Cardiology Frequency 6118 Percentage 95.00 %

Specialty Interventional Cardiology Frequency 322 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Procedure is expected to be pediatric patients.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93595 Tracking Number F3 Original Specialty Recommended RVU: **6.00**
Presented Recommended RVU: **6.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **6.00**

CPT Descriptor: Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old male with previously repaired coarctation of the aorta undergoes a 2D echocardiogram and Doppler study as well as CT angiogram demonstrating re-stenosis of the proximal descending thoracic aorta. This cardiac catheterization is being performed to measure the left heart hemodynamics to determine if surgical versus transcatheter intervention is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT, MRI, 3D printed model, or any other pertinent studies. Determine all potential components required for the procedure are present, including discussion with industry representatives to provide any atypical supplies not kept in stock. Perform and document a complete and/or interval history and physical exam, noting any and all prior cardiovascular sugeries and interventions. Provide a description of the underlying congenital anomaly and indication for intervention, description of the procedure, and expected results to the parents of the patient, a description of potential hazards, and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Set up a sterile table with all necessary sheaths and catheters, syringes, bowl with sterile heparinized flush, contrast, and any other necessary sterile equipment. Don surgical scrubs and lead. Supervise positioning the patient to allow for multiple access sites to be prepped. Prep, scrub, drape, and wait. Connect sterile tubing to flush system and pressure transducers and ensure the hemodynamic recording system is properly zeroed.

Description of Intra-Service Work: The far majority of procedures are conducted under general anesthesia. Palpate and identify the access site landmarks and administer local anesthesia. Access is obtained percutaneously, using Seldinger technique. Ultrasound guidance may be necessary for vascular access, and not additionally reportable. Typically the femoral artery is punctured, and a guidewire passed into the vessel. The vascular sheath is introduced into the artery, the guidewire and dilator removed, and the sheath flushed with sterile heparinized saline. Additional arterial access may be obtained in one of the radial, or axillary arteries, and occasionally, carotid arterial access is used. Frequently, multiple attempts much be made because of very small vessels and/or arterial thrombosis from previous procedures or postoperative arterial monitoring. A diagnostic end hole catheter is passed with a guidewire, through this sheath under fluoroscopic guidance and directed from the arterial system into the descending aorta, across the stenosis, around the aortic arch and to the ascending aorta, and further across the aortic valve into the left ventricle. Baseline measurements and blood sampling may be conducted in each of these chambers. The end hole guide catheter is used to precisely assess the location of pressure gradients to rule out any additional areas of stenosis. The end hole catheter is then used to again cross the coarctation and secure wire position either in the left ventricle, aortic root, or subclavian artery. The diagnostic catheter is

then exchanged over the wire for an angiographic catheter (separately reported). Angiography is then obtained, typically in the aortic arch, but can vary due to presence of multiple or long segment lesions (each separately reported). Additional angiography of the coronary arteries, carotid and subclavian arteries, or descending abdominal aorta may also be necessary (separately reported). In other conditions, angiography of the pulmonary arteries may be performed from the left heart, (eg, across a systemic-pulmonary surgical shunt) and is separately reported. Following measurement of baseline values, pharmacological intervention may be performed (separately reported) and the hemodynamic measurements repeated. Following the conduct of the catheterization proper, the catheter is removed and compression hemostasis achieved in the catheterization lab, and prior to being taken to the recovery area.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. The patient is transported to the recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed catheterization report is documented, which includes a more complex diagram of the congenital heart defect, description of the procedure performed, calculations and interpretations of all hemodynamic data obtained, review and interpretation of the angiograms, and listing of the findings and recommendations. All necessary data is then also entered into the appropriate national data registry, as indicated/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge instructions and follow up information prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC, AAP & SCAI					
CPT Code:	93595					
Sample Size:	646	**Resp N:**	46			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	10.00	**24.00**	50.00	250.00
Survey RVW:		2.50	5.25	**6.00**	7.00	11.05
Pre-Service Evaluation Time:				**46.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		15.00	32.00	**48.00**	60.00	180.00
Immediate Post Service-Time:	**46.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93595	**Recommended Physician Work RVU: 6.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**46.00**	**40.00**	**6.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**48.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**46.00**	**33.00**	**13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93458	000	5.60	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93454	000	4.54	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52351	000	5.75	**RUC Time**	22,929

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37212	000	6.81	**RUC Time**	3,012

CPT Descriptor 2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

Other Reference CPT Code	Global	Work RVU	Time Source
93453	000	5.99	**RUC Time**

CPT Descriptor Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 23.9 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 19.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93595	Top Key Reference CPT Code: 93458	2nd Key Reference CPT Code: **93454**
Median Pre-Service Time	64.00	30.00	30.00
Median Intra-Service Time	48.00	45.00	30.00
Median Immediate Post-service Time	46.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**158.00**	**105.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	18%	27%	55%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	27%	55%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	18%	46%	36%
Physical effort required	18%	55%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	27%	64%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	56%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	56%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	44%	56%
Physical effort required	0%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	44%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision

of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63 Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes.

These changes were recommended to address gaps in the prior codes and significant changes in the service as a result of technology evolution over the past two decades. Whereas a predominance of diagnostic catheterizations were previously performed in a healthier population of children, with simpler cardiac defects, the specialty has evolved towards performing a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures. Members felt the existing codes, created in the 1990s no longer captured the wider range of patient and procedural complexity. As a result, the ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the third of five new codes to report cardiac catheterization for congenital heart disease.

The key reference code is 93458 for catheter placement in the coronary artery. It was selected by 24% of respondents. 55% of the respondents indicated that 93595 was more complex. The second reference code was 93454 for catheter placement in coronary artery. It was selected by approximately 20% of respondents. 67% of the respondents indicated that 93595 was more intense/complex overall.

Rationale

Since 1997, when the to-be-deleted congenital catheterization codes were created, a specific left heart catheterization only code was never created. Pediatric cardiologists were therefore relegated to using the adult (non-congenital) left heart catheterization with / without coronary arteries to capture their work. Unfortunately, due to obvious differences in the work performed, this has caused significant confusion amongst billers and payers, often resulting to inappropriate denials. Furthermore, although the reference code does capture left heart catheterization, the work performed in diagnostic evaluation of non-congenital patients with normal hearts and normal vascular connections is not sufficient to capture the performed with congenital patients, where these assumptions cannot be made, and a more thorough evaluation is needed.

This, third of five new codes, is designed to capture a left heart catheterization procedure in patients with congenital heart and vascular defects. In addition to left heart obstructive lesions such as aortic valve stenosis and coarctation of the aorta, a left heart catheterization is often needed for evaluation of patients with pulmonary blood flow originating from the aorta; those with major aorto-pulmonary collateral arteries or, MAPCAs, for example. Such patients typically have numerous vascular connections from the aorta to supply the pulmonary blood flow in a secondary vascular tree, either in addition to, or as replacement for the native pulmonary arterial tree. These procedures require a significantly greater level of diagnostic evaluation, catheter and wire manipulation, and angiography to identify each and every vessel for surgical planning than previously afforded with the non-congenital diagnostic codes.

Furthermore, as the specialty has evolved into a much more complex patient population, several elements of the pre and post service packages, simply do not suit the work performed in a children's hospital. As previously described, there are additional reporting requirements and significant communication barriers not captured by these packages.

Recommendation

Therefore, for code 93595 the societies recommend an RVW of 6.00 with 64 minutes preservice time, 48 minutes intraservice time from the survey median, and 46 minutes postservice time. This compares favorably with multiple MPC codes and others that have identical or similar intraservice times, though each of those also have shorter total times, as shown in the summary spreadsheet.

We are recommending the complete preservice evaluation time from the survey as we believe it correctly captures additional time that is typically spent to prepare for the procedure, ensure all supplies are available, and discuss informed consent with the parents. We are recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to diagram the congenital heart defect in the EHR, speak with the family who are typically parents concerned about their infant child, and complete data submission to the registry. Package 9B with the placement of these additional minutes is presented below.

History and Exam (Performance and review of appropriate Pre-Tests)	15	

Prepare for Procedure (Check labs, plan, assess risks, review procedure)	4	+4
Communicate with patient and/or family (Discuss procedure/ obtain consent)	5	+2
Communicate with other professionals	5	
Check/set-up room, supplies and equipment	5	
Check/ prepare patient readiness (Gown, drape, prep, mark)	5	
Prepare/ review/ confirm procedure	1	
Perform/ supervise patient positioning	3	
Administer local/topical anesthesia	0	
Observe (wait anesthesia care)	15	
Dress and scrub for procedure	5	

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**33**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	
Operative Note	5	+5
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+8
Written post-operative note	5	
Post-Operative Orders and Order Entry	5	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4140
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on IMPACT Registry data collected on congenital cardiac catheterizations and Medicaid claims data.

Specialty Pediatric Cardiology Frequency 3933 Percentage 95.00 %

Specialty Interventional Cardiology Frequency 207 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Procedure is expected to be primarly for pediatric patients.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93458

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93596 Tracking Number F4 Original Specialty Recommended RVU: **7.91**
Presented Recommended RVU: **7.91**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **7.91**

CPT Descriptor: Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s) for hemodynamic evaluation; normal native connections.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-month-old male was noted to have a heart murmur. A 2D echocardiogram and Doppler study demonstrated a large ventricular septal defect. This cardiac catheterization is being performed to measure the magnitude of the left-to-right shunt and to measure the pulmonary artery pressure and resistance to determine if reparative surgery is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT, MRI, 3D printed model, or any other pertinent studies. Determine all potential components required for the procedure are present, plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the complex procedure and expected results to the parents of the patient, a description of potential hazards, and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Set up a sterile table with all necessary sheaths and catheters, syringes, bowl with sterile heparinized flush, contrast, and any other necessary sterile equipment. Don surgical scrubs and lead. Position patient. Prep, scrub, drape, and wait. Connect sterile tubing to flush system and pressure transducers and ensure the hemodynamic recording system is properly zeroed.

Description of Intra-Service Work: The far majority of all procedures are conducted under general anesthesia. Palpate and identify the access site landmarks and administer local anesthesia. Access is obtained percutaneously, using Seldinger technique into the internal jugular, subclavian, brachial, femoral venous systems, as well as femoral arterial access. Ultrasound guidance may be necessary/used for vascular access. Once the vessel is punctured, a guidewire is passed into the vessel. The vascular sheath is introduced into the vessel, the guidewire and dilator removed, and the sheath flushed with sterile heparinized saline. A diagnostic catheter is passed through this sheath under fluoroscopic guidance. The catheter is directed into any of the right heart structures including, the inferior and superior vena cavae, right atrium, right ventricle, right and left pulmonary arteries, and pulmonary capillary wedge positions. If an atrial septal communication is present, it may be crossed for purpose of sampling the left atrium, individual pulmonary veins, and left ventricle. If an atrial communication is not present and the left atrial or pulmonary venous sampling is required, a trans-septal perforation is performed (additionally reported). For the retrograde left heart catheterization, a diagnostic catheter is passed through the sheath under fluoroscopic guidance, and directed in retrograde fashion into any of the left heart structures or vessels including, the systemic arterial (usually left) ventricle, then pulled back into the ascending aorta, and further to the descending aorta. Baseline pressures may be recorded and blood sampling may be conducted in each of these chambers and vessels to be used later for hemodynamic calculations. Once hemodynamic data is collected, the diagnostic catheter is removed and an angiographic catheter inserted and used for any necessary angiography of these chambers or vessels (each

separately reported). Cardiac output is calculated using the Fick equation. In patients without intra-cardiac shunting, cardiac output may be measured by thermodilution (separately reported). Following the completion of the catheterization proper, all catheters and sheaths are removed and compression hemostasis is achieved in the catheterization lab, prior to the patient being taken to recovery.

Description of Post-Service Work: Following catheterization, a procedure note is documented in the medical record. The patient is transported to the recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed catheterization report is documented, which includes a diagram of the congenital heart defect, description of the procedure performed, calculations and interpretations of all hemodynamic data obtained, review and interpretation of the angiograms, and listing of the findings and recommendations. All necessary data is then also entered into the appropriate national data registry, as indicated/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge instructions and follow up information prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC, AAP, SCAI					
CPT Code:	93596					
Sample Size:	646	**Resp N:**	46			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	79.00	250.00
Survey RVW:	3.00	6.45	**7.91**	8.89	13.55
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	8.00	45.00	**60.00**	89.00	240.00

Immediate Post Service-Time:	**53.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93596	**Recommended Physician Work RVU: 7.91**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**53.00**	**33.00**	**20.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93460	000	7.10	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93461	000	7.85	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52353	000	7.50	**RUC Time**	11,180

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52356	000	8.00	**RUC Time**	78,507

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

Other Reference CPT Code	Global	Work RVU	Time Source
33952	000	8.15	**RUC Time**

CPT Descriptor Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 28.2 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 17.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 93596	Top Key Reference CPT Code: 93460	2nd Key Reference CPT Code: 93461
Median Pre-Service Time	68.00	30.00	35.00
Median Intra-Service Time	60.00	50.00	65.00
Median Immediate Post-service Time	53.00	30.00	35.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**181.00**	**110.00**	**135.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	23%	69%	8%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	23%	79%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	38%	54%
Physical effort required	0%	46%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	54%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	50%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	38%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	38%	63%
Physical effort required	0%	88%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	63%	37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63 Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes.

These changes were recommended to address gaps in the prior codes and significant changes in the service as a result of technology evolution over the past two decades. Whereas a predominance of diagnostic catheterizations were previously performed in a healthier population of children, with simpler cardiac defects, the specialty has evolved towards performing a substantially larger number of more complex diagnostic evaluations to guide complex interventional procedures. Members felt the existing codes, created in the 1990s no longer captured the wider range of patient and procedural complexity. As a result, the ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the fourth of five new codes to report cardiac catheterization for congenital heart disease.

The key reference code is 93460 for catheter placement in coronary artery. It was selected by 28% of respondents. Over three quarters of the respondents indicated that 93596 was more complex. The second reference code was 93461 for catheter placement in coronary artery. It was selected by approximately 17% of respondents. 75% of the respondents indicated that 93596 was more intense/complex overall.

Rationale

Since 1997, when to-be-deleted codes were surveyed, there has been a shift in patient population and change in how these codes are billed. The typical patient is now a more complex patient with significantly more pathology. Due to the shift in patient population, the IWPUT increases dramatically and more correctly, in line with other codes in the cardiac catherization family. We believe this also shows there are differences in RUC survey methodology from 1997 to now, and that the current codes' times and RVUs may no longer be accurate because of that evolution.

Originally, there were three codes created for various forms of combined right and left heart catheterization for congenital heart disease (93531, 93532, and 93533). Proceduralists believe these codes fail to properly capture the work performed in 2020 and beyond. Additionally, the existing codes had numerous significant flaws in the original valuation. For instance, 93533 combined right and left heart catheterization, through an existing septal opening was valued at significantly less than 93531, combined right and retrograde left heart catheterization (6.69 vs 8.34 RVU), despite the fact the description of work for 93533 clearly includes all of the work of 93531 as well as the additional work of evaluating the left atrium and pulmonary veins through the atrial septal opening.

The previous errors in valuation along with the significant change in patient population brought about a need to create two new codes rather than three; one for those with simple defects, defined in CPT as having normal connections, and a second code for the more complex patients with abnormal connections. This, fourth of five new codes, is for the former and designed to capture a right and left heart catheterization procedure in patients with normal native connections.

Furthermore, as the specialty has evolved into a much more complex patient population, several elements of the pre and post service packages, simply do not suit the work performed in a children's hospital. As previously described, there are additional reporting requirements and significant communication barriers not captured by these packages.

Recommendation

Therefore, for code 93596 the societies recommend an RVW of 7.91 with 68 minutes preservice time, 60 minutes intraservice time from the survey median, and 53 minutes postservice time. This compares favorably with multiple MPC codes and others that have identical or similar intraservice times, though each of those also have shorter total times, as shown in the summary spreadsheet.

We are recommending the complete preservice evaluation time from the survey as we believe it correctly captures additional time that is typically spent to prepare for the procedure, ensure all supplies are available, and discuss informed consent with the parents. We are recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to diagram the congenital heart defect in the EHR, speak with the family who are typically parents concerned about their infant child, and complete data submission to the registry. Package 9B with the placement of these additional minutes is presented below.

History and Exam (Performance and review of appropriate Pre-Tests)	15	
Prepare for Procedure (Check labs, plan, assess risks, review procedure)	4	+5
Communicate with patient and/or family (Discuss procedure/ obtain consent)	5	
Communicate with other professionals	5	+5
Check/set-up room, supplies and equipment	5	
Check/ prepare patient readiness (Gown, drape, prep, mark)	5	
Prepare/ review/ confirm procedure	1	
Perform/ supervise patient positioning	3	
Administer local/topical anesthesia	0	
Observe (wait anesthesia care)	15	
Dress and scrub for procedure	5	

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**33**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	
Operative Note	5	+12
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+8
Written post-operative note	5	
Post-Operative Orders and Order Entry	5	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93531-93533

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 33140
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on IMPACT Registry data collected on congenital cardiac catheterizations and Medicaid claims data.

Specialty Pediactic Cardiology Frequency 31483 Percentage 95.00 %

Specialty Interventional Cardiology Frequency 1657 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 424
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the Medicare data estimation reported in 2019 for 93531-93533. Service will be primarily pediatric.

Specialty Cardiology Frequency 212 Percentage 50.00 %

Specialty Interventional Cardiology Frequency 85 Percentage 20.04 %

Specialty Cardiac Electrophysiology Frequency 127 Percentage 29.95 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93531

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93597 Tracking Number F5 Original Specialty Recommended RVU: **11.74**
Presented Recommended RVU: **11.74**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **9.99**

CPT Descriptor: Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal connections

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year-old male with tricuspid atresia, secundum atrial septal defect, ventricular septal defect, pulmonary artery stenosis, and a hypoplastic right ventricle, who is status post stage II bidirectional Glenn procedure is referred for a cardiac catheterization for hemodynamic evaluation in order to determine if a total right heart bypass (Fontan procedure) is the next appropriate step.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT, MRI, 3D printed model, or any other pertinent studies. Determine all potential components required for the complex procedure are present, plus contingencies and backups, including discussion with industry representatives to provide any atypical supplies which are not already kept in stock. Perform and document a complete and/or interval history and physical exam, noting any and all prior cardiovascular sugeries and interventions. Provide a description of the underlying congenital anamoly and indications for intervention, description of the procedure and expected results to the parents of the patient, a description of potential hazards, and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team, including discussion regarding the plan for induction of anesthesia the high risk patient. Set up a sterile table with all necessary sheaths and catheters, syringes, bowl with sterile heparinized flush, contrast, and any other necessary sterile equipment. Don surgical scrubs and lead. Supervise positioning of the patient to allow for multiple access sites to be prepped. Prep, scrub, drape, and wait. Connect sterile tubing to flush system and pressure transducers and ensure the hemodynamic recording system is properly zeroed.

Description of Intra-Service Work: The far majority of all procedures are conducted under general anesthesia. Palpate and identify the access site landmarks and administer local anesthesia. Access is obtained percutaneously, using Seldinger technique into the internal jugular, subclavian, axillary, or femoral venous systems, as well as arterial access in the femoral, radial, or axillary arteries, and occasionally, carotid arterial access. Frequently, multiple attempts must be made because of very small vessels and/or vascular thrombosis from previous studies or presence of indwelling catheters. Additional ultrasound guidance for vascular access may be necessary/used due to these problems. In rare cases, the need for hepatic venous access may be necessary due to lack of any other possible venous access, and is separately reported. Once the vessel is punctured, a guidewire is passed into the vessel. The vascular sheath is introduced into the vessel, the guidewire and dilator removed, and the sheath flushed with sterile heparinized saline. A diagnostic catheter is passed through this sheath under fluoroscopic guidance. Catheter introductions are then performed through these sheaths and manipulated into the necessary positions. For the right heart catheterization, a catheter is passed through the sheath under fluoroscopic guidance and directed into any necessary venous structures and chambers comprising the “right heart”, which will vary depending on the congenital heart defect. Frequently, there are additional vessels, not encountered in patients with normal

connections that must also selectively be catheterized, such as a left sided vena cava. If an atrial septal communication is present, it may be crossed for purpose of sampling the left sided atrium, individual pulmonary veins, and left sided ventricle. If an atrial communication is not present and the left atrial or pulmonary venous sampling is required, a trans-septal perforation is performed and additionally reportable. For the left heart catheterization, a diagnostic catheter is passed through the sheath under fluoroscopic guidance, and directed typically in retrograde fashion into the systemic (right or left) ventricle, then pulled back into the ascending aorta, and further to the descending aorta. Frequently, the pulmonary arteries must be accessed from the left heart catheterization due to presence of an aorto-pulmonary surgical shunt. Alternatively, both the systemic arterial and pulmonary arterial catheterization must be performed from the same ventricle in patients with transposition of the great arteries, and a surgical right ventricle to pulmonary artery (SANO) shunt. In these scenarios, catheter placement across the systemic to pulmonary shunts, can be very poorly tolerated, as the pulmonary blood flow is obstructed by the catheter, and great care must be taken, as well as close communication between the cardiologist and anesthesiologist to ensure stable hemodynamics are maintained. Frequently, patients require catheterization from both venous (right heart), and arterial (left heart) in order to identify all possible sources of pulmonary blood supply. In these situations selective catheterizations of numerous individual vessels is performed for sampling and angiography (each being separately reported). Baseline pressures may be recorded and blood sampling may be conducted in each of these chambers and vessels to be used later for hemodynamic calculations. Positioning for angiography may occur in any of the heart chambers or blood vessels, which includes exchanging the diagnostic catheter used for physiologic data for an angiographic catheter, and each are separately reportable. Cardiac output is typically calculated using the Fick equation. In patients without intra-cardiac shunting, cardiac output may be measured by thermodilution, and is separately reported. Following the completion of the procedure, all catheters and sheaths are removed and compression hemostasis achieved in the catheterization lab, prior to the patient being taken to recovery.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. The patient is transported to the recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A very detailed catheterization report is documented, which includes a complex diagram of the congenital heart defect, description of the procedure performed, calculations and interpretations of all hemodynamic data obtained, review and interpretation of the angiograms, and listing of the findings and recommendations. All necessary data is then also entered into the appropriate national data registry, as indicated/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge instructions and follow up information prior to discharge..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC, AAP, SCAI					
CPT Code:	93597					
Sample Size:	646	**Resp N:**	46			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	23.00	**50.00**	79.00	250.00
Survey RVW:	3.50	7.81	**8.88**	10.00	15.70
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**83.00**	99.00	300.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93597	**Recommended Physician Work RVU: 9.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**55.00**	**40.00**	**15.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**83.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**60.00**	**33.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93461	000	7.85	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93460	000	7.10	**RUC Time**

CPT Descriptor Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52356	000	8.00	**RUC Time**	78,507

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36905	000	9.00	**RUC Time**	41,205

CPT Descriptor 2 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

Other Reference CPT Code	Global	Work RVU	Time Source
37241	000	8.75	**RUC Time**

CPT Descriptor Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 34.7 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 19.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93597	Top Key Reference CPT Code: 93461	2nd Key Reference CPT Code: **93460**
Median Pre-Service Time	73.00	35.00	30.00
Median Intra-Service Time	83.00	65.00	50.00
Median Immediate Post-service Time	60.00	35.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**216.00**	**135.00**	**110.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	6%	31%	63%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	19%	81%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	13%	87%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	13%	81%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	22%	67%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	11%	89%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	11%	89%
Physical effort required	0%	11%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	11%	89%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63 Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes.

These changes were recommended to address gaps in the prior codes and significant changes in the service as a result of technology evolution over the past two decades. Whereas a predominance of diagnostic catheterizations were previously performed in a healthier population of children, with simpler cardiac defects, the specialty has evolved towards performing a substantially larger number of more complex diagnostic evaluations to guide complex interventional procedures. Members felt the existing codes, created in the 1990s no longer captured the wider range of patient and procedural complexity. As a result, the ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the fifth of five new codes to report cardiac catheterization for congenital heart disease.

The key reference code is 93461 catheter placement in coronary artery. It was selected by 35% of respondents. 94% of the respondents indicated that 93597 was more complex. The second reference code was 93460 for catheter placement in coronary artery. It was selected by approximately 20% of respondents. 89% of the respondents indicated that 93597 was more intense/complex overall.

Rationale

Since 1997, when to-be-deleted codes were surveyed, there has been a shift in patient population and change in how these codes are billed. The typical patient is now a more complex patient with significantly more pathology. Due to the shift in patient population, the IWPUT increases dramatically and more correctly, in line with other codes in the cardiac catherization family. We believe this also shows there are differences in RUC survey methodology from 1997 to now, and that the current codes' times and RVUs may no longer be accurate because of that evolution.

Originally, there were three codes created for various forms of combined right and left heart catheterization for congenital heart disease (93531, 93532, and 93533). Proceduralists believe these codes fail to properly capture the work performed in 2020 and beyond. Additionally, the existing codes had numerous significant flaws in the original valuation. For instance, 93533 combined right and left heart catheterization, through an existing septal opening was valued less than 93531, combined right and retrograde left heart catheterization (6.69 vs 8.34 RVU), despite the fact the description of work for 93533 clearly includes all of the work of 93531 as well as the additional work of evaluating the left atrium and pulmonary veins through the atrial septal opening.

The previous errors in valuation along with the significant change in patient population brought about a need to create two new codes rather than three; one for those with simple defects, defined in CPT as having normal connections, and a second code for the more complex patients with abnormal connections. This, fifth of five new codes, is for the latter and designed to capture a right and left heart catheterization procedure in patients with abnormal native connections, and some of the most complex congenital heart defects which the specialty encounters very frequently.

Furthermore, as the specialty has evolved into a much more complex patient population, several elements of the pre and post service packages, simply do not suit the work performed in a children's hospital. As previously described, there are additional reporting requirements and significant communication barriers not captured by these packages.

Recommendation

Unlike the previous four codes where the survey produced a rational progression through the family with intensity increasing with each code, the fairly long service time here diluted that progression, we feel incorrectly. Therefore, for code 93597 the societies recommend crosswalking to 92924 to an RVW of 11.74 with 73 minutes preservice time, 83 minutes

intraservice time from the survey median, and 60 minutes postservice time. This produces an IWPUT that is appropriately the highest of the family.

We are recommending the complete preservice evaluation time from the survey as we believe it correctly captures additional time that is typically spent to prepare for the procedure, ensure all supplies are available, and discuss informed consent with the parents. We are recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to diagram the congenital heart defect in the EHR, speak with the family who are typically parents concerned about their infant child, and complete data submission to the registry. Package 9B with the placement of these additional minutes is presented below.

History and Exam (Performance and review of appropriate Pre-Tests)	15	
Prepare for Procedure (Check labs, plan, assess risks, review procedure)	4	+7
Communicate with patient and/or family (Discuss procedure/ obtain consent)	5	
Communicate with other professionals	5	+8
Check/set-up room, supplies and equipment	5	
Check/ prepare patient readiness (Gown, drape, prep, mark)	5	
Prepare/ review/ confirm procedure	1	
Perform/ supervise patient positioning	3	
Administer local/topical anesthesia	0	
Observe (wait anesthesia care)	15	
Dress and scrub for procedure	5	

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**33**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	
Operative Note	5	+15
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+12
Written post-operative note	5	
Post-Operative Orders and Order Entry	5	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93531-93533

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 33140
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on IMPACT Registry data collected on congenital cardiac catheterizations and Medicaid claims data.

Specialty ACC Frequency 31483 Percentage 95.00 %

Specialty AAP Frequency 1657 Percentage 5.00 %

Specialty Frequency Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Procedure is intended for pediatric patients.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93531

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93598 Tracking Number F6 Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.75**

CPT Descriptor: Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects
(List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year-old female with history of prematurity, chronic lung disease, and a previously repaired ventricular septal defect undergoes diagnostic right and left heart catheterization for evaluation of her congenital heart disease. Proper calculation of cardiac index by the Fick method is compromised as an accurate oxygen consumption cannot be measured. Therefore, following completion of the diagnostic hemodynamic evaluation, thermodilution studies are performed to confirm cardiac index. Pulmonary vasoreactivity testing is then performed (separately reported).

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work:

Description of Intra-Service Work: Following completion of a congenital, right heart catheterization or combined right and left heart catheterization (separately reported), the diagnostic catheter previously used is removed and a Swan Ganz catheter is introduced from the venous sheath, advanced through the right heart, and placed into the pulmonary artery for purpose of assessing cardiac output by thermodilution. The catheter is connected to the hemodynamic recording system. A series of saline injections are performed by the operator through the proximal port and the results recorded. Multiple, typically between 3 and 6 injections are performed and evaluated. If there is consistency in the initial 3 or 4, these are averaged. If not, additional injections are performed until the operator is satisfied that enough measurements have been obtained to represent the true cardiac output. If there are clinical changes in the patient's condition or changes in the level of anesthesia, administration of pressers, repeat thermo-dilution assessment may be performed and not additionally reportable. Following completion of the cardiac catheterization, the cardiac output data is evaluated, and the results converted to a cardiac Index and entered as part of the official catheterization report.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Sergio Bartakian, MD; Steven Krug, MD					
Specialty Society(ies):	ACC, AAP, SCAI					
CPT Code:	93598					
Sample Size:	676	**Resp N:**	46			
Description of Sample:	Random interventional cardiologists from ACC, all pediatric cardiologists from AAP & SCAI identifiable from membership rolls					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	30.00	300.00
Survey RVW:	0.20	1.00	**2.00**	3.00	13.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	12.00	**20.00**	45.00	300.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93598	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93567	ZZZ	0.97	**RUC Time**

CPT Descriptor Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	13,979

CPT Descriptor 2 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
20931	ZZZ	1.81	**RUC Time**

CPT Descriptor Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 32.6 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 26.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 93598	Top Key Reference CPT Code: 93567	2nd Key Reference CPT Code: **36227**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	20%	66%	7%	7%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	53%	14%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	7%	66%	27%

Physical effort required	7%	80%	14%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	53%	14%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	8%	33%	59%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	33%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	17%	33%	50%
Physical effort required	0%	58%	42%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	59%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In May 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel to replace four congenital cardiac catheterization codes with five new codes to report cardiac catheterization for congenital cardiac defect(s); the proposal also included replacement of two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects; revision of guidelines and parenthetical notes to reflect the proposed new and deleted codes; and revision of the Modifier 63

Procedure Performed on Infants Less than 4 kg guidelines to reflect these changes. These changes were recommended to address gaps in the prior codes and changes in the service as a result of technology evolution in the past two decades. As a result, the ACC, AAP, and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ survey was completed by physicians who have experience with the service. This is the new add-on code to report cardiac output measurement(s), performed during catheterization for congenital cardiac defects.

This new code replaces codes 93561 and 93562 that describe congenital cardiac indicator dilution studies—predominantly performed on pediatric patients—to measure cardiac output. These services were previously identified by societies for consideration under the RAW negative IWPUT screen. These were Harvard-valued codes that were 000 global procedures with the archaic "(separate procedure)" parenthetical. However, in reality they were always billed as an adjunct to congenital cardiac catheterization codes. In consultation with the Research Subcommittee a parallel CPT code change application was submitted for consideration at February 2019 CPT to align these codes with the current presentation of ZZZ global procedures codes which are tagged with an "add-on"/"+" sign and include "(List separately…)" language. The codes were surveyed as ZZZ procedures. The Research subcommittee also reviewed the newly written typical patient vignettes in advance of that 2019 survey.

The key reference code is 93567 for injection procedure. It was selected by 33% of respondents. Over half of the respondents indicated that 93598 was nearly identical. The second reference code was 36227 for selective catheter placement. It was selected by approximately 26% of respondents. Nearly 60% of the respondents indicated that 93598 was more intense/complex overall.

We believe the new code definition that discards archaic "separate procedure" nomenclature provided respondents with a better understanding of the service and the survey results track accordingly.

Recommendation

Therefore, for code 93598 the societies recommend an RVW of 2.00 with 20 minutes intraservice time from the survey median. This compares favorably with multiple MPC codes and others that have identical or similar intraservice times, though each of those also have shorter total times, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Cardiology How often? Commonly

Specialty Interventional Cardiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 300-400 interventional cardiologists focus on pediatric cases. Some perform these procedures several times a month while others' utilization is less frequent. Based on the estimated number of pediatric interventional cardiologists in the U.S. and known pediatric cardiac programs, we estimate approximately 1000 of these procedures are performed a year.

Specialty Pediatric Coardiology Frequency 900 Percentage 90.00 %

Specialty Interventional Cardiology Frequency 100 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This congenital service has been consistently below 100 services the past few years.

Specialty Pediatric Cardiology Frequency 90 Percentage 90.00 %

Specialty Interventional Cardiology Frequency 10 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93561

CARDIAC CATHETERIZATION IN THE DIAGNOSIS OF CONGENITAL HEART DISEASE *

BY

H. E. HOLLING AND G. A. ZAK *

From the Clinical Research Unit and the Cardiac Department, Guy's Hospital

Received October 24, 1949

Cardiac catheterization is now a recognized method of clinical investigation and in recent years has been applied to the diagnosis of malformed hearts (Cournand *et al.*, 1949; Warren *et al.*, 1946; Groom *et al.*, 1948; Handelsman *et al.*, 1948; Dexter *et al.*, 1947; Bing *et al.*, 1947; Taylor *et al.*, 1948; Burchell *et al.*, 1948; Geiger *et al.*, 1946; Brannon *et al.*, 1945; Howarth *et al.*, 1947; Baldwin *et al.*, 1946; Soulie *et al.*, 1949). So far we have used this method on a group of 70 patients with a wide range of cardiac malformations. Here we attempt to evaluate the method as a diagnostic procedure, using the published results of other workers to supplement our own experience.

Cases Investigated

The cases were selected from a large number sent to Guy's Hospital mainly with a view to surgical treatment of their condition; they were under the care of Dr. Maurice Campbell, Mr. R. C. Brock, and Dr. Charles Baker, and clinical diagnoses were often discussed together. Patients with congenital heart disease often have multiple cardiac malformations of which one may be judged as functionally the most important, and in the table below they are listed under what appears to be the chief lesion. Thirty-six were over 15 years of age, twenty-two between the ages of 10 and 15, and twelve between the ages of 5 and 10 years.

Diagnosis	Number of Cases
Fallot's tetralogy	29
Pulmonary stenosis with closed ventricular septum	9
Pulmonary or tricuspid atresia	8
Transposition of the great vessels	4
Eisenmenger's complex	2
Patent ductus arteriosus	3
Isolated atrial septal defect	1
Truncus arteriosus	2
Lutembacher's syndrome	1
Ebstein's disease	1
Partial dextrocardia	3
Diagnosis uncertain	5
Pulmonary hæmangioma	2

At the end of the paper the results of catheterization of 18 illustrative cases are given, with explanatory notes intended to show how the general principles of interpreting results apply in particular cases. The diagnosis of some of these cases, in spite of angiocardiography and cardiac

* Work undertaken on behalf of the Medical Research Council. G. A. Z. was in receipt of a personal grant from the Medical Research Council.

catheterization, is still in doubt, but they have been included to represent problems that arise in practice. Several of the cases have been or will be discussed elsewhere (Allanby and Campbell, 1949; Baker *et al.*, 1949; Brock, 1948; Campbell and Hills, 1950). We have not attempted to catheterize all the cases admitted, because we find the procedure too time-consuming to be used in this way. It requires a full day's work for two investigators and a technician, and the co-operation of the X-ray staff for at least two hours. Moreover, the investigation is not without danger to the patient, who in any case is likely to find it an uncomfortable experience. We have therefore restricted its use mainly to those where the clinical diagnosis was in doubt, or where it seemed important to obtain the information that cardiac catheterization can yield.

METHODS

The methods used do not differ materially from those of other workers and we comment only on points that seem important.

Sedation and anæsthesia. It is known (Hickam *et al.*, 1948) that anxiety on the part of the patient may increase the cardiac output without a parallel increase in oxygen consumption, thus decreasing the arteriovenous oxygen difference. Moreover, breath holding, crying, or struggling may materially alter the intracardiac pressures and gaseous content of the blood. It is important, therefore, that so far as possible the patient should remain under basal conditions throughout the catheterization. It is not easy to achieve this, particularly with children, because the method requires that the patient lie on the X-ray table for at least an hour. Moreover, the passage of the catheter into the heart often provokes tachycardia and sometimes extrasystoles, and in some patients manipulation of the catheter in the right ventricle causes a complaint of soreness under the sternum. We found that to engage the patient in easy conversation throughout the procedures is the best way of ensuring equable conditions. It is certainly undesirable to discuss technical points in the hearing of the patient. One to three grains of phenobarbitone were given about two hours before the start to adults and children down to the age of 8 years. Younger children, with one exception, required an anæsthetic. For this we first tried trilene or paraldehyde, which were recommended by the anæsthetists as being the safest agents, but their use disturbed the subsequent blood gas determinations. We have since found avertin satisfactory, given per rectum in a dose of 0·125 g. per kg. about half an hour before the insertion of the catheter. When deeper unconsciousness was required, avertin was supplemented with pentothal (about 0·15 g.). Though deepening of the anæsthesia probably altered the condition of the patient, it seemed preferable to risk this rather than to withdraw blood samples from a crying or struggling child.

Catheterization. The Cournand catheter was introduced into a cubital vein draining into the basilic system. The catheter sizes used ranged from 7 to 10, but usually an 8 or 9 was employed. A number of difficulties were met with during catheterization. It is inadvisable to try to force a catheter into a vein too small to accommodate it comfortably. In one instance when we attempted this an extensive thrombosis of the vein followed. On occasion the vein appeared to contract strongly, gripping the catheter and making its passage difficult. Usually in the experience of others and ourselves this can be avoided by gentle and smooth manipulation of the catheter. This happened once when the catheter tip was at the level of the outer border of the first rib, and for an hour and a half the catheter could neither be advanced nor withdrawn. Then following the injection of 1·5 ml. of 1 per cent procaine, through and alongside the catheter, and the application of hot water bottles to the arm, the catheter became free.

Either arm has been used for the insertion of the catheter, but in cases with a right-sided aortic arch it has seemed easier to enter the superior vena cava from the left, probably because of the more favourable angle between the left innominate vein and the superior vena cava. In one such case the catheter could not be advanced into the superior vena cava from the right in spite of a prolonged trial, but from the left arm this was achieved without difficulty.

On several occasions during the exploration of the right atrium for suspected septal defects

the tip of the catheter re-entered the superior vena cava and so formed a loop in the atrium. This has given rise to anxiety on the part of the operator because pushing the catheter caused the tip to move further into the vena cava, and pulling it caused the tip of the catheter to become wedged in the opening of the superior vena cava. On each occasion gentle manipulation of the catheter released it within a minute or two.

Since in our experience embolism has followed catheterization (see later) we emphasize the need for strict precautions against the formation of thrombi within the catheter or damage to the endocardium. The heparin saline drip (3000 units heparin per litre of normal saline) should be checked frequently, especially when entering chambers in which the blood is under high pressure, when it may be necessary to raise the saline reservoir. Manipulation of the catheter when inside the heart and great vessels, especially in the left ventricle, should be gentle to minimize the risk of trauma to the endothelium with subsequent thrombus formation. Cleaning the catheter should begin immediately after it is withdrawn.

Location of the catheter tip. In dealing with abnormal hearts in which unusual communications or obstructions may exist between the various chambers, it is important to locate the tip of the catheter as precisely as possible. The value of the lateral position should be remembered.

Fluoroscopic observation should start from the moment the catheter enters the thorax. The X-ray screening time has, however, to be limited, and in accordance with the measurements of Hills and Stanford (1950) we endeavoured not to exceed 25 per cent of the erythema dose. For us this meant about 20 minutes' screening time, though the diaphragms of the apparatus were adjusted to give as small a field as was required for directing the catheter tip within the heart. It is permissible to extend the screening time by 25 per cent when necessary for the completion of an important case.

Frequent measurement of intracardiac pressure is a great help in locating the tip of the catheter. For this purpose we have used saline, aneroid, and Hamilton manometers (Hamilton, 1934). The saline manometer is unsatisfactory mainly because of the slowness with which it reaches equilibrium, particularly when blood has passed into the catheter. The aneroid manometer requires the movement of only a small volume of fluid through the system before equilibrium is reached and so records quickly, but like the saline manometer it does not record systolic and diastolic pressures. However, the mean pressure is usually sufficient for diagnostic purposes, and because the aneroid manometer is so simple to use it can be generally recommended. Since it is not unlikely that evidence of value for diagnosis may be derived from a study of the form of the intracardiac pulse tracings, we have also used a Hamilton manometer with optical recording.

To aid in locating the catheter tip it is an advantage to ascertain the oxygen content of the blood samples while the catheterization is in progress. With this object some workers have arranged to have the blood analysed as it is taken so that the results may be known before the catheter is withdrawn, and further samples taken if necessary. We have not been able to do this, but undoubtedly it would be of great value. Wood *et al.* (1948) have described a photoelectric apparatus that may prove useful. Using this, the oxygen saturation of blood withdrawn from the catheter can be estimated almost as soon as it is taken, and samples from different parts of a cardiac chamber or chambers can be compared; and if they vary considerably, as many samples as necessary can be taken to estimate the average oxygen saturation of blood in the particular chamber.

The catheter sometimes enters the coronary sinus from the right atrium, but with experience this is quickly recognized and corrected; the following points are important. (1) As the catheter passes along the narrow coronary sinus it follows a fixed path and the curved tip cannot be turned around as when lying in the ventricle. (2) The catheter may appear as if its tip is about to pass into the pulmonary artery and occasionally as if it had entered the left branch of the pulmonary artery, but it always comes to a full stop within the cardiac shadow. (3) Although the catheter tip looks as if it is in the ventricle the pressure recorded is as low as in the atrium. However, if the catheter is advanced until it blocks the cardiac vein the pressure rises towards ventricular pressure (60/16 mm. Hg in Case 13, Fig. 12). Bing (1949) gives a record of the fall in pressure as the catheter

is withdrawn from blocking the cardiac vein. (4) The blood samples withdrawn from the coronary sinus are of a very low oxygen content (20 to 30% saturated).

Estimation of blood oxygen content. Blood samples from the catheter were withdrawn into vaselined syringes, and kept in them in the dark and in ice water until their oxygen content could be determined in a Haldane blood gas apparatus (Douglas and Priestley, 1948).

We found, as did Wassermann *et al.* (1949) and other investigators, that the oxygen content of the blood sometimes decreases if the blood is allowed to stand at room temperature. Our observations suggest this is not constant, for the blood sometimes shows only a negligible fall after standing at room temperature for 4 to 5 hours. In other cases, however, the blood oxygen content may show a considerable drop within an hour. In our experience the addition of sodium fluoride (0·6 mg./ml. blood) does not prevent the loss of oxygen. It is, however, greatly slowed by keeping the blood syringe in iced water, and kept in this way there is no material loss of oxygen over a period of 6 hours. For example, arterial blood was taken and the oxygen content (measured within 10 minutes of withdrawal) was found to be 15·4 ml./100 ml. (81% saturation) : one-half of the sample was kept in iced water, the other at room temperature (21° C.), and in all 13 estimations of oxygen content were done in the next 6 hours; these showed that the oxygen content of the blood kept in iced water remained steady for 6 hours at 15·4 to 15·3 ml. oxygen per 100 ml. but the oxygen content of that kept at room temperature slowly fell over 5½ hours to 14·6 ml. oxygen per 100 ml.

The blood was kept in the dark in order to prevent the formation of methæmoglobin, which is liable to form when blood is exposed to light.

Complications of Catheterization

Cardiac arrhythmias. Tachycardia up to 140 a minute in children may occur during catheterization, and is best avoided by the methods described under sedation. When the catheter tip is in the right ventricle the patient may be disturbed by extrasystoles but we have seen no harm come from them and our practice is to forewarn the patient and to reassure him that they are not of importance. Johnson *et al.* (1947) describe the onset of a paroxysm of auricular tachycardia or of 1 to 1 flutter which lasted for two hours after passing of a loop of catheter through the tricuspid orifice. Dexter *et al.* (1947) report auricular fibrillation in two of their patients with spontaneous restoration of normal rhythm within half an hour. Ventricular fibrillation is presumably a possibility though it has not been recorded.

General reactions. During the insertion of the catheter two of our female patients fainted, showing a cold, pale, sweating skin and a slow pulse; this occurred though they were supine and not complaining of any pain or discomfort. Several patients, especially when the catheterization has been prolonged, have complained of nausea immediately after the withdrawal of the catheter, and for the next five or six hours have felt very tired. Three children vomited immediately after and became temporarily more cyanosed; they also were extremely fatigued. Since any increase in the degree of the anoxia of these patients is dangerous, we have always had means of administering oxygen at hand.

Thrombosis and embolism. Localized thrombosis of the vein where the catheter was inserted often occurs, but it seldom extends far up the vein. Cournand (1949) finds that thrombosis is more likely to be limited if the incision is made at least 5 cm. distal to the opening of a branch vein into the basilic system.

It is generally held that cardiac catheterization is a safe procedure in man, and so far as we are aware there is only one reported case in which it is possible that catheterization had given rise to fatal thrombosis and embolism (Johnson *et al.*, 1947). The child died of an unspecified cause one month after catheterization and an unsuspected thrombus was found in the right atrium, inferior vena cava, and iliac and renal veins. Presumably the thrombosis had arisen at the site of the insertion of the catheter into the saphenous vein, or perhaps at the base of one of the tricuspid valves to which it was attached. Kinney *et al.* (1945) subjected the hearts of dogs to " traumatic "

catheterization for short periods and subsequent pathological examination of the hearts and great vessels showed no lesions attributable to the procedure. On the other hand some members of the same group later reported verbally endocardial lesions in dogs after catheterization of the pulmonary artery (Goodale *et al.*, 1947). Goodale had found mural thrombi and subendocardial hæmorrhages in the hearts of dogs that had been catheterized. These lesions were found to be more distinct when the animals were sacrificed more than 24 hours after the catheterization, and perhaps this may be the reason for the conflicting descriptions. In our experience with cases of congenital heart disease, cardiac catheterization is not without danger to the patient. Symptoms and signs indicating pulmonary or systemic thromboses or emboli have developed within 14 days of catheterization in no less than 6 of the 70 cases here reported. Details of these cases are as follows:

(1) O. D., aged 23 years (Case 9 of the appendix), a case of Eisenmenger's complex developed (the day after catheterization) an extensive thrombosis of her brachial vein. Seven days later she complained of pain in her chest and coughed up blood-stained sputum.

(2) C. L., aged 7 years (Case 13 of the appendix), had an unusual malformation of the heart described there. She was deeply cyanosed and bedridden, and was the most severley incapacitated of the children we have examined. Immediately after the withdrawal of the catheter she vomited and rapidly became unconscious and stopped breathing. Artificial respiration and oxygen were given for several minutes before consciousness returned. The next day she coughed up bloody sputum and remained critically ill for a fortnight. Having apparently recovered from the catheterization and a subsequent angiocardiogram, she died suddenly about seven weeks after the catheterization. No evidence of presumed pulmonary infarcts or of intravascular thrombi was found at necropsy.

(3) and (4) J. C. and R. C., aged 8 years, Fallot's tetralogy and tricuspid atresia respectively. Both complained of pain in the chest a few hours after catheterization, became dyspnœic and more cyanosed. J. C. had blood-stained sputum. They were nursed in an oxygen tent for a few days till they recovered.

(5) B. H., aged 10 years, a case of transposition of the great vessels. During catheterization the aorta was entered a number of times. About 8 hours after the catheterization he developed pyrexia, headache, and increasing drowsiness. The next day he was semiconscious, had neck rigidity, and a positive Kernig's sign. Lumbar puncture showed the cerebrospinal fluid to be under pressure and to contain blood. Several days later he also had diarrhœa. Chemotherapy was given from the start of his symptoms, but it was 3 weeks before he was well again. This unexpected sequel was thought to be the result of intravascular thrombosis.

(6) L. H., aged 19. Case described in detail (Baker *et al.*, 1950). One week after catheterization he developed sudden pain in both calves and died with bilateral gangrene of the legs 10 days later. At necropsy he was found to have the abnormality of the tricuspid valves known as Ebstein's disease. A partly organized thrombus was found on the septal wall of the left ventricle, which the catheter had entered via an atrial septal defect. In both popliteal arteries emboli were found, which had presumably originated from the intracardiac thrombosis.

Even without catheterization, thromboses and emboli may occur in these patients and at necropsy vegetations are often found on the deformed valves and edges of septal defects. In view of this tendency to spontaneous thromboses it is perhaps not unexpected that it should sometimes follow cardiac catheterization. To reduce the likelihood of endothelial damage we prefer to use the thinner and more flexible catheters, even though they are more difficult to direct in the heart.

The Interpretation of the Results of Blood Gas Estimations

The clinical differentiation of congenital heart disease may be uncertain because of the frequent occurrence of multiple defects. It is in this field that cardiac catheterization is being applied extensively, for by its use the presence of certain malformations may be proved. If, for instance, the catheter passes through a septal defect the fact can be recognized on the X-ray screen, or if the catheter is passed in to the pulmonary artery the stenosis can be recognized by the fall in pressure as the catheter tip passes through it. Often, however, direct proof is not obtained, though evidence of the defect may be found indirectly from comparison of the oxygen content of blood from the great vessels and chambers of the right heart.

An atrial septal defect with an arteriovenous shunt will result in blood in the right atrium being more oxygenated than blood in the venæ cavæ, or a patent ductus arteriosus will result in the blood

in the pulmonary artery being more oxygenated than in the right ventricle. Blood may flow either into the right or the left heart, and while an arteriovenous shunt would cause an increase in the oxygen content of the right heart blood, a venoarterial shunt would have no such effect. In practice it is not always easy to say whether an increase in oxygen content of the blood from right atrium, ventricle, or pulmonary artery indicates an admixture of oxygenated blood through a septal defect. This is because there are considerable variations in oxygen content of right heart blood, even in hearts with no septal defects or other abnormal communications. It is, therefore, important to know these variations so that the diagnosis of a septal defect may be made with more confidence.

Comparison of Blood from the Venæ Cavæ and Atrium

The difference in oxygen content that may occur between the blood of the venæ cavæ and the right atrium in the absence or presence of atrial septal defects is shown by the data from our own cases and those of other workers in Fig. 1, 2, and 3. The cases without atrial septal defect include not only malformed hearts, but also acquired heart disease and normal hearts. The diagnosis of an atrial septal defect, and whether the shunt through it was venoarterial or arteriovenous, was made on good clinical evidence, and in some cases confirmed by examination of the heart after

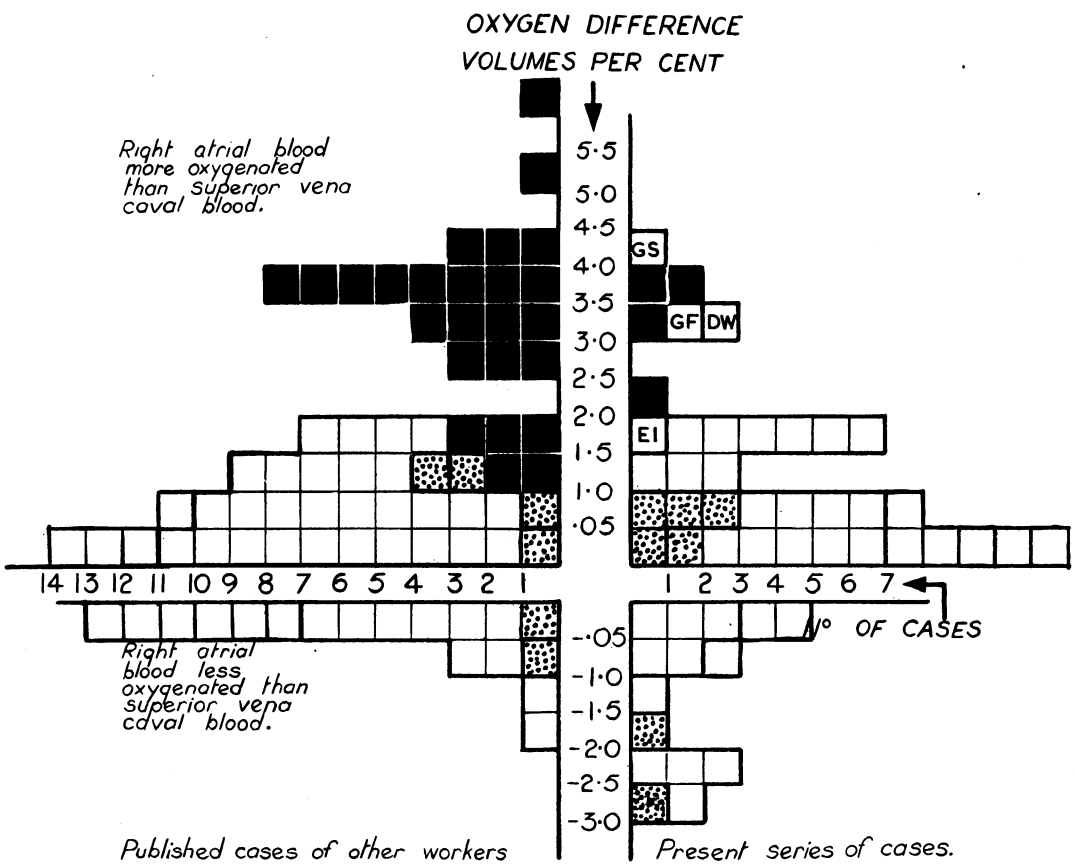


FIG. 1.—Differences in oxygen content (volumes per cent) of superior vena caval and right atrial bloods in 131 patients. The white squares represent cases with no atrial septal defect, black squares with an atrial septal defect through which a predominantly arteriovenous shunt occurs, and stippled squares with an atrial septal defect through which a predominantly venoarterial shunt occurs. The significance of the initialled squares is given in the text.

death. Cases in which the diagnosis of atrial septal defect was made largely or solely on the comparison of the oxygen content of blood samples could not, of course, be included in this series.

In Fig. 1, 2, and 3, the cases without atrial septal defect are shown as white squares, those with an atrial septal defect and a predominantly venoarterial shunt as stippled squares, and those with a predominantly arteriovenous shunt as black squares. The four lettered squares refer to cases that are discussed below.

Superior Vena Caval and Right Atrial Blood (Fig. 1)

Fig. 1 shows that in two-thirds of 95 patients with no atrial septal defect the oxygen content of right atrial blood exceeds that of superior vena caval blood, and that the difference may be as much as 2·0 volumes per cent. Of the other one-third with oxygen content of blood in the atrium lower than that in the superior vena cava, the majority show a difference of no more than 1 volume per cent, though this may reach as much as 3 volumes per cent. It follows that the diagnosis of an atrial septal defect with an arteriovenous shunt can only be made on the comparison of the oxygen content of blood samples if that from the right atrium exceeds that from the superior vena cava by more than 2 volumes per cent.

Using the standard of 2 volumes per cent a septal defect with arteriovenous shunt will be recognized in the large majority of cases; but a few, in which the difference lies between 1 and 2 volumes per cent, will be missed.

In those cases of atrial septal defect with a venoarterial shunt, the difference of oxygen content between superior vena caval blood and right atrial blood lies as would be expected, within the range of those with no atrial septal defect.

Inferior Vena Caval and Right Atrial Blood (Fig. 2)

Most workers have compared only superior vena caval and right atrial blood. Dexter *et al.* (1947), however, took blood samples from a few centimetres below the diaphragm and found that such blood from the inferior vena cava had a uniformly higher oxygen content than that from the superior vena cava or atrium. They believed that this was largely due to the influence of renal vein blood and abandoned the use of blood from the inferior vena cava for comparative purposes, relying solely on the comparison of right atrial and superior vena caval bloods. We have taken inferior vena caval samples routinely from a point just below the diaphram and find that the oxygen content is often, though not always, higher than that of atrial blood. Thus Fig. 2 shows that of 55 cases with intact atrial septa, in 34 the inferior vena caval blood was more oxygenated than that of the atrium, usually the difference was within 1 volume per cent, but reached as much as 3 volumes per cent. On the other hand, in 21 cases the inferior vena caval blood was less oxygenated than atrial blood; in most cases the difference was no more than 1 volume per cent, but exceptionally it was as great as 3 volumes per cent.

It is clear that if inferior vena caval blood is used for comparative purposes a higher oxygen difference (as much as 3 volumes per cent) must exist before a diagnosis of atrial septal defect can be made, and also that in a greater proportion of cases the diagnosis would be missed than when using superior vena caval blood.

It will be noted that in cases with a venoarterial shunt through the atrial septal defect the oxygen difference of inferior vena caval blood and atrial blood lies within the normal range.

Consideration of the oxygen content of inferior caval blood further demonstrates that (1) the vessel may contribute a stream of relatively oxygenated blood to the right atrium, (2) that for comparative purposes it would be better to use samples of both superior and inferior caval bloods, and to compare the mean of these two with that of the atrium.

Comparison of Right Atrial and Mean of Superior and Inferior Vena Caval Blood Samples (Fig. 3)

The difference in oxygen content of right atrial blood and the mean of inferior and superior vena caval blood (caval blood) in 84 patients is seen in Fig. 3. In 29 cases the right atrial blood was

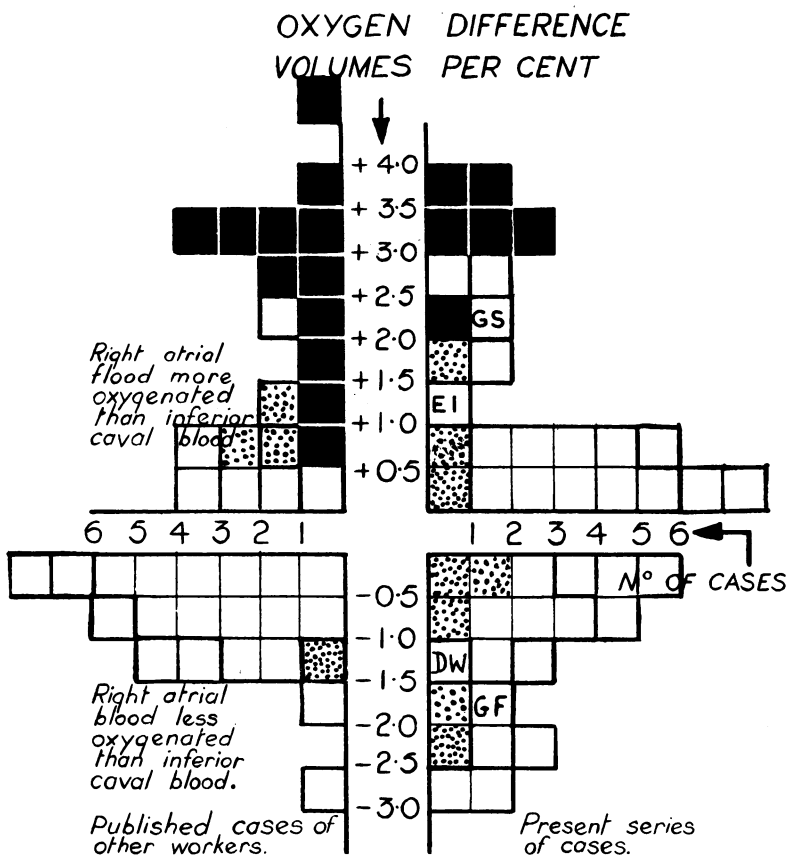


FIG. 2.—Differences in oxygen content (volumes per cent) of inferior vena caval and right atrial blood in 89 patients. White squares represent cases with no atrial septal defect, black squares cases with an atrial septal defect through which a predominantly arteriovenous shunt occurs, and stippled squares with an atrial septal defect through which a predominantly venoarterial shunt occurs.

more oxygenated than caval blood, in most cases by less than 1 volume per cent, and exceptionally by 1·5 volumes per cent. On the other hand, in 25 cases it was less oxygenated than atrial blood, in most cases by less than 1·5 volumes per cent, but exceptionally by as much as 2·5 volumes per cent. In all the cases of atrial septal defect with an arteriovenous shunt, the atrial blood was more than 2 volumes per cent higher in oxygen content than the mean of the superior and inferior caval bloods; so that taking the mean gives a better separation than if either the inferior or superior vena caval blood is used alone for comparison. In two of our cases, G. F. and D. W. (CB08 and O207) there was no reason to think that there was an atrial septal defect with an arteriovenous shunt. In these cases the right atrial blood sample was found to be 3·7 and 3·3 volumes per cent higher than that of the superior vena cava (Fig. 1), but in both the inferior vena caval blood had a considerably higher oxygen content than the atrial blood (Fig. 2). Fig. 3 shows that if the mean of the vena caval blood samples is taken in these two cases the oxygen difference between this and the right atrial blood falls within the range of cases without an atrial septal defect.

In Fig. 3 it is shown, as in previous figures, that when the shunt through an atrial septal defect is venoarterial the difference in oxygen content between caval and right atrial blood lies within the normal range. There is one exception in our cases, which was shown at necropsy to have an atrial septal defect so large that the two atria formed almost one chamber.

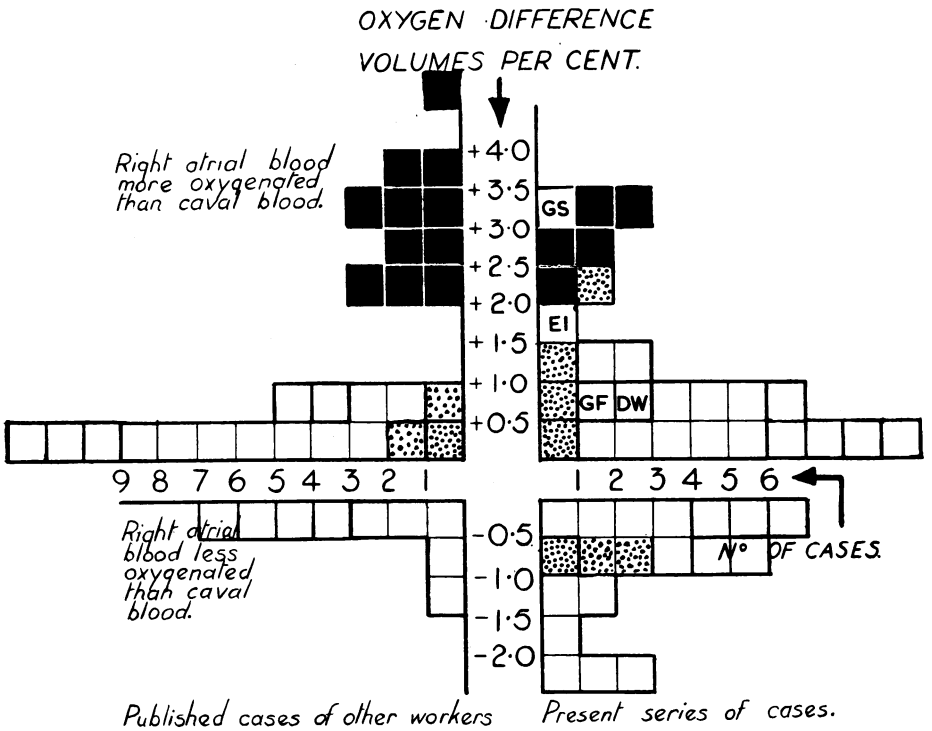


FIG. 3.—Difference in oxygen content between right atrial blood and the mean of the oxygen contents of the inferior and superior vena caval bloods in 84 patients. The white squares represent cases with no atrial septal defect, black squares cases with atrial septal defect through which a predominantly arteriovenous shunt occurs, and stippled squares cases with an atrial septal defect through which a predominantly venoarterial shunt occurs.

COMPARISON OF RIGHT ATRIAL AND RIGHT VENTRICULAR BLOOD SAMPLES

In Fig. 4 are shown the variations in oxygen content of right atrial and right ventricular blood in 49 cases considered to be without a ventricular septal defect and 98 with a presumed ventricular septal defect. In cases without ventricular septal defect the oxygen content of blood from the right ventricle may differ from that of the right atrium by $\pm 1{\cdot}0$ volumes per cent, and seldom more. This finding is not unexpected since blood in the right atrium, derived from superior vena cava, inferior vena cava, and coronary sinus is not uniformly mixed. Warren *et al.* (1945) showed that samples of blood taken from the right atrium might differ in oxygen content by as much as 2·3 volumes per cent. On the other hand, the blood in the right ventricle is better mixed so that samples taken from different parts of the ventricle differ by less than 1·0 volumes per cent. It follows, therefore, that when comparing the oxygen contents of blood samples from the venæ cavæ and right atrium it is useful also to compare the oxygen content of the atrium against that of the ventricle. If this is done the finding of an oxygen content of blood in the right atrium higher than the mean of the oxygen contents of caval bloods may arise (*a*) because the caval blood samples are not uniformly mixed and the catheter has withdrawn a sample derived mainly from the inferior vena cava, or (*b*) because the catheter had withdrawn a sample derived from an influx of highly oxygenated blood from the left atrium. If the high oxygen is due to (*a*) then the right ventricular blood should have a lower oxygen content than that of the atrial sample and should be about the mean of the caval samples. If the high oxygen content is due to (*b*) then the ventricular sample should also have a higher oxygen content than the mean of the caval samples. There are exceptional cases which do not fit into this conception ; for example in Case 2 (G. S., Fig. 1, 2, and 3) the right atrial sample

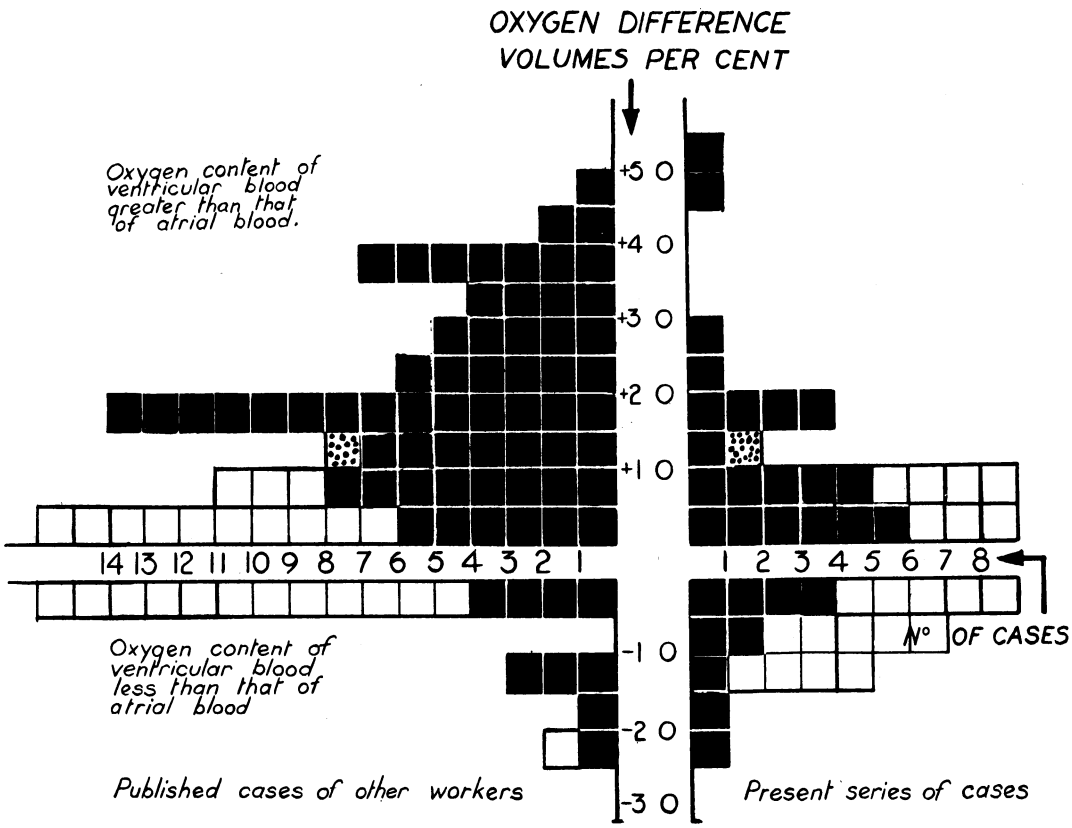


FIG. 4.—Difference in oxygen content (volumes per cent) between right atrial blood and right ventricular blood in 147 patients. The cases with ventricular septal defects are indicated by black squares, those with intact ventricular septums by white squares. The two stippled squares indicated that in two cases of patent ductus arteriosus in which probable pulmonary regurgitation had resulted in an increase in the oxygen content of right ventricular blood. The square indicating that the oxygen content of the ventricular sample was 2 to 2·5 volumes per cent less than the atrial sample represents a case of atrial septal defect in which the atrial sample had presumably been taken close to the defect.

was 3·5 volumes per cent higher than that of the mean of the caval blood samples and 2·5 volumes per cent higher than that of the inferior vena caval sample; this seems to point to an influx of blood through a septal defect. Nevertheless, the blood from the right ventricle was of considerably lower oxygen content than right atrial blood. A possible explanation of the case is that when the right atrial sample was taken the tip of the catheter lay close to a small atrial septal defect, and so withdrew blood of a high oxygen content. We have not been able to prove that such an atrial septal defect was present. In a second and similar case, E. I., with Fallot's tetralogy, the difference between caval and right atrial bloods was 1·7 volumes per cent, indicating a probable atrial septal defect (Fig. 3). In this case the right ventricular blood was nearer that of the atrium in oxygen content, which would also support the diagnosis of an atrial septal defect. However, at necropsy no atrial septal defect was found (Case P061). The explanation of these findings is unknown.

Of the 98 cases with a ventricular septal defect, the difference between right ventricular and right atrial blood oxygen content was greater in 55 than in cases without ventricular septal defect. It is clear, therefore, that only about one-half of the cases of ventricular septal defect can be recognized by a higher oxygen content of the ventricular blood. It is to be noted that this increase in oxygen content occurred in spite of the fact that in almost all these cases the predominant shunt was from right to left ventricle. This is because of turbulence in the neighbourhood of the defect.

A high oxygen content of the right ventricular blood may be brought about not only by a septal defect, but also by regurgitation of blood through the pulmonary valves in cases of patent ductus arteriosus. This is clearly displayed by Cournand's (1949) Case 7, where the blood from the right atrium contained 10·6 volumes per cent oxygen, that from the right ventricle 12·5, and that from the pulmonary artery 14·2. After ligature of the ductus arteriosus the oxygen content of the right ventricle and pulmonary artery fell to the same level as that of the blood in the right atrium. The same phenomenon possibly accounts for the findings in the two cases of patent ductus arteriosus, indicated by stippled squares in Fig. 4, in which the oxygen content of the ventricular blood exceeded that of the atrial blood by 2·0 to 2·5 volumes per cent.

Comparison of Right Ventricular and Pulmonary Blood Samples

Fig. 5 shows the difference in oxygen content between right ventricular and pulmonary artery bloods in 82 patients. Thirty-three cases were considered to have neither ventricular septal defects

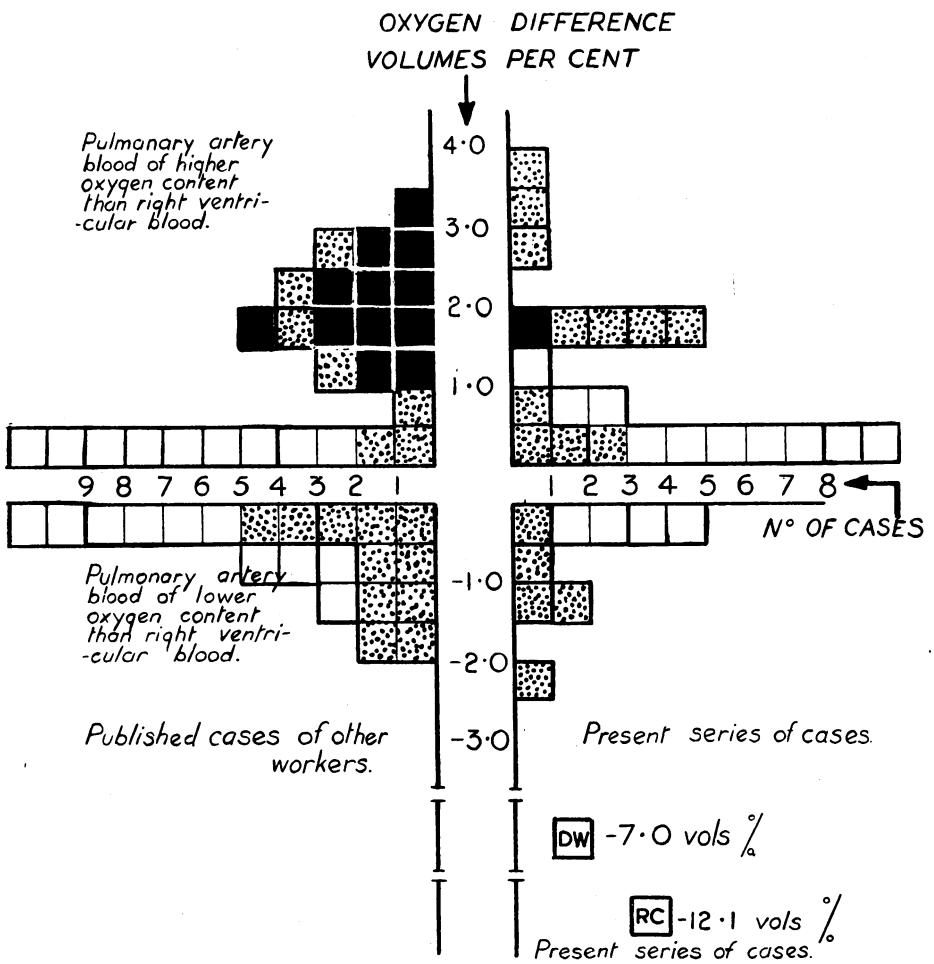


FIG. 5.—Difference in oxygen content (volumes per cent) of right ventricular and pulmonary artery bloods in 82 patients. White squares represent cases with no ventricular septal defect or patent ductus arteriosus, black squares represent cases with a patent ductus arteriosus, and stippled squares cases with a known ventricular septal defect. The significance of the two squares labelled D.W. and R.C. is given in the text.

nor patent ductus arteriosus. In the large majority the oxygen content of the right ventricular and pulmonary artery bloods differs by no more than 0·5 volumes per cent, and in only two by little more than 1·0 volumes per cent. In all 13 cases with a patent ductus arteriosus the difference in oxygen content was more than 1 volume per cent. Of the 34 cases with a ventricular septal defect but no patent ductus arteriosus, there are 11 with the pulmonary artery samples more than 1 volume per cent higher than that of the right ventricle. The explanation of this is probably that the defect is high in the ventricular septum so that the mixture of blood occurred in the region of the infundibulum and not in the main chamber of the ventricle from which the sample was taken. Whatever the reason it is clear that a higher oxygen content of the pulmonary artery blood may arise either from a patent ductus arteriosus or a high ventricular septal defect. A third possible cause of the oxygen content of the pulmonary artery blood being higher than that of the ventricular blood is pointed out by Dexter (1947). If the catheter is pushed too far into the pulmonary artery it may occlude the branch in which it lies so that when a sample is withdrawn oxygenated blood is aspirated from the pulmonary capillaries. This may be the explanation of the high oxygen content of the pulmonary artery blood reported by Soulie *et al.* (1949) in two cases in which there was neither a patent ductus arteriosus nor a septal defect. For this reason all our samples from the pulmonary artery have been taken not further than one inch past the bifurcation.

There are 10 cases in which the oxygen content of the pulmonary artery blood is more than 1 volume per cent lower than that of the right ventricle. This is difficult to account for, but since all but one of these cases had pulmonary stenosis this may have been a factor. A further clue is given by considering the two cases D. W. and R. C., in which the pulmonary artery blood sample was as much as 7 and 12 volumes per cent lower than that of the right ventricle. In both these cases there was probably a very gross stenosis of the pulmonary artery because the catheter seemed to be gripped in the orifice, and when it was withdrawn a sense of release of grip was obtained. Also in another (Case 7), a sample taken when the catheter had been in the pulmonary artery about five minutes was 29 per cent saturated with oxygen, but after another minute or two a second sample showed the saturation to have fallen to 15 per cent. These findings suggest that the catheter had materially obstructed the pulmonary orifice, reducing the amount of blood passing through the lungs and exaggerating the venoarterial shunt, thus increasing the patient's anoxia. The patients made no complaint whilst the catheter was in the pulmonary artery, and the darkness of the X-ray room prevented us from seeing an increase in cyanosis.

Calculation of Blood Flows and Shunts

In normal hearts the cardiac output can be calculated with a fair degree of accuracy by the Fick principle, using the oxygen consumption and the difference in oxygen content of arterial and mixed venous blood. It is clear that in malformed hearts calculation may be liable to error because of the existence of shunts. Nevertheless, in most instances an estimate may be made of the blood flow through the pulmonary artery and through the aorta, and thus of the volume of any shunt present. The pulmonary blood flow is calculated from the oxygen consumption and the difference in oxygen content between pulmonary venous and pulmonary artery blood, aortic blood flow is calculated from the oxygen consumption and the difference in oxygen content of arterial and mixed venous blood. It is usually easy to obtain a satisfactory sample of arterial blood but in malformed hearts it is not always easy to obtain equally satisfactory samples of mixed venous or pulmonary artery blood.

Mixed venous blood. In a heart with no arteriovenous shunts the blood from the outflow tract of the right ventricle can be regarded as mixed venous blood. In many malformed hearts with which we have dealt, right ventricular blood is not acceptable as mixed venous blood because of admixture of oxygenated blood either in the atrium or ventricle. In only 6 of 18 cases shown in the appendix could the right ventricular blood be regarded as free from admixture with arterialized blood. When blood from the right ventricle cannot be accepted as mixed venous blood, most authors, and we ourselves, have used a blood sample from the right atrium, provided there was no

evidence of an arteriovenous shunt through an atrial septal defect. If there was evidence of arterial admixture we have used the mean of the oxygen contents of the superior and inferior vena caval blood as representing that of mixed venous blood. This, however, is not altogether satisfactory because it is not known what volume each vena cava contributes to the blood entering the atrium, and the contribution to the mixed venous blood made by the coronary sinus and other veins entering the right atrium is neglected.

Pulmonary artery blood. Two factors may result in an unsatisfactory sample of blood being obtained from the pulmonary artery. If the catheter blocks the branch of the pulmonary artery in which it lies so that oxygenated blood is drawn from the lung capillaries the oxygen content of the blood sample will be unduly high. If the catheter obstructs even for a short time the stenosed pulmonary orifice the oxygen content of the sample of blood obtained may be unusually low. The presence of a ductus arteriosus makes it almost impossible to obtain a sample on which the estimation of the pulmonary blood flow can be reliably based. An approximation can be made by taking, as Cournand (1949) does, one sample from the artery and one from each main branch.

A further difficulty arises in many cases of suspected pulmonary stenosis when it is not possible to introduce the catheter into the pulmonary artery. In such cases blood from the right ventricular outflow tract is used as the best approximation. It is obvious from Fig. 5 that this would give rise to no great error, except when the ventricular septum is defective. For example, in Case 9, which showed the greatest difference between pulmonary artery and right ventricular blood (+4 volumes per cent) the pulmonary artery blood flow calculated on the pulmonary artery sample was 2 litres a minute per square metre, whereas when calculated on the right ventricular sample the pulmonary artery blood flow was 1·3 litres, or 35 per cent less. Apart from this case and those of patent ductus arteriosus, the two results never differed by more than 15 per cent when we have been able to calculate the pulmonary blood flow from both right ventricular and pulmonary artery samples. Even taking the higher of the two calculated flows the pulmonary blood flow in pulmonary stenosis was still reduced below normal.

Pulmonary venous blood. It is necessary in cases of cyanotic congenital heart disease to obtain evidence of the degree of saturation of the blood in the pulmonary veins, for though in patients with normal hearts it may be accepted that arterial blood gives a measure of pulmonary vein blood saturation, in cases of malformed hearts with a venoarterial shunt this assumption cannot be made. Bing *et al.* (1947) in 4 cases of Fallot's tetralogy obtained blood from a pulmonary vein by passing a catheter through an atrial septal defect and in each case the pulmonary vein blood was 95 per cent saturated. A few other isolated case reports have since been published which agree with this finding, and we have obtained pulmonary venous blood in 5 cases, either through an atrial septal defect or from a pulmonary vein draining into the right atrium. In each case we have found it to be 95 to 97 per cent saturated. None of these had signs of congestive failure or of pulmonary disease, either of which might have interfered with oxygenation of blood in the lungs; all had polycythemia, a factor that in the past has been thought to result in impaired oxygenation of blood passing through the lungs. It seems justifiable to conclude that in cases of congenital heart disease, provided that there is no congestive failure or pulmonary disease, the blood becomes 95 per cent saturated in passing through the lungs.

The Application of Cardiac Catheterization to the Diagnosis of Congenital Heart Disease

Fallot's tetralogy. The success of the operative treatment of Fallot's tetralogy has led to emphasis of the physiological features of the malformation (reduced pulmonary blood flow and venoarterial shunt) rather than the four anatomical features described by Fallot.

Operative treatment is directed towards increasing the blood flow through the lungs which is reduced by the pulmonary stenosis. Before operation one should, therefore, know that the pulmonary blood flow is in fact reduced below the normal. In the majority of cases clinical methods suffice to establish this, but there remain a few in which the reduction of the pulmonary blood flow

is in doubt. It is to be remembered that slighter degrees of stenosis of the pulmonary orifice do not necessarily result in a materially reduced pulmonary blood flow (see Case 5).

Cardiac catheterization can demonstrate the pulmonary stenosis by showing a reduction in blood pressure as the catheter tip passes from the right ventricle into the pulmonary artery (Fig. 6). By correlating the position of the catheter tip with the changes in pressure it can sometimes be shown whether the stenosis is at the pulmonary valves or in the infundibulum.

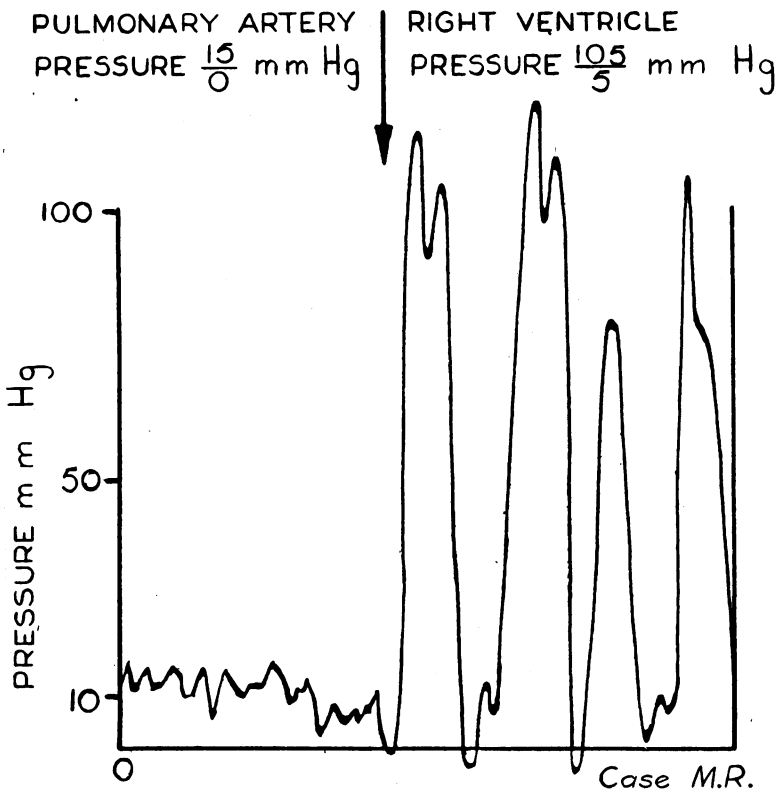


FIG. 6.—Tracing of pulse curve obtained on withdrawing the catheter through a pulmonary stenosis into the right ventricle. Case 3 (0051).

In our own experience, and that of other workers, catheterization directly demonstrates the stenosis in only about one-half of the cases of Fallot's tetralogy. In the other half of the cases it has not been found possible to catheterize the pulmonary artery, seldom because the stenosed ostium is too narrow but, as judged by the position of the catheter on the X-ray screen, because its tip is caught up by the muscle ridge surrounding an infundibular stenosis, or by the hypertrophied papillary muscles. In such cases the finding of a high pressure in the ventricle is not sufficient evidence on which to base a diagnosis of pulmonary stenosis, for this may occur in the absence of obstruction to the pulmonary orifice as, for example, in such conditions as patency of the ventricular septum, Eisenmenger's syndrome, or transposition of the great vessels. Estimation of the pulmonary blood flow, using the right ventricular sample of blood, may show whether the pulmonary blood flow is materially reduced. We have pointed out, however, that for various reasons this calculation is only approximate.

In a few cases dextroposition of the aorta can be demonstrated by passing the catheter through into it from the right ventricle (Fig. 8). Usually, however, the catheter passes into the pulmonary artery. The venoarterial shunt, resulting from the dextroposition, is shown by the lowered oxygen

saturation of the arterial blood. An approximate estimation of the volume of the shunt can be made by subtracting the pulmonary from the systemic blood flow.

For the selection of cases for operation, Taussig (1948) stresses the importance of showing a reduced pulmonary blood flow. From our own experience, however, the demonstration of a lowered arterial oxygen is of equal importance because the lower the saturation of the arterial blood the more useful will be its circulation through the lungs. For example, in a case of pulmonary stenosis with a very small septal defect, such as Case 6, with an arterial saturation of 91 per cent and a much reduced systemic blood flow, recirculation of the already arterialized blood through the lungs could improve the saturation but little. Moreover, it might be harmful to reduce further the systemic blood flow by diverting blood through the lungs.

Examples of the findings at catheterization in four cases of Fallot's tetralogy are given in the appendix (Cases 1, 2, 3, and 4).

Eisenmenger's Complex

Eisenmenger's complex consists of a high ventricular septal defect with an aorta that overrides the right ventricle, and a pulmonary artery that may be dilated. Though much less common, this condition is important because it may be confused clinically with Fallot's tetralogy. It differs from this, however, in that there is no pulmonary stenosis and little or no reduction in blood flow to the lungs. The operation of systemic-pulmonary anastomosis is therefore unlikely to help the patient.

Catheterization clearly excludes pulmonary stenosis by showing equal systolic pressures in right ventricle and pulmonary artery (Fig. 7). There should be no gross reduction in the pulmonary blood supply.

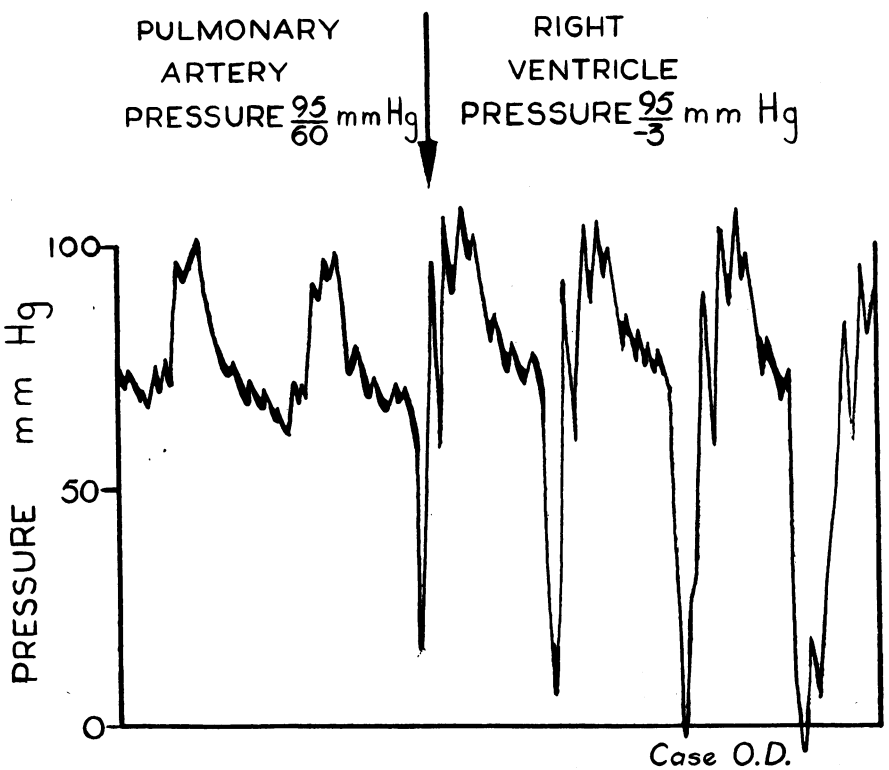


FIG. 7.—Pulse curve obtained in a case of Eisenmenger's syndrome on withdrawing the catheter from the pulmonary artery into the right ventricle. Case 9 (O261).

In Case 3 (see appendix) it was difficult on clinical grounds to know if the increased pulmonary shadows indicated Eisenmenger's complex or an increased collateral circulation. Cardiac catheterization, however, showed a pulmonary stenosis. The calculated pulmonary blood flow was 2·6, and the systemic blood flow 4·3 litres per square metre a minute. The reduction in pulmonary blood flow was therefore small, though there was no doubt about the pulmonary stenosis.

Eisenmenger's complex is generally regarded as a malformation distinct from transposition of the great vessels. There is evidence, however, to show that the effect upon the circulation is the same in the two conditions. In one (Case 9) of our cases of Eisenmenger's complex we were able to pass the catheter into the pulmonary artery. The oxygen content of the blood sample withdrawn from it was higher (25·6 volumes per cent) than that from the right ventricle (21·6 volumes per cent), thus showing that the pulmonary artery received blood from both ventricles. The reduced arterial saturation showed that the aorta also received blood from both ventricles. Analysis of the data given by Bing (1947*b*) for four cases of Eisenmenger's complex shows that in three the oxygen content of the pulmonary artery blood was, as in our case, higher than that in the right ventricle and that the arterial oxygen saturation was reduced. Eisenmenger's complex may therefore be regarded as in effect a functional form of transposition of the great vessels.

A point of interest may be noted in passing. Bing (1947) finds that in all four of his cases the diastolic pressure in the pulmonary artery was raised, and this, together with a nearly normal blood flow through the lungs, points to an increased resistance in the pulmonary vascular bed. Fig. 7 shows the high diastolic pressure in the pulmonary artery in our Case 9. In this instance the calculated pulmonary blood flow was 2·1 litres per square metre a minute. The cause of this increased resistance is not known, though Bing seems to suggest that it is due to an endarteritic change in the pulmonary arterioles. In other conditions, however, in which the pulmonary vascular bed is subjected to a high blood pressure (transposition of great vessels and widely patent ductus arteriosus) the pulmonary blood flow is often increased and not reduced.

Transposition of the Great Vessels

Catheterization is of great value in establishing the diagnosis of transposition of the great vessels since only by this means can it be shown that the blood in the pulmonary artery is of higher oxygen content than blood in the aorta. Also, an estimation can be made of the relative amounts of right ventricular and left ventricular blood entering the two great vessels. In two of our four suspected cases the catheter passed, from the right ventricle into the aorta but could not be inserted into the pulmonary artery (Fig. 8). In these two cases, therefore, catheterization did not establish the diagnosis of transposition of the great vessels. One of them, thought clinically to be a case of Fallot's tetralogy, later came to necropsy, and transposition with stenosis of the pulmonary artery was revealed (Case P088); in the other transposition of the aorta and pulmonary artery was suspected on clinical grounds and confirmed by angiocardiography (Case O052). In the other two of our four (Cases 10 and 11) the catheter passed from the right ventricle into the pulmonary artery and not into the aorta. Transposition was shown by the finding that the pulmonary artery blood was more oxygenated than that in the systemic arteries. The calculated pulmonary blood flow in both these cases was greater than normal (5·1 and 8·3 litres per square metre a minute) and the pressure in the pulmonary artery increased (88 mm. Hg mean pressure and 80/50 mm. Hg respectively).

Pulmonary Stenosis with Closed Ventricular Septum

This condition has been termed " pure pulmonary stenosis," but for reasons discussed by Allanby and Campbell (1949) the term " pulmonary stenosis with closed ventricular septum " is to be preferred. In most cases there is a defect of the atrial septum through which a venoarterial shunt occurs, though some are entirely without septal defects. There is no difficulty in recognizing the pulmonary stenosis, clinically or by the pressure readings during catheterization of the pulmonary artery, or indirectly by calculation of the pulmonary blood flow. A case with no atrial septal defect,

and therefore no venoarterial shunt, is readily recognized by the normal arterial oxygen saturation (Case 5), even though the greatly reduced cardiac output may be associated with a high degree of peripheral cyanosis (Case 6).

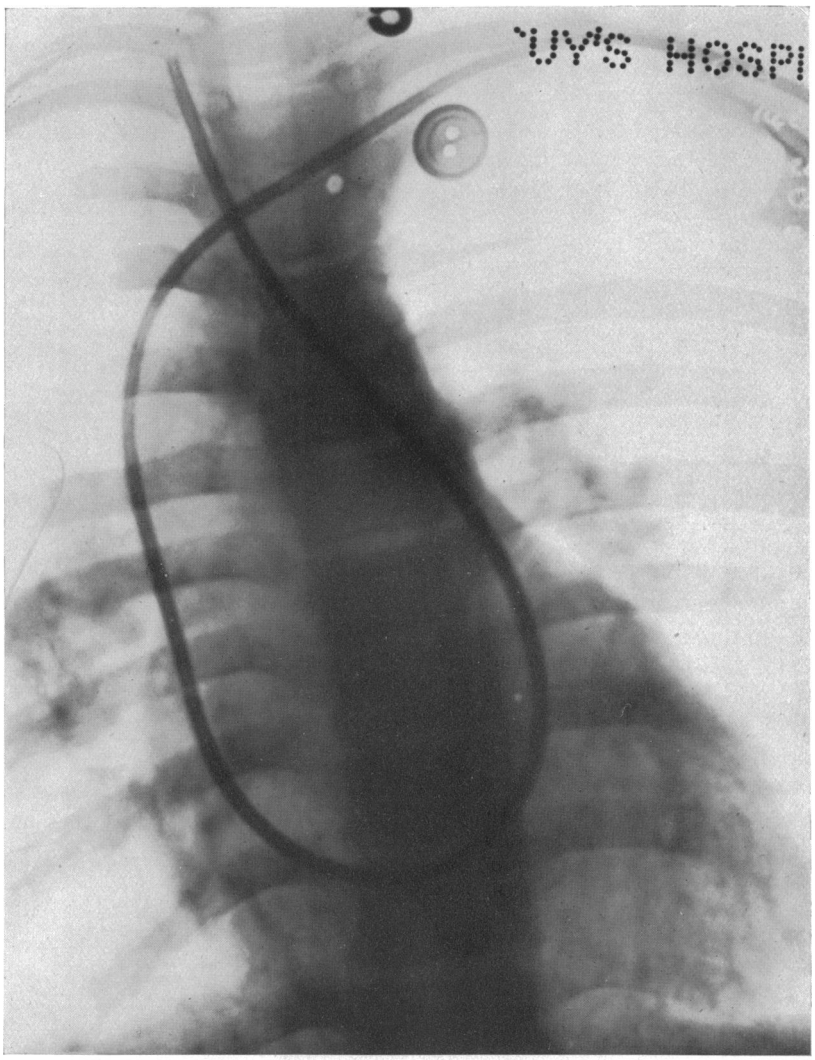


FIG. 8.—Passage of the catheter from the right ventricle into the carotid artery in a case of transposition of the great vessels with right-sided aortic arch. Reference No. O052.

There are patients in whom it is difficult to decide whether the venoarterial shunt occurring with a pulmonary stenosis passes through a ventricular septal defect (Fallot's tetralogy) or through a defect of the atrial septum (pulmonary stenosis with closed ventricular septum) or through both. Unfortunately cardiac catheterization often fails to make the differentiation (see Case 8). The defect, generally a patent foramen ovale, is small in these cases and there is no record of it having been recognized by passing the catheter through it into the left atrium. It has also been shown (Fig. 1, 2, and 3) that an atrial septal defect with a venoarterial shunt can very seldom be recognized by the comparison of the oxygen content of atrial and vena caval bloods. Catheterization, there-

fore, in pulmonary stenosis with closed ventricular septum and atrial septal defect is unlikely to demonstrate the atrial septal defect, but the latter may be inferred when the venoarterial shunt is found to be small. Of those cases of the group that have a ventricular septal defect, only one-half may be expected to be diagnosed by the increase in oxygen content on passing from atrium to ventricle (Fig. 4). In the absence of a patent ductus arteriosus the ventricular septal defect may also be shown by the increase in oxygen content on passing from the right ventricle to the pulmonary artery (Fig. 4 and Case 4). The position of the stenosis can be judged on the X-ray screen by the position of the catheter tip when the abrupt increase in pressure occurs between the pulmonary artery and the right ventricle as the catheter is withdrawn. If the change is seen to take place high in the pulmonary conus it is in favour of a valvular or high infundibular stenosis, and if low in the pulmonary conus in favour of a lower infundibular stenosis. Since a valvular stenosis occurs more frequently with a closed ventricular septum, and an infundibular stenosis with a ventricular septal defect the position of the stenosis may provide a further aid to diagnosis.

Whether the septal defect in these cases is atrial or ventricular is, however, not of great surgical importance. The practical point is to decide on the relative volumes of the cardiac output and venoarterial shunt, for the smaller the venoarterial shunt the more is valvulotomy to be preferred to systemic-pulmonary anastomosis.

Atrial Septal Defect

The shunt through an atrial septal defect is always arteriovenous when the lesion is an isolated one or associated with mitral stenosis (Bedford *et al.*, 1941; Brannon *et al.*, 1945; Cournand, 1947). When, however, the atrial septal defect is associated with other cardiac malformations the shunt through it is usually venoarterial. To account for the reversal of the direction of the intra-atrial shunt (as, for example, in pulmonary stenosis with closed ventricular septum) a fall in the left atrial pressure must be inferred, since measurements show no increase in right atrial pressure. Such a reduction in pressure might result from the diminished pulmonary venous return.

An atrial septal defect can sometimes be recognized by passing the catheter through the defect. Even a direct demonstration of a septal defect does not prove that there is normally a shunt as it may be a patent foramen ovale normally covered by a valve; it is still desirable to show by blood oxygen comparisons that a shunt occurs through it. The course of the catheter passing through an atrial septal defect is characteristic (Fig. 9), crossing to the left at a higher level than when going through the tricuspid valve. The catheter tip can sometimes be advanced into a pulmonary vein, the catheter then leaving the heart shadow. Confirmatory evidence is the high oxygen saturation of the blood obtained from the left side of the heart. When the catheter cannot be passed through the atrial septal defect a comparison of the oxygen content of the vena caval and atrial bloods will reveal the presence of the defect if an arteriovenous shunt occurs, but not if the shunt is venoarterial.

With an arteriovenous shunt through an atrial septal defect, the right heart output and pulmonary blood flow are increased, the pulmonary blood flow being as much as 5 times increased (Taylor *et al.*, 1948, Case 6). In such cases, in spite of the large amount of blood passing through the atrial septal defect into the right atrium, the right atrial pressure is rarely raised above normal. Right ventricular and pulmonary artery pressure may be slightly raised but occasionally may be much increased (Dexter, 1947, Case 1, and Taylor *et al.*, 1948, Case 3). The systemic blood flow, calculated from the mean of the oxygen contents of the superior and inferior venæ cavæ, is not reduced.

It should be noted that a number of malformations may also give rise to increased oxygen content of the right atrial blood and so lead to the suspicion of an atrial septal defect. The most frequently encountered (three times in our series) is the opening of an anomalous pulmonary vein directly into the right atrium. Until recently this condition has been recognized only after death (Brody, 1942; Taussig, 1947) but Cournand *et al.* (1949) have described one case diagnosed during life. In Cournand's, as in our three cases, this was shown when the catheter slipped from the atrium into a pulmonary vein of the right lung (Fig. 10). We have verified the location of the tip by

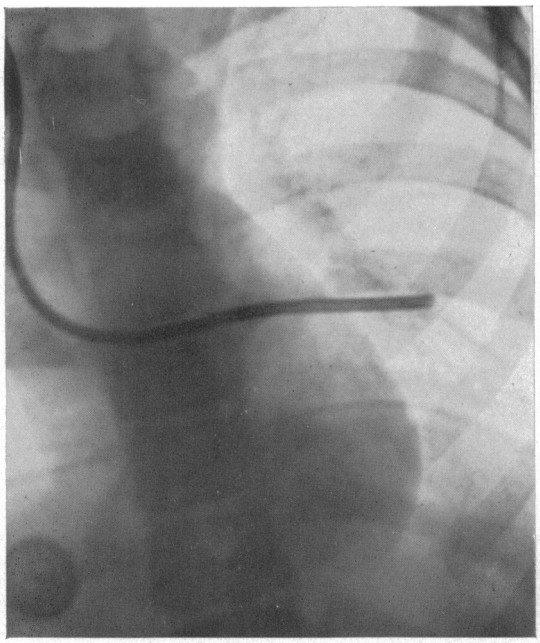


FIG. 9.—Passage of the catheter through an atrial septal defect and into a left pulmonary vein. The catheter passes from the right atrium over to the left side of the heart at a higher level than when passing into the right ventricle. Reference No. P021.

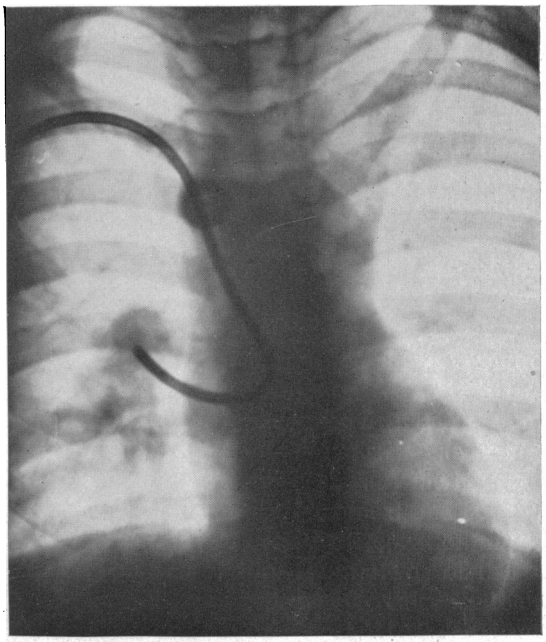


FIG. 10.—Passage of the catheter from the right atrium into a pulmonary vein which opens directly into the atrium. Reference No. P021.

screening in the oblique position and by drawing arterialized blood from the catheter. In two of the three patients an atrial septal defect was also demonstrated. The other and rarer conditions which we have not encountered personally are (1) an arteriovenous fistula between a coronary artery and the coronary sinus, (2) tricuspid insufficiency associated with a ventricular septal defect, (3) pulmonary and tricuspid valve insufficiency in the presence of a patent ductus arteriosus, (4) a congenital communication between the left ventricle and the right atrium (Perry *et al.*, 1949), and (5) a persistent common atrio-ventricular ostium.

Lutembacher's Syndrome

The association of an atrial septal defect with mitral stenosis was first described by Lutembacher (1916). The clinical diagnosis of the condition usually presents no difficulties, but doubt may arise whether mitral stenosis is present in a case of atrial septal defect, or whether an atrial septal defect is present in a case of mitral stenosis.

There is yet insufficient evidence to show how far catheterization can assist in the diagnosis of Lutembacher's syndrome. So far as we are aware no catheterization findings have been reported in this condition. Among Brannon *et al.* (1945) cases of atrial septal defect there is, however, one (Case 8) described as having a low-pitched rumbling diastolic murmur at the apex of the heart which, though the authors do not refer to it, may be an instance of Lutembacher's syndrome. We ourselves have one example (Case 17) in which mitral stenosis was recognized by the characteristic murmur and clinical evidence of atrial septal defect was also present; on catheterization proof of an atrial septal defect consisted in the passage of the catheter through the defect into the left atrium, and the finding of blood of a high oxygen content in the right atrium. In both these cases right atrial, ventricular, and pulmonary artery pressure were raised well above normal. These findings are to

be expected from the combination of mitral stenosis and atrial septal defect. In our patient the systemic flow, calculated from the mean oxygen content of the superior and inferior vena caval bloods was considerably reduced, but was normal in the case of Brannon *et al.* There is as yet no necropsy confirmation of the condition in either of these.

Whilst the findings obtained in these two cases were to be expected in Lutembacher's syndrome, there is some doubt whether they are diagnostic because some instances of atrial septal defect without a suggestion of mitral stenosis have been reported with markedly raised pressures in the right ventricle and pulmonary artery (Dexter *et al.*, 1947, Case 1, and Taylor *et al.*, 1948, Case 3). This rise of pulmonary arterial pressure is unusual in uncomplicated atrial septal defect, and in the discussion Dexter and Taylor do not consider the possibility of mitral stenosis having been present. Whilst a reduced systemic blood flow would be in favour of mitral stenosis, a normal systemic blood flow would not exclude the condition.

Tricuspid Atresia and Pulmonary Atresia

In tricuspid atresia the blood passes from the right atrium through a septal defect into the left atrium and ventricle, and thence directly or indirectly into the pulmonary artery and aorta. In pulmonary atresia the blood reaches the lungs through either a patent ductus arteriosus or from dilated bronchial vessels arising from the aorta. In both tricuspid and pulmonary atresia there may be a small right ventricle. The two abnormalities are considered together since they resemble each other functionally and in both blood for the pulmonary and systemic circulations is derived from the left ventricle. In a patient with the signs and symptoms of Fallot's tetralogy, an electrocardiogram showing left ventricular preponderance is thought to be diagnostic of tricuspid atresia, and angiocardiograms show the abnormal path of the blood through the heart (Campbell and Hills, 1950). On catheterization, the catheter may be seen not only to pass through the atrial septal defect but also to pass into the left ventricle (Case 13, Fig. 11 and 12). Catheterization cannot, however,

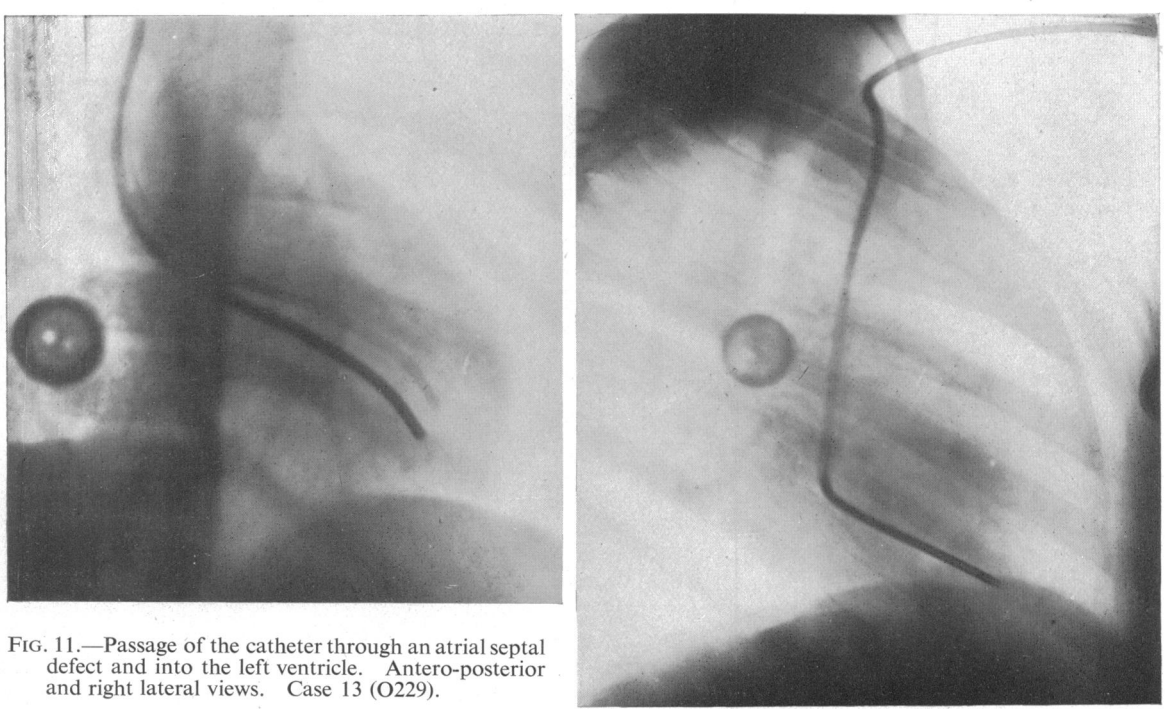


FIG. 11.—Passage of the catheter through an atrial septal defect and into the left ventricle. Antero-posterior and right lateral views. Case 13 (O229).

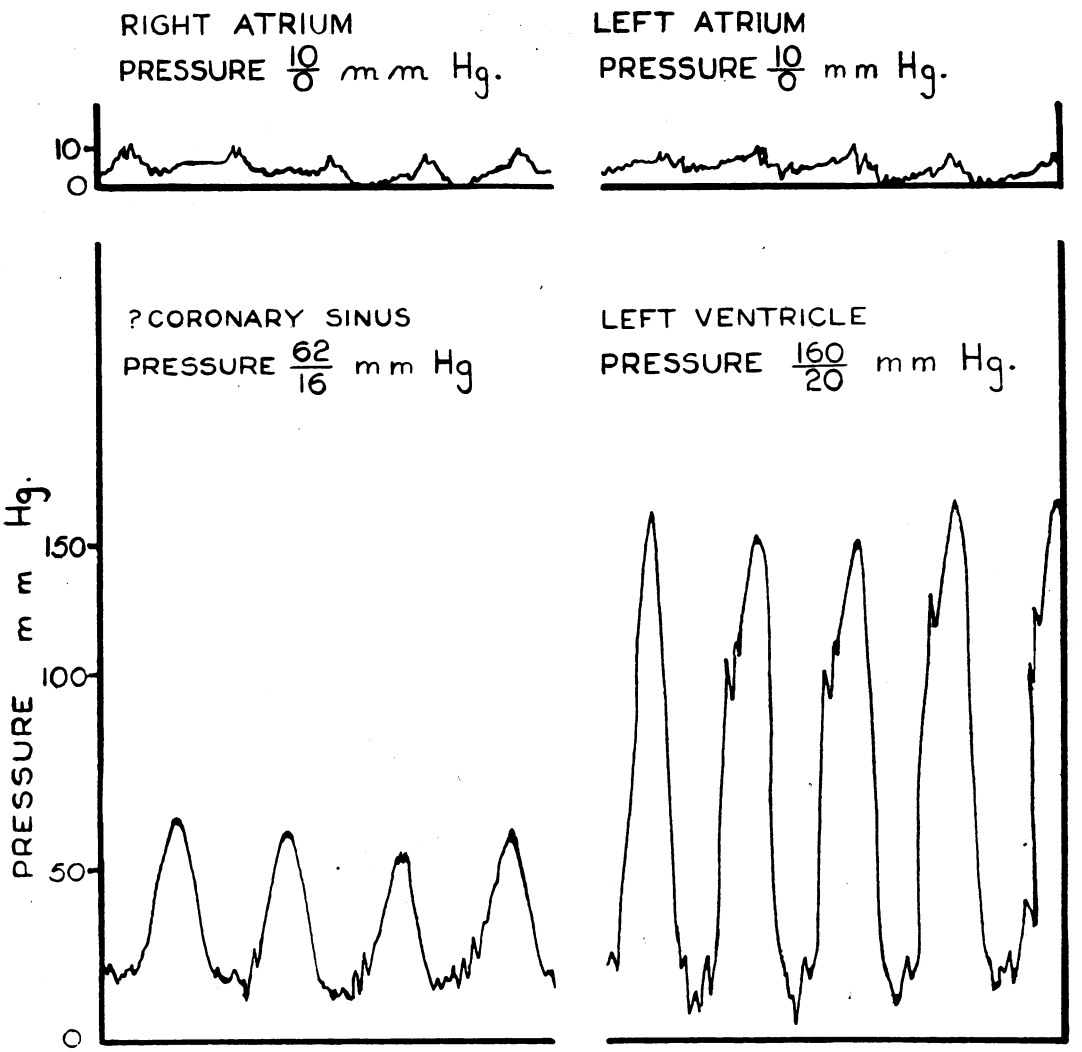


FIG. 12.—Pressure tracings obtained from the right atrium, ? coronary sinus, left atrium, and left ventricle in Case 13 (O229).

distinguish between tricuspid atresia and pulmonary atresia, except in those instances when the catheter is passed from the right atrium into the right ventricle, as, for example, the case reported by Geraci *et al.* (1948).

It is generally assumed that the pulmonary blood flow is reduced, and on this assumption pulmonary systemic anastomosis is carried out with apparent benefit (Potts and Gibson, 1948; Baker *et al.*, 1949; Soulie *et al.*, 1949). The pulmonary blood flow can be calculated if we assume complete mixing of the blood in the left ventricle so that the oxygen content of blood supplied to the lungs can be taken as that of the arterial blood. In 7 of our 9 cases diagnosed on clinical grounds the calculated pulmonary blood flow was decreased (1·2 to 2·5 litres per square metre a minute) but in two slightly increased (3·4 and 3·9 litres per square metre a minute). So far only those of our patients with reduced pulmonary blood flow have been operated on. Operation has been delayed on the two cases with increased blood flow because they have a fairly good exercise tolerance. In most of the accounts given by others data are wanting on which pulmonary blood flow can be

calculated so it is not known whether the successful operations include any in which the pulmonary blood flow was increased. Geraci *et al.* (1948) give the data from two adults, one with tricuspid and the other with pulmonary atresia, from which the pulmonary blood flow can be calculated and shown to be increased. Whether operation was carried out on these two is not recorded, but both are noted to have relatively good exercise tolerances.

That the pulmonary blood flow may be increased or decreased is not unexpected in view of the necropsy findings. In tricuspid atresia the pulmonary artery may arise directly from the left ventricle and if this occurs, as Taussig (1948) points out, increased pulmonary blood flow will be likely. In most cases, however, there is some obstruction to the pulmonary flow.

Truncus Arteriosus and Pulmonary Atresia

Under this heading we are discussing the malformations in which the blood supply to both pulmonary and systemic circulations is derived from a single great vessel which overrides both ventricles. This condition may be either a true truncus arteriosus, or the vessel may be the aorta, in which case an atresic pulmonary artery can be found post-mortem. The diagnosis of these two conditions is difficult to establish by any method and, except at necropsy, the differential diagnosis between them is presumptive. Clinical and X-ray examinations may suggest the condition and angiocardiography and cardiac catheterization may support the diagnosis.

Since the blood supply to the lungs is of the same oxygen content as that of arterial blood it is possible without catheterization to calculate the pulmonary blood flow from the oxygen content of the arterial blood. In three cases where the diagnosis was confirmed (at necropsy in two and at operation in the third), the pulmonary blood flow was thought to be slightly increased in one (3·8 litres) and slightly decreased in the other two (2·5 and 2·0 litres per square metre a minute). The presumed diagnosis of truncus arteriosus in the two catheterized cases has not yet been confirmed. Assuming the diagnosis to be correct, the calculated pulmonary blood flow was normal in one (Case 12); in the other, again assuming the diagnosis, the calculated pulmonary blood flow is about three times the normal. Since the X-ray appearances of the lungs suggest a decreased rather than an increased blood flow, this finding is against the clinical diagnosis.

Patent Ductus Arteriosus

In patent ductus arteriosus, arterial blood flows from the aorta to the pulmonary artery and so an increase in blood oxygen content is found on passing from right ventricle to pulmonary artery. Such an increase in oxygen content may be brought about in several ways (see section on comparison of right ventricular and pulmonary artery bloods) so that confirmatory evidence is required before patent ductus arteriosus can be diagnosed on the grounds of oxygen differences. We have found the characteristic murmur to be the most satisfactory indication of a patent ductus, though proved cases have occurred that do not present this sign.

In most instances of patent ductus arteriosus the pulmonary artery pressure is within normal limits, but in some it is increased. Dexter (1947) found it increased in three of twelve cases. In contrast to Eisenmenger's syndrome (Case 9 and Bing, 1947) in which an increased pulmonary artery pressure was associated with a reduced pulmonary blood flow, the calculated pulmonary blood flow in the three cases was increased (16·9, 14·2, 8·8 litres per square metre a minute). This finding indicates that increased pulmonary artery pressure is not always associated with a marked increase in pulmonary vascular resistance.

Pulmonary Arteriovenous Fistula

The symptoms and some of the signs of pulmonary arteriovenous fistula are so similar to those of congenital heart disease that the condition should be mentioned here. Catheterization does not help in the diagnosis but is useful for assessing the volume of the shunt. From the oxygen saturation of the arterial blood the proportion of the total blood stream passing through the fistulæ can

be calculated, but to calculate the actual blood flows mixed venous blood must be obtained by catheterization (Case 18).

General Remarks

The information that cardiac catheterization can afford in the diagnosis of congenital heart disease has been discussed under the heading of the different malformations. It remains to compare briefly the diagnostic aid to be obtained from cardiac catheterization and angiocardiography, and to state in general terms the value of the former.

Both cardiac catheterization and angiocardiography are proving valuable, the more so because their findings are often complementary. Angiocardiography gives more anatomical, cardiac catheterization more physiological information. Cardiac catheterization gives an indication of the necessity for surgical measures and whether a pulmonary-systemic anastomosis or a valvulotomy operation would be more useful. Angiocardiography is useful, particularly from the surgeons' point of view, in demonstrating the disposition of the great vessels. Angiocardiography is more useful in showing shunts when they are venoarterial whereas cardiac catheterization more surely demonstrates arteriovenous ones. For example, in tricuspid atresia angiocardiography would show the atrial shunt that might escape the cardiac catheter; but in uncomplicated atrial septal defect angiocardiography does not show the shunt as does cardiac catheterization. Angiocardiography does not measure the degree of pulmonary stenosis, and indeed may fail to show minor degrees of the condition; on the other hand, by successful cardiac catheterization pulmonary stenosis can not only be shown but its effects measured, and improvement after surgical treatment can be assessed.

In cases of congenital heart disease presenting no great difficulty in diagnosis, the findings of catheterization can be expected to support the diagnosis. In those instances when difficulties arise in clinical diagnosis, usually when multiple malformations exist, cardiac catheterization may be of great value. If the investigation fails to supply useful information, and this is still a frequent source of disappointment, the reason is either that the catheter cannot be introduced into all the compartments of the heart desirable, or because alternative explanations are possible for the abnormal intracardiac pressures or oxygen contents of the blood samples that have been found. In all but the simplest malformations it is necessary to bring every possible piece of evidence together before making a diagnosis.

Summary

Certain points in the technique of cardiac catheterization are discussed.

In congenital heart disease cardiac catheterization is not without danger. Six of 70 cases developed signs indicative of pulmonary or systemic thrombosis or embolism. One case died.

The difference in oxygen content of blood obtained from the venæ cavæ, right atrium, right ventricle, and pulmonary artery are discussed in relation to the diagnosis of septal defects and patent ductus arteriosus. In the absence of intracardiac shunts and patent ductus arteriosus the oxygen content of right atrial blood should not exceed;

(*a*) that of the superior vena cava by more than 2 volumes per cent * (Fig. 1);
(*b*) that of inferior vena caval blood by more than 3 volumes per cent (Fig. 2);
(*c*) that of the mean of superior and inferior vena caval blood by more than 2 volumes per cent (Fig. 3).

The oxygen content of right ventricular blood should not exceed that of right atrial blood by more than 1 volume per cent (Fig. 4). The oxygen content of pulmonary artery blood should not exceed that of right ventricular blood by more than 0·5 volumes per cent (Fig. 5).

The use of cardiac catheterization in the diagnosis of the following conditions is considered:

* In cases with normal hæmoglobin saturation a difference of oxygen content of 1 volume per cent amounts to 5 per cent difference in oxygen saturation. In polycythæmic cases the same difference of oxygen content represents a smaller difference in oxygen per cent saturation.

Fallot's tetralogy, Eisenmenger's complex, transposition of the great vessels, pulmonary stenosis with closed ventricular septum, tricuspid and pulmonary atresia, truncus arteriosus, atrial and ventricular septal defects, Lutembacher's syndrome, patent ductus arteriosus, and pulmonary hæmangioma.

We are indebted to Dr. Maurice Cambell for his interest in these investigations, and for valuable discussions in the interpretation of clinical and catheterization findings. Our thanks are also due to the Departments of Medical Illustration and Photography for help with the illustrations.

APPENDIX

Normal Standards for Cardiac Output

Cournand (1945) gives the normal cardiac output for the healthy male adult when estimated by the catheter technique as 3·1 litres a minute per square metre of the body surface. The values for females and children are not known.

Intracardiac Pressures

Bloomfield, Cournand *et al.* (1946) give values for normal intracardiac pressures. Their pressure measurements are referred to the plane of 5 cm. below the angle of Ludwig, and ours to the plane of the skin of the back. It is therefore necessary to add 10 mm. Hg to their figures to make them comparable with ours. If this is done the figures for normal intracardiac pressures become:

Right Atrium	8 to 12 mm. Hg
Right Ventricle	
Systolic	35 to 40 mm. Hg
Diastolic	5 to 15 mm. Hg
Mean	20 mm. Hg
Pulmonary Artery	
Systolic	35 to 40 mm. Hg
Diastolic	15 to 20 mm. Hg
Mean	25 mm. Hg

In our cases the systolic and diastolic pressures were obtained from Hamilton manometer records, and the mean pressure from the aneroid manometer readings.

NOTES ON THE 18 CASES

*Fallot's Tetralogy**

Case 1. The clinical diagnosis of Fallot's tetralogy was supported by the catheterization findings. The oxygen content of the right ventricular blood agreed with that from the right atrium, but the oxygen content of the pulmonary artery blood was distinctly lower. This finding was almost certainly an artefact due to obstruction of the stenosed pulmonary orifice by the catheter for several minutes before the specimen was obtained. Therefore, the oxygen content of the right ventricular blood had to be used in calculating the pulmonary blood flow.

Case 2. The clinical diagnosis of Fallot's tetralogy was supported by the catheterization findings. The increased oxygen content of the right atrial blood as compared with that from the venæ cavæ (see Fig. 1, 2, and 3) suggested the presence of an atrial septal defect, but this was made doubtful by the low oxygen content of the right ventricular blood (see p. 162). The mean of the values of the oxygen content of the vena caval samples was used in the calculation of the systemic blood flow.

Case 3. Clinically there was doubt whether the pulmonary shadows were due to collateral circulation or indicated Eisenmenger's complex. The findings, however, showed pulmonary stenosis to be present, and therefore support the diagnosis of Fallot's tetralogy. The significance of the lowered oxygen content of the pulmonary artery as compared with the right ventricular sample is uncertain. It is probably due to the catheter materially obstructing the lumen of the stenosed artery, though it may also have been due to the restlessness of the child. Because of this the oxygen content of the right ventricular sample was used in the calculation of the pulmonary blood flow. The pulmonary stenosis was of moderate severity and a venoarterial shunt occurred presumably through a ventricular septal defect.

Case 4. The clinical diagnosis was pulmonary stenosis with doubt about the condition of the ventricular septum. Samples were taken from the trunk and from the right and left branches of the pulmonary artery and all showed the same oxygen content which was considerably higher than that obtained on samples from

* All these four cases were greatly improved by subclavian-pulmonary anastemosis or rescetion of the infundibulum (Case 4).

the right ventricle. This finding suggested that either a patent ductus arteriosus or a high ventricular septal defect was present. In the absence of a ductus murmur the latter explanation seemed the more likely one, and at subsequent operation no evidence of a patent ductus arteriosus was found. Evidence of mixing of the blood of the two ventricles in both directions through the ventricular septal defect was given, not only by the increased oxygen content of the pulmonary artery blood, but also by the decreased saturation of the arterial blood. Though the blood flow calculations suggested a slight preponderance of arteriovenous shunt through the defect, the figure for this was well within the limits of experimental error (Dexter *et al.*, 1947). This case appeared to be one of pulmonary stenosis with a small high ventricular septal defect.

Pulmonary Stenosis with Closed Ventricular Septum

Case 5. The clinical diagnosis was pulmonary stenosis. Catheterization results showed that pulmonary stenosis was present but gave no evidence of a septal defect. The mild degree of pulmonary stenosis appeared to be largely compensated for by the increased systolic pressure of the right ventricle so that there was only a slight reduction of the pulmonary flow. The small calculated venoarterial intracardiac shunt was within the limits of experimental error, and in view of the normal arterial oxygen saturation such a shunt was unlikely.

Case 6. In this case of pulmonary stenosis with an intact ventricular septum the right ventricle was only once entered, and though the pressure in it was read no blood sample was obtained. This patient had signs of congestive failure which presumably account for the raised right atrial pressure and the enlargement of this chamber demonstrated by the catheter. The same oxygen saturation was found in samples taken from two different points in the right atrium. The right atrial sample was therefore considered to represent mixed venous blood and used for the calculation of the systemic flow. The low value of the latter, and the almost normal arterial oxygen saturation indicate that the pulmonary blood flow is much reduced and that not more than a minimal septal defect is present. Post-mortem, the pulmonary valves were severely stenosed and a very small opening to a probe was found through the valve covering the foramen ovale.

Case 7. The clinical diagnosis was of severe pulmonary stenosis, and at first angiocardiography failed to show any right to left shunt. The catheterization findings are incomplete because the patient did not stand the procedure well. The extremely low value for the oxygen saturation of the blood from the right pulmonary artery is almost certainly an artefact caused by the prolonged obstruction to the stenosed artery by the catheter, especially as a sample taken from the common pulmonary artery two minutes later showed a still lower oxygen saturation of only 15 per cent. There is no doubt that both pulmonary and systemic blood flows were very low, though accurate figures cannot be given. The lowered arterial oxygen saturation was evidence of a small venoarterial shunt. Post-mortem, severe pulmonary stenosis was found and a slit-like opening (7 by 3 mm.) in the valve covering the foramen ovale.

Case 8. The catheterization findings supported the diagnosis of pulmonary stenosis and showed up a significant venoarterial shunt. The right atrial and right ventricular samples were in good agreement and when compared with them the lowered oxygen saturation of the pulmonary blood sample suggested that the catheter had obstructed the pulmonary artery. This was also suggested by the sense of release from grip which was felt when the catheter was withdrawn from the pulmonary artery. The right ventricular sample was used, therefore, in calculating the pulmonary blood flow. A pulmonary vein draining blood 97 per cent saturated with oxygen into the right atrium was demonstrated; the right atrial sample, therefore, has probably a higher oxygen content than that of true mixed venous blood. The mean oxygen content of the vena caval blood samples would have been more accurate in calculating the systemic blood flows, but unfortunately these had not been taken. The calculated systemic blood flow is therefore likely to be higher than the actual one. This appears to be a case of marked pulmonary stenosis with a moderate venoarterial shunt, and no evidence is obtained as to whether the shunt occurs through the atrial or ventricular septum.

Eisenmenger's Syndrome

Case 9. The clinical diagnosis of Eisenmenger's complex was supported by the catheterization results. There was clear evidence of interventricular mixture of blood, but no preponderance of shunt either to the right or left. The difference in oxygen saturation of the right ventricular and pulmonary artery blood samples suggests a high septal defect and some degree of left to right shunt. Pressure tracings from this case are shown in Fig. 7.

Transposition of the Great Vessels

Case 10. A reliable diagnosis could not be made before catheterization, though transposition with a septal defect was suspected. The finding that the pulmonary artery blood was 82 per cent saturated whilst that of the systemic artery was only 72 per cent made it clear that this was a case of transposition of the great vessels. The figure for the pulmonary artery blood oxygen saturation was duplicated in samples from both the common trunk and the right branch of the pulmonary artery, and the figure for the arterial oxygen saturation was confirmed (68%) by a second arterial sample collected 5 hours after the catheterization.

FINDINGS IN 18 ILLUSTRATIVE CASES

Case No.	Reference number, initials	Sex, age	Surface area, sq. metres (1)	O_2 consumption ml./min./ sq. metre. B.M.R. % of normal (2)	Pressures (mm. Hg.) from skin of back (3)			
					Right atrium	Right ventricle	Pulmonary artery	Systemic artery
	Fallot's Tetralogy							
1.	O105 K. C.	F 15	1·59	132 +6%	10	62	10	128/90
2.	H120 G. S.	F 11	1·01	163 +6%	10	40	10	110/60
3.	O051 M. R.	F 8	0·82	194 +20%	4/−2	105/−5	15/0	80/55
4.	CB11 A. A.	F 20	1·70	115 −6%	12	37	16	108/70
	Pulmonary Stenosis with closed Ventricular Septum							
5.	P206 J. F.	M 16	1·54	132 −14%	10/0	140/21	40/21	130/80
6.	P031 M. C.	F 22	1·53	120 −5%	24	70	—	115/85
7.	H117 D. S.	F 30	1·53	118 −8%	—	100+	16	—
8.	O207 D. W.	F 26	1·48	137 +10%	11	85	11	120/75
	Eisenmenger's Complex							
9.	O261 O. D.	F 23	1·42	152 +20%	0	95/−5	95/55	130/80
	Transposition of Great Vessels							
10.	O076 E. T.	M 14	1·09	169 +6%	10	47	88	100/70
11.	OA06 K. M.	M 7	0·82	182 +3%	8	65/10	80/50	85/?
	Truncus Arteriosus							
12.	P098 H. W.	F 12	0·96	230 +54%	4/−8	117/7	—	120/78 Hamilton manometer
	Pulmonary and/or Tricuspid Atresia							
13.	O229 C. L.	F 6	0·69	222 +30%	4	—	—	160/20 (left ventricle)
14.	O021 V. F.	F 14	1·12	178 +25%	14	—	—	100/55
15.	P057 S. H.	M 19	1·32	168 +19%	11	—	—	95/60
	Patent Ductus Arteriosus							
16.	O280 L. S.	M 27	1·70	138 0	9	14	18	130/55
	Atrial Septal Defect (Lutembacher's Syndrome)							
17.	C227 J. M.	M 25	1·53	167 +12%	20	62	72	105/75
	Pulmonary Hæmangioma							
18.	D. C.	M 27	1·57	147 +7%	8	17	15	105/80

(1) From Du Bois formula.
(2) Percentage of normal calculated on Boothby and Sandiford's (1929) figures.

OF CONGENITAL HEART DISEASE

Oxygen content (volumes %) Percentage saturation							Blood flow litres/min./sq. metre		
Inferior vena cava	Superior vena cava	Right atrium	Right ventricle	Pulmonary artery	Artery	Total capacity	Pulmonary	Systemic	Shunt (4)
16·9	15·7	16·2	16·2	14·1	18·5	30·2	1·0	6·0	5·0
56%	52%	54%	54%	47%	62%	—			
20·5	18·5	23·0	20·7	20·5	24·5	34·1	1·4	3·2	1·8
60%	54%	68%	61%	60%	72%	—			
11·3	13·5	12·2	12·4	11·0	16·7	20·9	2·6	4·3	1·7
54%	65%	58%	59%	53%	80%	—			
—	14·2	13·9	14·7	16·4	21·1	23·8	1·9	1·7	−0·2
—	60%	59%	62%	69%	89%	—			
12·5	10·2	10·9	10·3	10·3	15·4	16·1	2·6	3·0	0·4
78%	63%	68%	64%	64%	96%	—			
—	—	9·0	—	—	22·0	24·3	Very small	0·85	Very small
—	—	37%	—	—	91%	—			
—	—	—	—	9·8	26·4	34·5	Very small	Very small	Small
—	—	—	—	29%	77%	—			
—	—	12·9	13·5	6·3	19·8	28·6	1·0	2·0	1·0
—	—	45%	47%	22%	69%	—			
18·8	22·5	19·8	21·6	25·6	26·8	34·7	2·1	2·2	—
54%	64%	57%	62%	74%	77%	—			
—	15·8	14·0	19·6	21·5	18·8	26·1	5·1	3·5	−1·6
—	61%	54%	75%	82%	72%	—			
15·6	14·5	15·4	20·2	20·8	16·9	24·2	8·3	12·1	3·8
65%	60%	64%	84%	86%	70%	—			
—	—	13·2	14·1	—	13·1	21·8	Not reduced	—	—
—	—	61%	65%	—	60%	—			
				(Left atrium)	(Left ventricle)				
7·8	10·8?	6·4	6	9·6	11·4	31·4	—	—	—
25%	34%?	20%	2%	30%	36%	—			
19·6	—	18·6	—	—	25·6	31·6	4·4	app. 2·5	−1·9
62%	—	59%	—	—	81%	—			
17·4	19·2	16·5	—	—	21·7	29·8	>1·4<3·5	3·2	veno-arterial
59%	65%	56%	—	—	73%	—			
—	—	12·9	14·0	15·5	18·5	20·2	3·7	2·4	−1·3
—	—	64%	70%	77%	92%	—			
—	12·1	12·2/15·7	15·6/17·3	16·2	21·5	23·5	2·7	1·8	−0·9
—	52%	52%/67%	67%/74%	69%	92%	—			
23·6	21·1	21·0	20·6	21·2	23·1	31·6	1·7 (alveoli)	7·0	5·3 (hæmangioma)
75%	66%	66%	65%	67%	73%	—			

(3) A single number indicates mean pressure (aneroid manometer); two numbers indicate systolic and diastolic pressure.

(4) A negative sign indicates an arteriovenous shunt, otherwise the shunts are venoarterial.

This transposition may have been more functional than anatomical because though the catheter could be passed easily through into the pulmonary artery it could not be passed into the aorta. Mean blood pressures only were obtained, but it was likely that systolic pressures in the right ventricle, pulmonary artery, and aorta were equal. Further evidence of considerable interventricular mixing of blood was given by the higher oxygen content of the right ventricle as compared with the superior vena cava and right atrial samples. The pulmonary blood flow was greatly increased. It was concluded that a large ventricular septal defect with transpositions of the great vessels was present.

Case 11. The clinical diagnosis lay between transposition with a septal defect and Eisenmenger's complex. The catheterization was done under avertin and pentothal anæsthesia. The results showed interventricular mixing of blood by the increase in oxygen content in passing from the right atrium to ventricle, and demonstrated the transposition by the fact that the oxygen saturation of the arterial blood was markedly lower than that obtained from the pulmonary artery. For some reason unknown the systolic pressure in the pulmonary artery appeared to be higher than that in the right ventricle. The calculated blood flows were greatly increased. The final diagnosis was of transposition of the great vessels with a ventricular septal defect.

Truncus Arteriosus

Case 12. The clinical diagnosis of a truncus arteriosus was supported by the results of catheterization. A pulmonary vein draining blood (97% saturated) into the right atrium was demonstrated, and also an atrial septal defect. The catheter passed into what appeared to be a vessel of wide diameter (? truncus) and on into a right-sided aortic arch. No pulmonary branches were demonstrated. The blood samples were of limited value because the child was anxious and cried at times, but they indicated that complete mixing of systemic and pulmonary venous bloods had occurred in the common atrium. The systemic blood flow cannot be computed because no sample of mixed venous blood was obtainable as the child finally ceased to co-operate before vena caval samples could be obtained. Assuming that the pulmonary vessels are derived from a truncus arteriosus, the pulmonary blood flow can be calculated as 3 litres a minute per square metre of body surface. The conclusions to be drawn from the investigation are that an atrial septal defect was present, and that an anomalous pulmonary vein drained into the right atrium; there was evidence in favour of a common arterial trunk and the presence of two ventricles, but the existence of a pulmonary artery cannot be ruled out.

Tricuspid Atresia and Pulmonary Atresia

Case 13. The clinical diagnosis in this case was tricuspid atresia. The child was catheterized under only local anæsthesia and remained co-operative throughout. From the right atrium the catheter entered what was at first thought to be a small right ventricle, as judged by the position of the catheter and the pressure measured. The sample of blood obtained from it, however, was only 2 per cent saturated and it seems more likely that the structure entered was the coronary sinus, which the catheter had obstructed. The catheter was withdrawn and the left atrium entered through a large atrial septal defect; from there the tip was advanced into the left ventricle (Fig. 11). For fear of injuring the endocardium the catheter was not further manipulated in the ventricle and the aorta was not entered. As all blood samples, especially the one obtained from the right ventricle, were of such low oxygen content calculation of blood flows does not appear to be justified. The conclusions drawn were that the child had an atrial septal defect through which a venoarterial shunt occurred. The pressure tracings are shown in Fig. 12.

At the end of the catheterization the child complained of nausea and vomited twice, following which she passed into coma. Respirations stopped about two minutes later when a feeble pulse could still be felt. She improved with artificial respiration and oxygen and regained consciousness about 10 minutes later. One month later she had an angiocardiogram, and a few weeks later she suddenly collapsed in bed and died. The post-mortem findings were a large atrial septal defect producing what was practically a common atrium, a small right ventricle with hypertrophied walls, narrowed tricuspid valve, and shortened chordæ tendineæ. There was a slit-like opening high in the ventricular septum and several small ones in the lower part of the septum. The aorta arose entirely from the right ventricle, from which also arose a hypoplastic pulmonary artery with under-developed but well separated cusps. A high degree of pulmonary subvalvular stenosis was present, narrowing the lumen to a little over 1 mm. in diameter. The blood supply to the lungs arose from well developed anterior and superior bronchial arteries. This case was therefore strictly neither an example of tricuspid or of pulmonary atresia, but of complete transposition of the aorta and marked pulmonary stenosis. The case is being reported fully in the Guy's Hospital Reports.

Case 14. This girl was diagnosed clinically as a case of Fallot's tetralogy with a large compensating ductus arteriosus. She was twice catheterized but on neither occasion could an exit be found from the right atrium. Post-mortem, there was a large patent foramen ovale and atresia of the pulmonary orifice and a small right ventricle. There was a well developed pulmonary artery which was supplied from the aorta via a large patent ductus arteriosus. With the knowledge of the post-mortem findings the blood flows shown in the table were calculated.

Case 15. The clinical diagnosis was tricuspid atresia. At catheterization no exit could be found from the right atrium into either the right ventricle or the left atrium. In the absence of a sure anatomical diagnosis two figures were calculated for the pulmonary blood flow, the larger assuming that the pulmonary blood supply was derived entirely from the arterial blood, and the smaller assuming that the pulmonary blood supply was derived from such mixed venous blood as was sampled in the right atrium. In either case it appears that the pulmonary blood flow was reduced.

Patent Ductus Arteriosus

Case 16. The obvious clinical diagnosis of patent ductus arteriosus was confirmed by the finding that there was a significantly higher oxygen content of the blood in both branches of the pulmonary artery than that in the right ventricle. It will be noticed that the oxygen content of the right ventricular blood is somewhat higher than that of the right atrial blood. This may be due to the right atrial sample not being a representative one, it may be questionable evidence of a ventricular septal defect, or perhaps evidence of regurgitation through the pulmonary valves; had vena caval samples been taken the answer to the first of these possibilities would have been available.

Atrial Septal Defect and Mitral Stenosis (Lutembacher's Syndrome)

Case 17. The catheterization findings confirmed the clinical diagnosis of atrial septal defect. The right atrial pressure was raised, as was also the mean right ventricular and pulmonary artery pressures. The samples of blood of various oxygen content obtained from the right atrium and ventricle gave evidence of incomplete mixing of blood therein. The slightly lowered oxygen saturation of the arterial blood suggests that there may be some admixture of venous blood from the right to the left atrium even though the overall shunt is arteriovenous. The systemic blood flow is significantly reduced and the pulmonary blood flow is a low normal value. These findings suggest that mitral stenosis is also present, making this case an example of Lutembacher's syndrome.

Pulmonary Hæmangioma

Case 18. This case was diagnosed clinically. It was thought that catheterization had diagnosed an angioma of the liver, for it was found that the oxygen content of the inferior vena caval blood was the same as that of the arterial blood. In cases of cyanotic heart disease, however, it is not very unusual to find that the oxygen content of inferior vena caval blood is nearly that of the arterial blood, but it is unusual to find them the same. Since he was known to have arteriovenous fistulæ in lips and buttocks it was thought that the inferior vena caval specimen derived from the effluent of an angioma of the liver. The cardiac output was greatly increased and it can be calculated that about 75 per cent of the right ventricular output passed through the angioma rather than through the alveolar capillaries. The diagnosis was confirmed post mortem, but the diagnosis of the hepatic angioma proved to be incorrect, though dilated sinuses suggested that a large proportion of the increased systemic circulation was passing through the liver. This case is fully described by Baker and Trounce (1949).

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JACC: CARDIOVASCULAR INTERVENTIONS
VOL. 7, NO. 12, 2014
© 2014 BY THE AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION
ISSN 1936-8798/$36.00
PUBLISHED BY ELSEVIER INC.
http://dx.doi.org/10.1016/j.jcin.2014.06.022

Cardiac Catheterization in the Early Post-Operative Period After Congenital Cardiac Surgery

George T. Nicholson, MD,* Dennis W. Kim, MD, PhD,* Robert N. Vincent, MD,* Brian E. Kogon, MD,† Bruce E. Miller, MD,‡ Christopher J. Petit, MD*

ABSTRACT

OBJECTIVES This study sought to demonstrate that early cardiac catheterization, whether used solely as a diagnostic modality or for the use of transcatheter interventional techniques, can be used effectively and with an acceptable risk in the post-operative period.

BACKGROUND Cardiac catheterization offers important treatment for patients with congenital heart disease. Early post-operative cardiac catheterization is often necessary to diagnose and treat residual anatomic defects. Experience with interventional catheterization to address post-operative concerns is limited.

METHODS This was a retrospective cohort study. The medical and catheterization data of pediatric patients who underwent a cardiac catheterization ≤30 days after congenital heart surgery between November 2004 and July 2013 were reviewed. Patients who underwent right heart catheterization and endomyocardial biopsy after heart transplantation were excluded.

RESULTS A total of 219 catheterizations (91 interventional procedures, 128 noninterventional catheterizations) were performed on 193 patients. Sixty-five interventions (71.43%) were dilations, either balloon angioplasty or stent implantation. There was no difference in survival to hospital discharge between those who underwent an interventional versus noninterventional catheterization ($p = 0.93$). One-year post-operative survival was comparable between those who underwent an intervention (66%) versus diagnostic (71%) catheterization ($p = 0.58$). There was no difference in the incidence of major or minor complications between the interventional and diagnostic catheterization cohorts ($p = 0.21$).

CONCLUSIONS Cardiac catheterization, including transcatheter interventions, can be performed safely in the immediate post-operative period after congenital heart surgery. (J Am Coll Cardiol Intv 2014;7:1437–43)
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Cardiac catheterization is often uniquely valuable in the evaluation and treatment of patients with congenital heart disease. Although the safety of catheterization in the non-acute setting has been described (1-4), early post-operative cardiac catheterization (EPOCC) is often regarded as high risk, particularly when patients are unstable or when interventions are anticipated. There is significant institutional variability with regard to access and timely referral for EPOCC. There is limited reported experience with cardiac catheterization in the early post-operative period (5-7).

At our institution, patients are often referred for cardiac catheterization in the early post-operative period to determine the significance of a residual cardiac lesion noted by noninvasive means (e.g.,

From the *Division of Pediatric Cardiology, Department of Pediatrics, Children's Healthcare of Atlanta/Emory University School of Medicine, Atlanta, Georgia; †Division of Cardiothoracic Surgery, Department of Pediatrics, Children's Healthcare of Atlanta/Emory University School of Medicine, Atlanta, Georgia; and the ‡Division of Pediatric Cardiac Anesthesia, Department of Pediatrics, Children's Healthcare of Atlanta/Emory University School of Medicine, Atlanta, Georgia. All other authors have reported that they have no relationships relevant to the contents of this paper to disclose.

Manuscript received April 18, 2014; revised manuscript received May 20, 2014, accepted June 13, 2014.

ABBREVIATIONS AND ACRONYMS

ECMO = extracorporeal membrane oxygenation

EPOCC = early post-operative cardiac catheterization

IQR = interquartile range

echocardiography) or to assess physiology and/or anatomy in the struggling post-operative patient. We reviewed our institutional experience with perioperative cardiac catheterization in this patient group. The purpose of this study is to describe the safety and overall outcomes of cardiac catheterization procedures performed within 30 days after congenital heart surgery. We hypothesized that early cardiac catheterization, whether used solely as a diagnostic modality or as a percutaneous intervention, can be used effectively and with an acceptable risk in the post-operative period.

METHODS

STUDY PATIENTS. This is a single-center, retrospective cohort study. Medical and catheterization data of all pediatric patients who underwent a cardiac catheterization ≤30 days after congenital heart surgery at Children's Healthcare of Atlanta between November 2004 and July 2013 were reviewed. Patients were included if they underwent either a diagnostic or interventional cardiac catheterization ≤30 days after surgical repair/palliation for congenital heart disease. Patients who underwent right heart catheterization and endomyocardial biopsy as routine surveillance after orthotopic heart transplantation were excluded. This study was approved by the institutional review board.

TABLE 1 Patient Characteristics

	Total (N = 193)	Interventional (n = 65)	Diagnostic (n = 128)	p Value
Patient characteristics				
Age, yrs	0.32 (0.01–18.48)	0.31 (0.01–17.14)	0.35 (0.01–18.48)	0.49
Weight, kg	5.20 (3.40–8.50)	4.90 (2.30–51.31)	5.50 (2.20–98.50)	0.45
Time from surgery, days	6 (0–30)	8 (0–29)	5 (1–30)	0.01
Mechanical ventilator support	131	47	84	0.35
Inotropic support	129	39	90	0.16
ECMO	22	8	14	0.77
Genetic syndrome	45	11	34	0.14
Primary diagnosis				
Single ventricle	96 (50)	45 (69)	51 (40)	<0.01
Conotruncal anomalies (TOF, DORV, TA, PA-VSD, TGA)	55 (28)	15 (23)	40 (31)	0.24
AVSD	10 (5)	1 (2)	9 (7)	0.11
Other	31 (16)	3 (5)	28 (22)	<0.01

Values are median (range), n, or n (%).

AVSD = atrioventricular septal defect; DORV = double-outlet right ventricle; ECMO = extracorporeal membrane oxygenation; PA-VSD = pulmonary atresia–ventricular septal defect; TA = truncus arteriosus; TGA = transposition of the great arteries; TOF = tetralogy of Fallot.

CATHETERIZATION PROCEDURE. Demographic data collected included weight at catheterization (in kilograms), age at catheterization (years), and primary cardiac diagnosis. We also reported the initial surgical procedure performed, the interval from surgery to EPOCC (days), the indication(s) for EPOCC (cyanosis, low cardiac output, or other), the diagnosis of a genetic syndrome, the need for mechanical ventilation before EPOCC, the need for inotropic support, extracorporeal membrane oxygenation (ECMO) use at time of catheterization, in-hospital mortality, and 1-year survival post-surgery. Catheterization data collected included the procedure performed, the intervention involving a surgical anastomotic site, procedural mortality, the need for blood transfusion during the catheterization, and procedural complications (minor/major). Major complications included death, stroke, cardiopulmonary arrest, and the need for unplanned emergent surgery/procedure/ECMO support as a result of complication.

STATISTICAL ANALYSIS. Continuous variables were reported as median and interquartile range (IQR). The data were initially analyzed with a univariate followed by a multivariate regression analysis when applicable. The primary outcome measure was procedural complication. Covariates and factors were assessed using either a Wilcoxon rank sum test or a chi-square test, when applicable. Secondary endpoints included hospital discharge survival and 1-year survival. Kaplan-Meier log-rank univariate analysis was performed for time-dependent outcomes, and multivariable analysis was performed using Cox regression with SPSS Version 21.0 software (IBM, Armonk, New York).

RESULTS

During the study period, there were a total of 7,755 surgical cases at our institution. A total of 219 early post-operative catheterizations (91 interventional procedures, 128 noninterventional catheterizations) were performed on 193 of these patients. At the time of EPOCC, the median age was 0.32 years (IQR: 0.05 to 0.95 years), the median weight was 5.2 kg (IQR: 3.4 to 8.5 kg), and the median interval from surgery was 6 days (IQR: 3 to 12 days). A total of 132 patients were on mechanical ventilatory support, and 129 patients were receiving inotropic support. Twenty-two patients were on ECMO at the time of catheterization, whereas 45 patients were known to have a genetic disorder. Patient characteristics and indications for cardiac catheterization are summarized in Tables 1 and 2.

TABLE 2 Indications for Catheterization (N = 193)

	Interventional	Diagnostic	p Value
Cyanosis	28	26	<0.01
Low cardiac output	4	31	<0.01
Concern for residual defect	20	42	0.78
Effusion	2	6	0.64
Unable to wean ventilator support	5	9	0.85
Unable to wean CPB	3	9	0.54
Other	3	5	0.80

Values are n.
CPB = cardiopulmonary bypass.

A total of 65 patients underwent 91 interventional procedures, and 128 patients underwent diagnostic catheterization. In patients in whom an intervention was performed, catheterization occurred at a median of 8 days post-operatively compared with a median of 5 days post-operatively for patients who underwent a diagnostic evaluation ($p = 0.01$). Otherwise, the interventional and diagnostic EPOCC groups were similar (Table 1).

In total, 91 interventions were performed in 65 patients (Table 3). Sixty-five interventions (71.43%) were dilations, either balloon angioplasty or stent implantation. The interventional EPOCC group was more likely to have single-ventricle heart disease ($p < 0.01$) and to present for EPOCC due to cyanosis, whereas the indication of low cardiac output was associated with diagnostic catheterization ($p < 0.01$) (Table 2). There were 65 stent/angioplasty procedures and 14 occlusion procedures (Figures 1 to 3). Details of the range of interventions are presented in Table 3. A total of 45 (49.5%) of the interventional procedures were interventions at a fresh anastomotic site.

A total of 18 complications occurred among the entire EPOCC cohort; there were 7 major and 11 minor complications (Table 4). There was no difference in the incidence of major or minor complications between the interventional and diagnostic catheterization cohorts ($p = 0.21$).

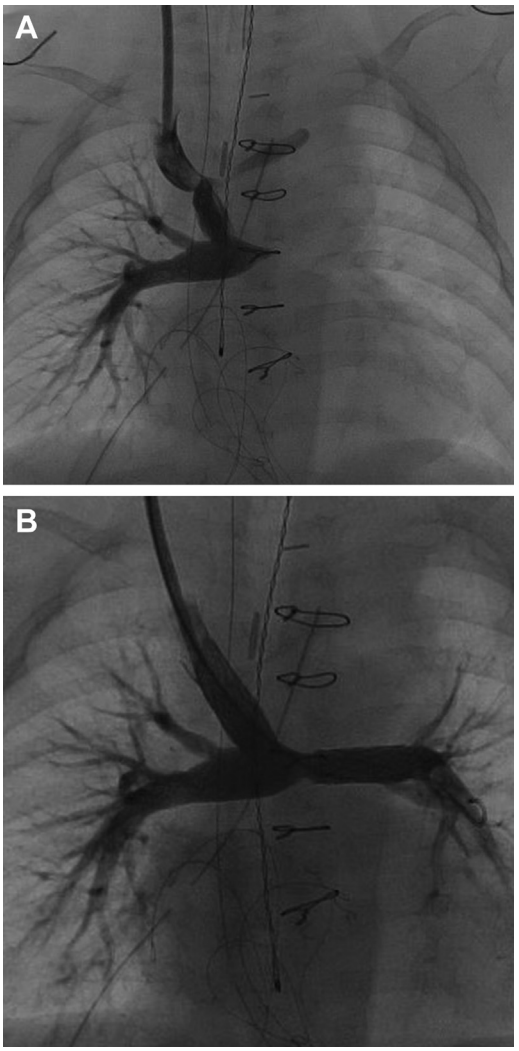


FIGURE 1 Left Pulmonary Artery Stenosis

(A) Hours after completion of a superior cavopulmonary connection, this patient was found to have complete left pulmonary artery occlusion and superior vena caval stenosis. **(B)** After recanalization and stenting of the left pulmonary artery and stenting of the superior vena cava, the patient improved rapidly.

TABLE 3 Interventional Procedure Types (N = 91)

	Location	n
Stent implantation, n = 28	Pulmonary artery	15
	Systemic vein	3
	BTS/RV-PA conduit	6
	Carotid/innominate artery	3
	Fontan circuit	1
Balloon angioplasty, n = 37	Pulmonary artery	13
	Aorta	6
	Systemic vein	15
	BTS	3
Occlusion, n = 14	AP collateral	7
	VV collateral	7
Other, n = 12	Thrombectomy	9
	Atrial septostomy	3

AP = aortopulmonary; BTS = Blalock-Taussig shunt; RV-PA = right ventricle pulmonary artery; VV = venovenous.

JACC: CARDIOVASCULAR INTERVENTIONS VOL. 7, NO. 12, 2014
DECEMBER 2014:1437–43

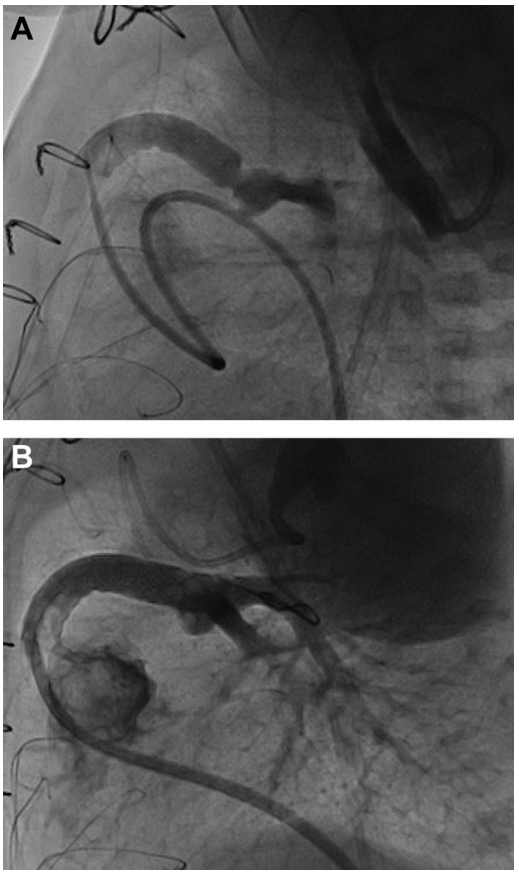


FIGURE 2 Distal Shunt Stenosis

Lateral projection demonstrating discrete distal right ventricle-to-pulmonary artery shunt stenosis before **(A)** and after **(B)** stent placement.

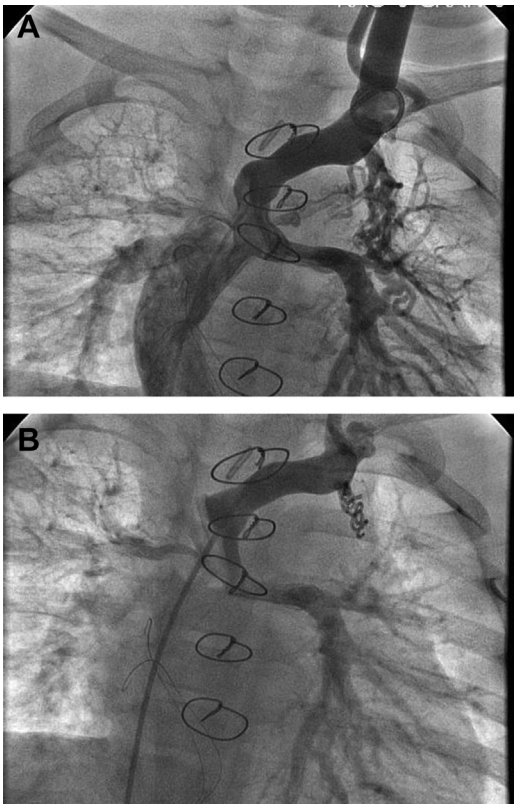


FIGURE 3 Venovenous Collateral

Anteroposterior projection demonstrating a venovenous collateral from the innominate vein to the left upper pulmonary vein before **(A)** and after **(B)** coil occlusion.

There were 7 major complications: 3 during interventional EPOCC and 4 in diagnostic EPOCC. One patient had pulmonary artery avulsion after angioplasty with a balloon-to-vessel diameter ratio of 6:1, and 1 patient had arterial dissection requiring ECMO rescue. Diagnostic EPOCC in 3 patients was associated with cardiac arrest; 1 of these patients then required ECMO. No single risk factor was associated with EPOCC-associated complications.

EPOCC was followed by return to the operating room to address important residual lesions in 43% of patients. In the interventional EPOCC group, 32 patients (49%) returned to the operating room within 10 days of the catheterization; in 17 patients, findings during catheterization prompted reoperation. In the diagnostic EPOCC group, 51 patients (40%) were brought back to the operating room within 10 days of catheterization. Of these, 33 reoperations can be attributed to findings during catheterization (Table 5).

Although procedural mortality was very low, survival to discharge and 1-year survival were disappointing in the entire EPOCC group. There was no difference in survival to hospital discharge between the interventional and diagnostic EPOCC groups ($p = 0.93$). In addition, 1-year post-operative survival was comparable in those who underwent an intervention (66%) versus diagnostic (71%) catheterization ($p = 0.58$) (Figure 4A). Not surprisingly, single-ventricle heart disease patients had a lower 1-year survival (Figure 4B).

For the entire cohort, multivariate regression analysis demonstrated that younger age at the time of surgery ($p = 0.05$), ECMO support at the time of EPOCC ($p = <0.01$), and single-ventricle heart disease ($p = 0.02$) were associated with a higher 1-year mortality rate.

DISCUSSION

After surgical repair of congenital heart disease, most patients follow a predictable post-operative course toward recovery. Many patients, unfortunately, do not follow the typical, expected course. Residual unaddressed cardiac lesions, post-surgical anatomic stenosis, and myocardial injury from prolonged cardiopulmonary bypass may account for the delay in recovery after cardiac surgery (8). In these situations, an early post-operative cardiac catheterization can delineate the physiology and the anatomy, prompting effective therapy that might otherwise have been delayed. Our findings justify this approach because a substantial number of patients underwent reoperation on the basis of findings during cardiac catheterization. Of course, the decision to take unstable patients to the catheterization laboratory involves weighing the potential risks and benefits of an invasive procedure. These infants and children pose challenges in transport to the catheterization laboratory, in ventilator and hemodynamic management during the procedure, as well as in performance of an often technically demanding procedure. As others have noted, dedicated anesthesia, surgical, and interventional teams are required to undertake such challenging procedures (7,9,10).

There are limited data on the safety and utility of cardiac catheterization in the immediate post-operative period after surgical repair of congenital heart disease (5–7,11). The most comprehensive review to date was published by Zahn et al. (7) in 2004. In that study, children catheterized within 6 weeks of cardiac surgery were reviewed. The authors noted that in the 26 patients (42% of the cohort) who underwent interventions across suture lines, no vascular disruptions were noted. Rosales et al. (6) reported their experience with angioplasty and stenting in the early post-operative period. The authors reported that angioplasty was inherently riskier than stenting; in particular, balloon diameter-to-stenosis ratios >2.5:1 were associated with vascular disruptions and major complications including death. Interestingly, the single death in our cohort was encountered after balloon angioplasty of a severely hypoplastic left pulmonary artery; the balloon-to-stenosis ratio in this patient was 6:1.

Our report is on the largest cohort of early post-operative catheterizations in children undergoing cardiac surgery. Our study involved patients who are younger and underwent catheterization closer to surgery than previously published data (5–7,11); this likely represents the trend over the past decade to undertake increasingly complex surgical repairs in increasingly smaller and more fragile patients. Our entire population underwent catheterization within 4 weeks after surgery, with two-thirds undergoing catheterization within 12 days of surgery, at a median age of 3.8 months.

Periprocedural complications are more commonly encountered in hemodynamically unstable patients (12). There is a commonly accepted notion that one should wait ~6 weeks after surgery before performing an intervention (10). Yet there are no published data indicating unusual suture fragility in the early post-operative period. Zahn et al. (7) astutely note an

TABLE 4 Catheterization Outcomes

	Rates of Events During Catheterization		
	Interventional Procedures (n = 91)	Diagnostic Procedures (n = 128)	p Value
Blood transfusion	22 (24)	22 (17)	0.01
Intervention involving surgical anastomotic site	45 (48)	–	–
In-hospital death	14/65 (22)	27/128 (21)	0.93
1-yr survival rate, %	66	71	0.58
Cath lab complications			
Procedural death	1	0	–
ECMO cannulation in the cath lab	1	1	0.67
Cardiopulmonary resuscitation	0	2	–
Cardiac rhythm disturbance*	1	8	0.16
Device/stent migration, retrieved percutaneously	2	0	–
Vascular tear†‡	2	0	–
Entrapment of venous catheter in ECMO cannula	0	1	–

Values are n (%), n, or n/N (%). *Spontaneous resolution or required direct current cardioversion or rapid atrial pacing to convert to normal sinus rhythm. †Umbilical artery, left pulmonary artery. ‡The vascular tear of the left pulmonary artery was the only procedural mortality.
ECMO = extracorporeal membrane oxygenation.

TABLE 5 Reoperation Characteristics

Reoperation	Total	Interventional	Diagnostic
Branch pulmonary arterioplasty	11	6	5
Systemic venoplasty	1	0	1
Open thrombectomy	3	2	1
Residual VSD closure	2	1	1
SCPC takedown, BTS placement	7	2	5
Fontan revision	2	1	1
Semilunar/atrioventricular valve repair/replacement	3	1	2
Systemic-to-PA shunt revision	9	3	6
Unifocalization of AP collaterals	3	1	2
Pulmonary vein repair	3	0	3
Coronary artery revision	4	0	4
Coarctation of the aorta repair	1	0	1
Atrial septectomy	1	0	1

Values are n.
AP = aortopulmonary; SCPC = superior cavopulmonary connection; VSD = ventricular septal defect; other abbreviations as in Tables 1 and 3.

inherent distinction between the placement of a single running suture line and a series of interrupted sutures. Indeed, at our center, vascular anastomoses are typically performed with running Prolene suture, which appears to accommodate larger balloon-to-vessel ratios. Our study provides further validation of the utility, feasibility, and safety of transcutaneous intervention and diagnostic evaluation in this high-risk patient population.

It is inherently challenging to demonstrate the benefit and utility of a hemodynamic/noninterventional cardiac catheterization in the early post-operative period. There is no reasonable control group with whom to compare the cohort who presented to the laboratory. However, we demonstrate acceptable safety in these cases. Given the cohort's intrinsic vulnerability, this safety is indeed notable.

Theoretically, performing an interventional procedure in the immediate post-operative period should be higher risk than performing a diagnostic catheterization in the same time period; however, we have shown similar survival rates among the 2 groups. In our patient cohort, overall prognosis was disappointing because 21% died in-hospital and 31% died within 1 year of surgery. There was no difference in survival whether the patient underwent a diagnostic or interventional catheterization. The high 1-year mortality rate likely reflects the generally poor prognosis that the patient faces who is so unwell as to need an early post-operative cardiac catheterization.

STUDY LIMITATIONS. This was a retrospective cohort study with the usual biases of such investigations. The timing of catheterization was not standardized; rather, it depended on the differing management strategies of both the cardiothoracic surgeon and cardiac intensivist. In addition, time to extubation and discontinuation of vasoactive infusions were not included in the analysis due to an inherent lack of control over differing management strategies.

CONCLUSIONS

Cardiac catheterization, including transcatheter intervention across newly created suture lines, can be performed with an acceptable risk and detects clinically significant residual defects in the immediate post-operative period after congenital heart surgery. Caution must be used whenever balloon dilation at suture lines is anticipated.

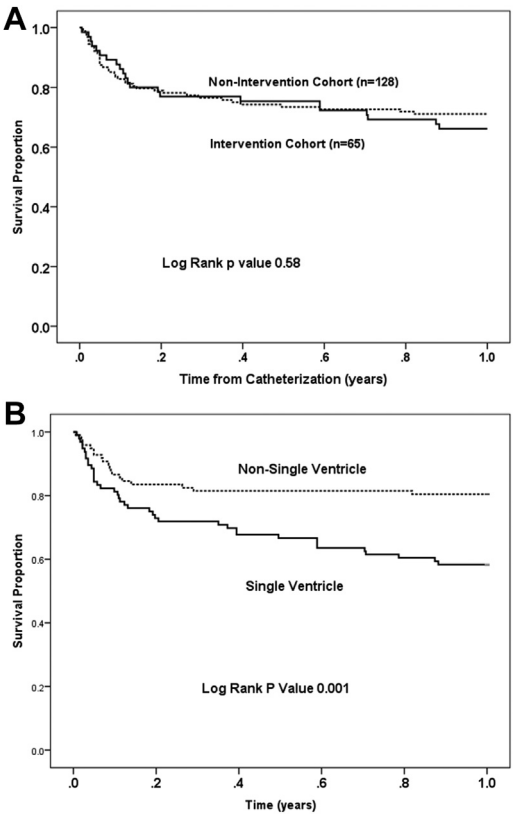


FIGURE 4 One-Year Survival

(A) Kaplan-Meier survival curves demonstrating no survival difference between those who underwent an intervention and those who underwent a diagnostic catheterization. **(B)** Patients with single-ventricle heart disease had a poor 1-year survival rate.

REPRINT REQUESTS AND CORRESPONDENCE: Dr. Christopher J. Petit, Children's Healthcare of Atlanta, Emory University School of Medicine, 1405 Clifton Road NE, Atlanta, Georgia 30322-1062. E-mail: petitc@kidsheart.com.

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KEY WORDS **cardiac catheterization, congenital cardiac surgery, congenital heart disease**

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Pediatr Cardiol. Author manuscript; available in PMC 2014 November 19.

Published in final edited form as:
Pediatr Cardiol. 2010 October ; 31(7): 977–985. doi:10.1007/s00246-010-9736-3.

What is the Clinical Utility of Routine Cardiac Catheterization Before a Fontan Operation?

Puja Banka[1], **Doff B. McElhinney**[1], **Emile A. Bacha**[2], **John E. Mayer Jr.**[2], **Kimberlee Gauvreau**[1], **Tal Geva**[1], and **David W. Brown**[1]

[1]Department of Cardiology, Children's Hospital Boston, 300 Longwood Avenue, Boston, MA 02115, USA

[2]Department of Cardiac Surgery, Children's Hospital Boston, 300 Longwood Avenue, Boston, MA 02115, USA

Abstract

Patients with single-ventricle circulation presenting for Fontan completion routinely undergo cardiac catheterization despite ongoing debate concerning its additive value. Increasing interest in noninvasive preoperative evaluation alone led the authors to analyze the utility of routine pre-Fontan catheterization and to determine whether a subset of patients could avoid this invasive procedure. Patients younger than 5 years referred for pre-Fontan evaluation were retrospectively reviewed. Medical records and catheter angiograms were examined, and catheterizations were categorized as "additive" based on predetermined criteria. Associations between precatheterization variables, catheterization findings, and short-term postoperative outcomes were evaluated. Cardiac catheterization was clinically nonadditive for 89 of 175 patients undergoing pre-Fontan evaluation (51%). There were no robust precatheterization predictors of a nonadditive catheterization. Echocardiography did not fully demonstrate the relevant anatomy of 115 patients (66%), most frequently due to inadequate visualization of the pulmonary arteries, and 22 patients had additive catheterizations due to new diagnostic findings alone. Interventions at catheterization were frequent and deemed "important" for 64 patients (37%). Catheterization hemodynamic data were not associated with early postoperative outcomes. Minor catheterization complications occurred for 51 patients (29%) and major complications for 4 patients (2%). Although at least 50% of the patients presenting for Fontan completion may be able to avoid routine catheterization safely, an echocardiography-based imaging strategy alone is insufficient to allow proper identification of those who could be evaluated noninvasively. A more comprehensive imaging strategy not based solely on echocardiography should be considered.

Keywords

Cardiac catheterization; CHD; Echocardiography; Fontan; Imaging; Univentricular heart

Correspondence: David W. Brown, david.brown@cardio.chboston.org.

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Patients with a functionally univentricular heart typically undergo a series of palliative operations that culminate in a modified Fontan procedure. Before Fontan, echocardiography and cardiac catheterization are routinely performed to assess anatomic and hemodynamic suitability for Fontan completion. This is standard practice at many centers [8]. However, catheterization may be associated with morbidity for high-risk patients [2, 4, 5, 28, 30], and there is mounting evidence that ionizing radiation exposure in childhood is associated with an increased risk of cancer [19].

Published information is limited regarding the utility of pre-Fontan catheterization compared with noninvasive imaging for high-risk patients, and in the current era, few patients are excluded from Fontan completion based on catheterization data [8, 23]. As a result, there has been recent interest in reexamining the role of routine pre-Fontan catheterization in an attempt to identify a group that could safely avoid this procedure [24, 25].

We conducted a retrospective review of patients undergoing pre-Fontan evaluation at our institution to analyze the role of routine preoperative catheterization, including the utility of hemodynamic data as well as the frequency and nature of new diagnostic findings and catheter-based interventions. We also sought to identify precatheterization predictors of a nonadditive catheterization that could be used to identify patients for whom catheterization would provide no additional benefit beyond clinical evaluation and noninvasive imaging alone.

Methods

Subjects

After obtaining approval from the Department of Cardiology Scientific Review Committee and the Children's Hospital Committee on Clinical Investigations, we reviewed the medical records of patients younger than 5 years undergoing catheterization at our institution from January 2001 through December 2005. Patients listed as undergoing pre-Fontan evaluation and those who may have been Fontan candidates based on anatomy and prior procedures were included in the review.

To minimize bias related to institutional practice variability, only patients undergoing both pre-Fontan echocardiography and catheterization at our institution were included. Patients whose echocardiogram preceded catheterization by more than 6 months were excluded. Demographic, anatomic, and prior surgical data were obtained from the medical record.

Echocardiography

Data from the pre-Fontan echocardiogram were abstracted from the final report. For patients with multiple echocardiograms, the study in closest temporal proximity to the pre-Fontan catheterization was selected. Echocardiograms were considered complete if they visualized all the following: superior vena cava in patients with a Glenn circulation, pulmonary veins, atrial septum, atrioventricular valves, pulmonary outflow in patients with antegrade pulmonary blood flow, mediastinal pulmonary arteries, systemic outflow, ascending aorta and aortic isthmus in patients at risk for arch obstruction (e.g., prior Norwood procedure or left-sided obstructive lesions), and ventricular function.

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Catheterization

Hemodynamic and interventional data from the pre-Fontan catheterization were recorded. Due to practice variability in the catheterization laboratory and the discretionary nature of many transcatheter interventions, we convened a panel of experts not initially involved in the study (a senior interventional catheterizer, a cardiac surgeon, and a noninvasive cardiologist within our department) to develop definitions of a clinically “important” intervention during pre-Fontan catheterization (Table 1).

Using these criteria, all available angiograms and hemodynamic data were reviewed by a single cardiologist, and each intervention was categorized as “important” or “discretionary.” Any catheterization that showed new diagnostic information affecting perioperative management or during which an “important” intervention was performed was considered clinically additive. For example, a catheterization that showed pulmonary artery stenosis not seen by echocardiography in a patient who subsequently went on to have pulmonary artery plasty at surgery was considered clinically additive. Similarly, catheterizations that included a pulmonary artery balloon angioplasty meeting the definition of an “important” intervention (Table 1) were considered additive.

Statistical Analysis

Continuous data are presented as mean ± standard deviation or as median and range. Patient characteristics and echocardiographic information were compared for additive versus nonadditive catheterizations, new diagnostic findings, and “important” transcatheter interventions using the Wilcoxon rank sum test for continuous variables and Fisher’s exact test for categorical variables. Variables significant at the 0.20 level in univariate analysis were considered for inclusion in multivariable logistic regression models. Variables significant at the 0.05 level were retained in the final models. Odds ratios (OR) and 95% confidence intervals (CI) were calculated. The Spearman rank correlation coefficient was used to examine relationships between short-term post-Fontan outcomes and catheterization hemodynamic variables.

Results

Subjects

Of the 175 patients who met the inclusion criteria, 105 (60%) were male. Six patients were excluded from the review: five because the interval between echocardiography and catheterization exceeded 6 months and one due to missing hemodynamic records. The median age at catheterization was 30 months (range, 4–49 months). The mean weight was 12 ± 2.3 kg, and the mean height were and 87 ± 8 cm. The mean hemoglobin level was 16.3 ± 1.5 gm/dl, and the mean systemic oxygen saturation was 84 ± 5%. The most common diagnosis was hypoplastic left heart syndrome (n = 69, 39%). Other common diagnoses included tricuspid atresia (n = 28), double-outlet right ventricle (n = 18), and unbalanced atrioventricular canal defect (n = 17). Heterotaxy syndrome was present in 24 patients (14%).

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Most patients had undergone a prior bidirectional Glenn operation (*n* = 159, 91%), 22 (13%) of which were bilateral. Three patients (2%) had undergone a Kawashima operation, and 6 (3%) had a pulmonary artery band alone.

Echocardiography

The echocardiographic findings are summarized in Table 2. Two-thirds of echocardiograms were performed with the patient under sedation, but only 34% were considered complete. The most common reason for an incomplete echocardiogram was inadequate visualization of the Glenn pathway and pulmonary arteries (57%). The median time from echocardiogram to catheterization was 1 day (range, 0–157 days).

Catheterization

The catheterization results are summarized in Table 3. The results showed that 12 patients (7%) had pulmonary arterial pathway obstruction, 5 patients (3%) had arch obstruction that required intervention, and 4 patients (2%) had pulmonary vein stenosis. The mean fluoroscopy time was 61 ± 38 min. New diagnostic findings resulted from 48 procedures (27%). Interventions were performed for 112 patients (64%) and determined to be "important" for 64 patients (37%) (Table 4). Thus, 86 patients in the entire cohort (49%) had clinically additive catheterizations: 38 based on important interventions alone, 22 based on new findings alone, and 26 based on both.

Complications of Cardiac Catheterization

As summarized in Table 5, 4 patients (2%) had major catheterization complications, and 51 patients (29%) had minor complications. One cardiac arrest occurred for a patient with hypoplastic left heart syndrome undergoing catheterization for progressive tricuspid regurgitation and new-onset complete heart block. Early in the procedure, before any interventions, the patient experienced worsening hypoxemia, bradycardia, and subsequent cardiac arrest, which was treated with cardiopulmonary resuscitation and mechanical circulatory support. On day 2 after catheterization, the patient underwent tricuspid valvuloplasty and pacemaker placement but remained in critical condition and died on postoperative day 13.

Exclusion from Fontan Completion or Its Delay

All but 13 patients (7%) underwent Fontan completion as planned. Of these 13, two were excluded from Fontan because of newly diagnosed pulmonary vein stenosis. One patient had Fontan surgery postponed because of an unexplained elevated ventricular end-diastolic pressure (17 mmHg). One patient had prominent systemic-to-pulmonary arterial collateral flow with elevated pulmonary artery pressure (20 mmHg) and therefore underwent coil embolization of multiple collateral arteries with a plan to reassess with catheterization in the future. Two patients underwent tricuspid valvuloplasty without Fontan completion. One of these patients was found at catheterization to have left pulmonary artery occlusion and underwent placement of an aorta-to-left pulmonary artery shunt only. Four patients underwent conversion to a biventricular circulation and therefore did not complete a Fontan procedure. The remaining two patients were favorable Fontan candidates, but the first

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patient was lost to follow-up evaluation, and the second patient with good hemodynamics and lack of symptoms had Fontan surgery postponed.

Predictors of Nonadditive Catheterization

Preoperative demographics and clinical characteristics were not predictive of an additive or nonadditive catheterization. In both uni- and multivariate analysis, the only precatheterization predictor of a nonadditive catheterization was the presence of a restrictive atrial septal defect on echocardiography (OR, 2.6; 95% CI, 1.2–5.9; $p = 0.02$). Furthermore, the only significant predictor of new findings at catheterization was incomplete echocardiographic visualization of the pulmonary pathway (OR, 2.2; 95% CI, 1.0–5.0; $p = 0.03$), and the most common new finding at catheterization was pulmonary artery stenosis (30 patients). Univariate analysis did not identify any independent predictors of important interventions at cardiac catheterization.

Short-Term Postoperative Outcomes

Table 6 summarizes the short-term postoperative outcomes. Of the 162 patients who underwent Fontan completion, the majority (92%) had an intracardiac lateral tunnel Fontan, and nearly all (98%) were fenestrated. There was no short-term (<30 days) postoperative mortality and no Fontan failures requiring a takedown of the Fontan circulation or heart transplant. Three patients (2%) required postoperative mechanical support, and 18 patients (11%) underwent reintervention, defined as repeat operative procedure such as pacemaker implantation or interventional catheterization, within 30 days of surgery.

Of the 18 patients requiring reintervention, 14 underwent postoperative catheterization: 7 patients for dilation or stenting of their Fontan fenestration, 4 patients for other interventions such as coiling of collaterals, and 3 patients for hemodynamic assessments alone. Four patients required placement of a permanent pacemaker, and two patients underwent chest exploration or mediastinal cleanout for bleeding and infection. Some patients had more than one postoperative intervention.

The median of intensive care unit (ICU) stay was 4 days (range, 2–106 days), and the median hospital stay was 10 days (range, 6–180 days). The median duration of mechanical ventilation was 2 days (range, 1–68 days), and the median duration of chest tube drainage was 7 days (range, 3–132 days). Catheterization hemodynamic data were not significantly associated with any of the short-term post-Fontan outcomes assessed, including duration of chest tube drainage, mechanical ventilation, and ICU or hospital stay (data not presented). Clinically additive catheterizations were weakly associated with exclusion from Fontan (10% vs. 3%; $p = 0.08$) but not with length of postoperative hospital stay or reintervention within 30 days.

Discussion

Recently, there has been interest in reexamining the role of routine catheterization before single-ventricle palliative procedures. A retrospective study from our institution suggested that in a subset of patients, routine cardiac catheterization before Glenn operation rarely results in new findings or interventions [4]. A subsequent prospective trial demonstrated that

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cardiac magnetic resonance imaging (MRI) can be used effectively instead of routine catheterization for pre-Glenn evaluation, with fewer complications, lower cost, and similar perioperative and short-term outcomes [5].

Two retrospective studies have also evaluated the role of routine catheterization before Fontan completion. The first study, by Ro et al. [25], indicated that cardiac catheterization might be avoided for a subset of patients undergoing pre-Fontan evaluation. However, a large number of Fontan candidates were excluded from their study, and relatively few pre-Fontan transcatheter interventions were performed at their institution (6% of patients). Thus, the generalizability of their findings regarding the frequency of clinically additive catheterizations to other centers is unclear.

The second study, by Prakash et al. [24], evaluated whether history, echocardiographic data, or angiography alone would provide sufficient preoperative information to predict both candidacy for Fontan completion and postoperative adverse events. They found that their algorithm correctly identified all patients subsequently deemed inoperable, and although the sensitivity and specificity of the algorithm at predicting postoperative outcome was only 51% and 78%, these were not improved by addition of hemodynamic markers from catheterization. However, catheter interventions in their cohort were common (48% of patients), but these were not incorporated into their analyses. Consequently, the actual utility of catheterizations in their study group may be uncertain.

In the large, unselected group of patients presenting to our institution, in which transcatheter interventions are common, we still found that preoperative catheterization was clinically nonadditive for approximately half of the patients. Although transcatheter interventions were common among our patients, a large number of these interventions were considered discretionary by our predetermined criteria. Furthermore, hemodynamic information obtained at catheterization did not predict short-term postoperative outcomes.

Catheterization complications, mostly minor, were also common in this patient population. Appropriate stratification of patients into those who are and those who are not likely to benefit from catheterization could therefore allow a large number of patients to avoid the risks of catheterization, including exposure to ionizing radiation and procedural complications.

For many years, one of the primary indications for pre-Fontan catheterization has been the ascertainment of hemodynamic data [1]. Measurements of ventricular end-diastolic pressure [6], pulmonary artery pressure [18], and pulmonary vascular resistance [15] have been used to identify and exclude patients at risk for a poor post-Fontan outcome. A prior study from our institution found that for patients undergoing a Fontan operation from 1987 through 1991, preoperative pulmonary vascular resistance was associated with early Fontan failure [26]. However, with more contemporary cohorts both in our study and that by Prakash et al. [24], no significant correlation between preoperative hemodynamic data and the short-term post-Fontan outcome variables evaluated was found. Furthermore, only two patients in our current cohort had Fontan surgery postponed on the basis of hemodynamic findings alone: one patient with an elevated end-diastolic pressure of unknown etiology that improved with

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a few weeks of medical therapy and another patient with an elevated end-diastolic pressure and multiple systemic-to-pulmonary collateral vessels who underwent coil occlusion of these vessels then returned for repeat catheterization followed by Fontan completion at a later date. These differences likely reflect evolution in practice and surgical technique over time. Patients in the previous cohort from our institution were older at the time of Fontan (mean age, 3.9 vs. 2.7 years), had fewer prior bidirectional Glenn procedures (13% vs. 93%), and had fewer fenestrated Fontan procedures (63% vs. 98%). Our data suggest that catheterization for the purpose of hemodynamic assessment alone may be avoided for a majority of patients presenting for Fontan completion in the current era.

Another commonly cited indication for pre-Fontan catheterization is the optimization of preoperative hemodynamics and anatomy via transcatheter interventions. In fact, interventions such as arch angioplasty and coil embolization of collateral vessels were common in our cohort (64% of patients), with more than one-third of our patients having “important” interventions according to our predefined criteria. This rate of interventions is considerably higher than in the study by Ro et al. [25] but similar to that reported by Prakash et al. [24]. Our data reflect an institutional bias toward aggressive transcatheter treatment of collateral vessels, pulmonary artery stenosis, and aortic arch obstruction.

For some interventions such as relief of aortic arch obstruction, the clinical benefit is widely accepted [7, 9]. For others, such as coil embolization of systemic-to-pulmonary collaterals, however, data are contradictory or lacking, and no consensus exists in the literature [3, 16, 17, 20, 21]. Until prospective data evaluating the clinical benefit of such interventions are available, however, identifying patients who may benefit from such procedures preoperatively will continue to be an integral part of the pre-Fontan assessment.

Identifying this subgroup of patients, however, continues to be a challenge. In contrast to previous reports, we did not attempt to predefine a low-risk group but rather examined all patients presenting for Fontan to identify predictors of a nonadditive catheterization and were unable to find any such robust predictors. This may have been due, in part, to the fact that we did not exclude patients who could be categorized as requiring catheterization based on history and electrocardiography alone. This included, for example, patients with a history of tachyarrhythmias who required electrophysiologic testing and possible intervention before Fontan. Similarly, patients being considered for higher-risk surgeries, such as a two-ventricle repair, would not be regarded as “routine” candidates for single-ventricle palliation, and for such patients, catheterization may help in stratification to a bi- or univentricular circulation.

Furthermore, our difficulty in finding predictors of a nonadditive catheterization may have been further impaired by the frequent inability of echocardiography to demonstrate the relevant anatomy of this patient population. Adequate noninvasive imaging should help in discriminating between those who should and those who should not undergo catheterization. Patients with significant aortic arch obstruction on noninvasive imaging, for example, could be identified as potentially requiring transcatheter balloon angioplasty. Similarly, those with significant tricuspid regurgitation or ventricular dysfunction may be in the subset of “high-risk” patients for whom hemodynamic assessment at catheterization may allow better

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perioperative planning and management. With echocardiography frequently failing to provide sufficient anatomic information, however, many patients had clinically additive catheterizations on the basis of new anatomic findings not visualized by echocardiography. Indeed, nearly all the new diagnostic findings at catheterization were anatomic, most frequently pulmonary artery stenosis, which echocardiography often was unable to assess. Even among patients with “complete” echocardiograms, catheterization often identified pulmonary artery stenosis not seen by ultrasound so that echocardiographic data were a poor predictor of additive catheterizations.

More comprehensive preoperative imaging may allow better stratification than can be achieved using echocardiography alone by providing better anatomic assessment, thus helping to recognize patients at “high risk” and identifying those who may benefit from transcatheter interventions. Although not evaluated in this study, other studies have shown that cardiac MRI accurately and adequately visualizes anatomic details including mediastinal vessels such as the aortic arch, branch pulmonary arteries, and large systemic-to-pulmonary collateral vessels in patients with congenital heart disease [10–13, 22, 27, 29]. Its preoperative use could, therefore, show additional anatomic abnormalities missed by echocardiography and significantly reduce the need for anatomic assessment by catheterization. It also may identify the patients who may benefit from preoperative transcatheter interventions such as those with significant proximal pulmonary arterial obstruction or large collateral vessels. However, the use of cardiac MRI is not yet a part of the standard preoperative assessment at our institution, and the published data comparing cardiac MRI to cardiac catheterization in this patient population are limited.

One report by Harris et al. [14] retrospectively evaluated whether cardiac MRI assessment of pulmonary arteries could predict postoperative outcomes and found that branch pulmonary artery size on pre-Fontan cardiac MRI was inversely correlated with post-Fontan length of hospital stay. However, half of their patients also underwent cardiac catheterization, but very little data regarding the catheterizations were provided. Moreover, comparisons between those who did and those who did not undergo catheterization were not done. Furthermore, their sample size precluded multivariable analyses accounting for potential confounders that may also be associated with length of hospital stay.

Despite the limited data, however, some centers have already begun to use a preoperative strategy that replaces routine cardiac catheterization with thorough noninvasive assessment using echocardiography and cardiac MRI. The clinical utility and cost effectiveness of this strategy should be evaluated by a prospective clinical trial, especially because robust predictors of nonadditive catheterization are lacking.

Study Limitations

This study was prone to all the limitations inherent in retrospective investigations. However, as a large retrospective review, it provides the background data and highlights the need for a prospective trial.

An additional limitation was the exclusion of patients who did not have both echocardiogram and catheterization at our institution. In so doing, we may have excluded

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patients who had a reassuring outside echocardiogram that was not repeated here before catheterization, thereby omitting a number of “low-risk” patients and falsely elevating the relative frequency of additive catheterizations. However, we also eliminated any potential between-center variability in echocardiographic and catheterization techniques.

A further limitation was the use of an expert panel rather than published data to define “important” transcatheter interventions. Until data regarding the importance of these interventions are available, however, expert opinion is the only available standard. By convening a panel that crossed disciplines within our program, we created a set of criteria that would be acceptable to many cardiologists and surgeons.

Finally, as a single-center report from our institution that relies heavily on transcatheter treatment of anatomic abnormalities as well as routine fenestration of the Fontan pathway, our results may not be strictly applicable to other centers who prefer alternative management strategies.

Conclusions

In this large retrospective study from a single institution, the pre-Fontan catheterization was not clinically additive for approximately half of the patients. Hemodynamic data were not associated with short-term postoperative outcomes. However, echocardiography often provided incomplete anatomic information, and transcatheter interventions were common and frequently not predicted by the echocardiographic findings. Thus, although at least 50% of patients presenting for Fontan completion may be able to avoid routine catheterization safely, an echocardiography-based imaging strategy alone is insufficient to allow proper identification of those who could be evaluated noninvasively. A prospective study is needed to assess whether careful patient selection and a more comprehensive imaging strategy will allow targeted referral of more appropriate patients for pre-Fontan catheterization and help in evaluating the efficacy of preoperative transcatheter interventions.

Acknowledgments

This work was supported by the Higgins Family Noninvasive Imaging Research Fund and The National Institutes of Health under award number: T32HL007572.

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Table 1

Criteria used to categorize interventions as important by expert panel consensus

Intervention type	Criteria for nondiscretionary interventions[a]
Hemodynamic[b] testing	Necessary
Electrophysiology studies	Necessary
Pulmonary vein angioplasty	Necessary
Aortic arch angioplasty	Significant obstruction (peak gradient ≥15 mmHg or ≥50% luminal narrowing), even with normal hemodynamics and function
	Or
	Mild obstruction (peak gradient = 10–14 mmHg or 30–50% luminal narrowing) and evidence of hemodynamic compromise (≥moderate systemic ventricular dysfunction, filling pressures ≥14 mmHg, or calculated cardiac index ≤2.5 l/min/m^2)
Pulmonary artery balloon angioplasty	Significant pulmonary artery obstruction (≥50% angiographic obstruction or gradient ≥2 mmHg) in an arterial segment not normally accessible to surgical plasty at Fontan (e.g., peripheral pulmonary vessels)
Venovenous collateral coiling	A systemic-to-systemic venous collateral measuring >2 mm in patients not going on to either Fontan or biventricular repair surgery
	Or
	A systemic-to-pulmonary venous collateral (or other effective right-to-left shunting collateral) measuring >2 mm
Systemic-to-pulmonary collateral coiling	Systemic-to-pulmonary arterial collaterals to a lobar lung segment supplied by a patent pulmonary artery that does not receive antegrade flow on pulmonary arterial angiography
	Or
	Systemic-to-pulmonary arterial collaterals in the setting of ventricular end-diastolic pressure >14 mmHg with no other anatomic or functional cause for elevated end-diastolic pressure
Other interventions	Evidence of significant hemodynamic effect of the lesion, coupled with poor accessibility to the surgeon and no likelihood of improved accessibility after the Fontan operation

[a] Interventions not meeting these thresholds were considered discretionary

[b] Includes vasodilator testing (oxygen, inhaled nitric oxide) and test occlusion of atrial septal defects

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Table 2

Echocardiographic findings (n = 175)

	***n* (%)**
Complete echocardiogram	60 (34)
Incomplete visualization of the branch pulmonary arteries	100 (57)
Echocardiograms with patient under sedation	118 (67)
Branch pulmonary artery or Glenn obstruction	27 (15)
≥Moderate systemic atrioventricular valve regurgitation	27 (15)
≥Moderate systemic ventricular dysfunction	12 (7)
≥Moderate aortic arch obstruction	5 (3)
Restrictive or absent atrial septal defect	4 (2)
Pulmonary vein stenosis	4 (2)

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Table 3

Results of catheterization (n = 175)

Hemodynamic data	
Superior vena cava saturation	63 ± 7%
Cardiac index	3.5 ± 1.0 l/min/m^2
Common atrial pressure	9 ± 3 mmHg
Systemic ventricular end-diastolic pressure	10 ± 3 mmHg
Mean pulmonary artery pressure	13 ± 4 mmHg
Pulmonary resistance	1.9 ± 0.8 WU
New diagnostic findings affecting management[a]: n (%)	
Total	48 (27)
Glenn pathway or pulmonary artery stenosis	30 (17)
Persistent left superior vena cava	10 (6)
Pulmonary venous anomaly	4 (2)
Aortic arch obstruction	2 (1)
Hemodynamic abnormalities[b]	2 (1)
Other[c]	4 (2)
Interventions performed: n (%)	
Any intervention	112 (64)
At least one “important” intervention	64 (37)

[a] Some patients had more than one new finding at catheterization

[b] Unexplained elevated end-diastolic pressure of 17 mmHg (n = 1), elevated pulmonary artery pressure of 20 mmHg in a patient with significant bilateral systemic-to-pulmonary collaterals (n = 1)

[c] Relationship between ventricular septal defect and pulmonary artery (n = 1), subaortic stenosis (n = 1), large leak in hemi-Fontan patch (n = 1), right ventricular aneurysm (n = 1)

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Table 4

Interventions at catheterization

Intervention type	Discretionary *n* (%)	Important *n* (%)	Total *n* (% of patients)
Hemodynamic testing	–	–	–
Electrophysiology studies	–	9	9 (5)
Pulmonary vein angioplasty	–	2	2 (1)
Aortic arch angioplasty	2	6	8 (5)
Pulmonary artery angioplasty	9	3	12 (7)
Venovenous collateral coiling	10	18	28 (16)
Systemic-to-pulmonary collateral coiling	51	34	85 (49)
Other interventions	6	1[a]	7 (4)
Any interventions: *n* (% of patients)	49 (28%)[b]	64 (37%)[c]	112 (64)

[a] Creation of a ventricular septal defect in a patient with a severely hypertensive left ventricle not amenable to surgical treatment

[b] Catheterizations where all interventions were deemed discretionary

[c] Catheterizations where at least one intervention was deemed important. Some catheterizations had more than one important intervention

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Table 5

Complications of catheterization

	n **(%)**
Minor complications[a]	51 (29)
Acidosis (pH <7.25)	20 (11)
Transient access-site complications[b]	19 (11)
Blood product transfusion	11 (6)
Intensive care unit admission	8 (5)
Arrhythmia >30 s or requiring therapy	6 (3)
Unplanned intubation	5 (3)
Initiation of vasopressor medications	2 (1)
Laryngospasm	2 (1)
Stridor	2 (1)
Pneumonia	2 (1)
Major complications	4 (2)
Pneumothorax/hemothorax requiring chest tube	3 (2)
Cardiac arrest[c]	1 (1)

[a] Some patients had more than one minor complication

[b] Self-resolved access-site hematomas and transient loss of distal pulse

[c] See text for details

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Table 6

Fontan surgical outcomes (n = 162)

	***n* (%)**
Type of Fontan procedure	
Intracardiac	149 (92)
Extracardiac	13 (8)
Fenestrated Fontan procedures	158 (98)
Additional procedures at time of Fontan[a]	73 (45)
Pulmonary artery plasty	24 (15)
Atrioventricular valve plasty	19 (12)
Main pulmonary artery division	14 (9)
Atrial septal defect enlargement	10 (6)
Other[b]	21 (13)
Short-term (<30 days) postoperative outcomes	
Mortality	0
Fontan failure[c]	0
Need for mechanical circulatory support	3 (2)
Need for reintervention	18 (11)
Catheterization	14 (9)
Pacemaker implantation	5 (3)
Mediastinal exploration	2 (1)

[a] Some patients had more than one additional procedure

[b] Including electrophysiology procedures such as pacemaker implantation (n = 7), right ventricular plication (n = 3), pulmonary vein surgery (n = 3), aortic arch plasty (n = 2), and other miscellaneous procedures (n = 8)

[c] Defined as the need for Fontan takedown or transplantation

Capture of Complexity of Specialty Care in Pediatric Cardiology by Work RVU Measures

WHAT'S KNOWN ON THIS SUBJECT: Few reports have explored the measurement validity of the relative value unit (RVU) system, particularly in pediatrics. The RVU system, although broadly applied in health care settings, was developed for the adult population and thus may possess unique inadequacies in pediatrics.

WHAT THIS STUDY ADDS: We found deficiencies in the ability of the RVU system to capture features of case mix complexity and differences related to age. Additional investigation may be warranted to determine the validity of RVU as a measurement tool in pediatrics.

abstract

OBJECTIVE: We sought to determine the relationship between relative value units (RVUs) and intended measures of work in catheterization for congenital heart disease.

METHODS: RVU was determined by matching RVU values to Current Procedural Terminology codes generated for cases performed at a single institution. Differences in median case duration, radiation exposure, adverse events, and RVU values by risk category and cases were assessed. Interventional case types were ranked from lowest to highest median RVU value, and correlations with case duration, radiation dose, and a cases-predicted probability of an adverse event were quantified with the Spearman rank correlation coefficient.

RESULTS: Between January 2008 and December 2010, 3557 of 4011 cases were identified with an RVU and risk category designation, of which 2982 were assigned a case type. Median RVU values, radiation dose, and case duration increased with procedure risk category. Although all diagnostic cases had similar RVU values (median 10), adverse event rates ranged from 6% to 21% by age group ($P < .001$). Median RVU values ranged from 9 to 54 with the lowest in diagnostic and biopsy cases and increasing with isolated and then multiple interventions. Among interventional cases, no correlation existed between ranked RVU value and case duration, radiation dose, or adverse event probability ($P = .13$, $P = .62$, and $P = .43$, respectively).

CONCLUSIONS: Time, skill, and stress inherent to performing catheterization procedures for congenital heart disease are not captured by measurement of RVU alone. *Pediatrics* 2013;131:258–267

AUTHORS: Lisa Bergersen, MD MPH, Kimberlee Gauvreau, ScD, Doff McElhinney MD, Sandra Fenwick MPH, David Kirshner MPA, CPA, Julie Harding, CPC, Patricia Hickey, PhD, MBA, RN, FAAN, John Mayer, MD, and Audrey Marshall, MD

Children's Hospital Boston, Harvard Medical School, Boston, Massachusetts

KEY WORDS

RVU, congenital heart disease, catheterization, outcomes

ABBREVIATIONS

AE—adverse event
ASD—atrial septal defect
CHARM—Congenital Heart Disease Adjustment for Risk Method
CPT—Current Procedural Terminology
PDA—patent ductus arteriosus
RUC—Relative Value Update Committee
RVU—relative value unit

All of the authors made substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; participated in drafting the article or revising it critically for important intellectual content; and provided final approval of the version to be published.

www.pediatrics.org/cgi/doi/10.1542/peds.2012-0043

doi:10.1542/peds.2012-0043

Accepted for publication Oct 4, 2012

Address correspondence to Lisa Bergersen, MD, MPH, Department of Cardiology, The Children's Hospital, 300 Longwood Ave, Boston, MA . E-mail: lisa.bergersen@cardio.chboston.org

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: *The authors have indicated they have no financial relationships relevant to this article to disclose.*

FUNDING: The John F. Keane Fund, which provides support for research in the interventional catheterization division of Children's Hospital Boston.

COMPANION PAPER: A companion to this article can be found on page 340, and online at www.pediatrics.org/cgi/doi/10.1542/peds.2012-1434.

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In the 1980s, reform of the traditional physician payment system was prioritized by the US government, physicians, insurers, and patients. An alternative system developed at the Harvard School of Public Health, based on resource-input costs, was proposed, enacted into federal law (Omnibus Budget Reconciliation Act 1989), and subsequently implemented in 1992 by the Health Care Financing Administration, which changed the Medicare Fee Schedule to a system based on the concept of the relative value of work.[1,2]

Absent any previous attempts to quantify physician work except for the California relative value scale, investigators began by attempting to determine physician work associated with specific services. The specific services were identified, of convenience, by Current Procedural Terminology (CPT)-4. Physicians were surveyed as to relative work for CPT-defined services taking into account 4 components: time spent, skill required (technical and cognitive), and stress incurred. Of the 7000 CPT-coded services at the time, ~400 were studied and results were extrapolated to the remainder. The results of the physician estimates of relative amounts of work, relative value units (RVUs), were found to be reasonable and consistent.

It was understood that this scale was provisional and subject to change; thus, by congressional mandate, the RVU system and scale are reassessed every 5 years. In addition, the Relative Value Update Committee (RUC) meets 3 or 4 times each year to consider requests to revalue procedures and assign values to new procedures.[3,4] Soon after the development of the RVU system, most payers adopted the fee schedule established by the Health Care Financing Administration.[5] Some health care institutions use the scale to determine the value of physician work and, in some cases, to determine reimbursement relative to other health care providers.[6–8]

TABLE 1 Example Cases, Corresponding CPT Codes, and RVU Values

Case	CPT	RVU	Definition
Biopsy case after heart transplant	93505	4.37	Endomyocardial biopsy
	93530	4.22	Right heart catheterization for congenital anomalies
Biopsy case after heart transplant with coronary angiography	93505	4.37	Endomyocardial biopsy
	93530	4.22	Right heart catheterization for congenital anomalies.
	93545	0.4	Injection for coronary angiography
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Diagnostic case–1-y-old preoperative assessment	93531	8.34	Combined right/retro left heart catheterization for congenital anomalies
	93542	0.29	Injection procedure for right ventricular or right atrial
	93544	0.25	Injection procedure for aortography.
	93555	0.81	Radiologic angiography for ventricular and/or atrial
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Diagnostic case–50 y after tetralogy of Fallot repair with left ventricle dysfunction	75710	1.14	Angiography, unilateral extremities
	75710	1.14	Angiography, unilateral extremities
	93531	8.34	Combined right/retro left heart catheterization for congenital anomalies
	93542	0.29	Injection procedure for right ventricular or right atrial
	93544	0.25	Injection procedure for aortography
	93555	0.81	Radiologic angiography for ventricular and/or atrial
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Isolated interventional case–ASD closure	93580	17.97	Percutaneous closure of septal defect with implant
isolated interventional case–aortic valvuloplasty	92986	22.85	Percutaneous balloon valvoplasty aortic
	93510	4.32	Left heart catheterization retro
	93543	0.29	Injection procedure for left ventricular or left atrial angiography
	93544	0.25	Injection procedure for aortography
	93555	0.81	Radiologic angiography for ventricular and/or atrial
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Isolated interventional case–pulmonary valvuloplasty	92990	18.27	Percutaneous balloon valvoplasty pulmonary artery
	93531	8.34	Combined right/retro left heart catheterization for congenital anomalies
	93541	0.29	Injection procedure for pulmonary angiography
	93542	0.29	Injection procedure for right ventricular or right atrial
	93544	0.25	Injection procedure for aortography
	93545	0.4	Injection for coronary angiography
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Multiple interventions–3 y old single ventricle after Fontan	37204	18.11	Trans-catheter occlusion of vascular malformation
	75710	1.14	Angiography, unilateral extremities
	75827	1.14	Venography superior vena cava
	75894	1.31	Trans-catheter radiologic and supervision of occlusion of vascular malformation

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TABLE 1 Continued

Case	CPT	RVU	Definition
	92997	11.98	Percutaneous balloon angioplasty of pulmonary artery
	93541	0.29	Injection procedure for pulmonary angiography
	93542	0.29	Injection procedure for right ventricular or right atrial
	93544	0.25	Injection procedure for aortography
	93556	0.25	Injection procedure for aortography
	93580	17.97	Percutaneous closure of septal defect with implant
Multiple interventions–49 y old single ventricle patient with failing Fontan	37205	8.27	Trans-catheter placement intravascular stent
	75960	0.82	Radiologic intravascular stent placement
	92997	11.98	Percutaneous balloon angioplasty of pulmonary artery
	93530	4.22	Right heart catheterization for congenital anomalies
	93541	0.29	Injection procedure for pulmonary angiography
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography
Multiple interventions–3 mo patient with single ventricle and pulmonary vein stenosis	35476	6.03	Venous balloon angioplasty (dilation)
	75827	1.14	Venography superior vena cava
	75978	0.54	Radiologic imaging of venous angioplasty
	92997	11.98	Percutaneous balloon angioplasty of pulmonary artery
	93539	0.4	Injection selected arterial conduits
	93541	0.29	Injection procedure for pulmonary angiography
	93542	0.29	Injection procedure for right ventricular or right atrial
	93543	0.29	Injection procedure for left ventricular or left atrial angiography
	93544	0.25	Injection procedure for aortography
	93555	0.81	Radiologic angiography for ventricular and/or atrial
	93556	0.83	Imaging for pulmonary aortagraphy, coronary and bypass grafts angiography

The potential inaccuracy of applying adult-based RVUs to pediatric practice was immediately recognized by pediatric specialties and professional organizations. In the early 1990s, 81 congenital heart operations were assigned CPT codes and corresponding RVUs. These RVUs were found to be reasonable relative measures of physician work in a validation study by Jenkins et al.[9] However, in these same patients, catheterization procedures involving an increasingly diverse set of therapeutic interventions have not systematically been assigned RVUs.

Since the inception of the RVU scale, few studies have questioned the relationships between the assigned RVU and the time, skill, and stress, which the RVU values are intended to capture. We suspected that the CPT-based RVU assignment method did not accurately reflect the unique physician work component among catheterization procedures for congenital heart disease. To test this proposition, we used available proxies for physician time, skill, and stress. Time was relatively straightforward to quantify and we simply chose case times. For skill, we considered the amount of radiation required as a surrogate for the amount of information obtained and processed during the procedure, and for technical skill, we used the number of interventions. Stress is clearly less quantifiable, and therefore we assumed that stress was higher in cases with a known higher incidence of adverse events (AEs). We considered that in the relatively young field of pediatric catheterization, where many of the procedures have only become common practice in the period since the inception of the RVU system, the CPT-based RVU system might be uniquely inadequate to measure the intended components of relative value.

METHODS

Database

The database maintained in the Children's Hospital Boston cardiac catheterization laboratory for reporting and quality assessment was queried for this study. This is a prospectively collected database that includes patient and procedural characteristics as well as a record of AEs.[10] Patient characteristics collected included age, gender, diagnosis, and presence of a genetic or noncardiac comorbidity. Type of case, admission type, method of airway management, types of interventions, duration of case (defined as time sheaths were inserted until removed), fluoroscopy dose-area product (μGy · m^2), and AEs were reported in this cohort. AEs were classified according to the International Pediatric Congenital Cardiac Code catheterization complication nomenclature 5 scale severity ranking[11] in which severity level 3, 4, and 5 classified events are high severity and potentially life-threatening events.

RVU

In the catheterization database, all angiograms, interventions, and type of diagnostic procedure performed are recorded and linked to CPT codes. Angiograms are assigned the most appropriate CPT codes by site. Types of

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interventions and sites are chosen at the time the catheterization procedure according to an intervention list similar to the nomenclature developed by the International Pediatric Congenital Cardiac Code, published in 2011.[12] In some cases, specific CPT codes exist for highly specific interventions such as atrial septal defect (ASD) closure, Fontan fenestration closure, and patent ductus arteriosus (PDA) closure. In other cases such as angioplasty and stent placement, interventions may be performed in very dissimilar patients in a variety of vascular sites but have common CPT codes. All cases were assigned an acquired or congenital diagnostic procedure code for right and/or left catheterization as appropriate.

RVU values available from the 2010 National Physician CMS Fee Schedule Relative Value File were matched to corresponding CPT codes (copyright 2009 by the American Medical Association). We calculated the RVU value for cases in the CHB catheterization database by matching the RVU value to the CPT codes generated for the case. Examples of cases, designated CPT codes, and corresponding RVU values are provided in Table 1. The database was queried for diagnostic, interventional, or biopsy cases performed from January 1, 2008, to December 31, 2010. Six cases with an RVU value of 0 and 329 cases with a CPT code of 93799 or 92992, which do not have an assigned RVU value, were excluded from the cohort of 4011 for a sample of 3676 cases.

Risk Category

Risk categories were originally created as a way of grouping a relatively large number of diverse and sometimes infrequently encountered procedures into categories with similar risk of AEs (Table 2).[10,13] Categories were developed by using expert judgment and empirical methods in a derivation cohort and validated in a prospective cohort in the Congenital Cardiac Catheterization Project on Outcomes database. A case is assigned to 1 category based on the characteristics of the case; for diagnostic procedures the cases are stratified by age group. If 1 or more interventions are performed, the case is assigned to the highest category. The categories have a strong association with the occurrence of clinically important AEs; therefore, although this association has not been tested, we considered them a surrogate for physician stress associated with performing a procedure. Of the 3676 cases meeting inclusion criteria, 119 could not

TABLE 2 Risk Categories

Diagnostic Case	Risk Category 1	Risk Category 2	Risk Category 3	Risk Category 4
	Age ≥1 y	Age ≥1 mo <1 y	Age <1 mo	
Valvuloplasty		Pulmonary valve ≥1 mo	Aortic valve ≥1 mo Pulmonary valve <1 mo Tricuspid valve	Mitral valve Aortic valve <1 mo
Device or coil closure	Venous collateral LSVC	PDA ASD or PFO Fontan fenestration Systemic-to-pulmonary artery collaterals	Systemic surgical shunt Baffle leak Coronary fistula	VSD Perivalvar leak
Balloon angioplasty		RVOT Aorta dilation <8 ATM	Pulmonary artery <4 vessels Pulmonary artery ≥4 vessels all <8 ATM Aorta >8 ATM or CB Systemic artery (not aorta) Systemic surgical shunt Systemic-to-pulmonary collaterals Systemic vein	Pulmonary artery ≥4 vessels Pulmonary vein
Stent placement		Systemic vein	RVOT Aorta Systemic artery (not aorta)	Ventricular septum Pulmonary artery Pulmonary vein Systemic surgical shunt Systemic pulmonary collateral
Stent redilation		RVOT Atrial septum Aorta Systemic artery (not aorta) Systemic vein	Pulmonary artery Pulmonary vein	Ventricular septum
Other	Myocardial biopsy	Snare foreign body Trans-septal puncture	Atrial septostomy Recanalization of jailed vessel in stent Recanalization of occluded vessel	Atrial septum dilation and stent Any catheterization <4 d after surgery Atretic valve perforation

ATM, atmospheres; CB, cutting balloon; LSVC, left superior vena cava; PFO, patent foramen ovale; RVOT, right ventricular outflow tract.

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TABLE 3 Group Designation and Case Types

Group	Case Type (long definition)	Case Type (short definition)
0	RV biopsy elective post transplant (isolated)	RV biopsy
	Diagnostic catheterization	Diag cath
1	Proximal right or left angioplasty and or stent only (exclude RVOT intervention)	Proximal right or left PA
	RVOT dilation and or stent (no PA angioplasty)	RVOT only
	Aorta dilation and or stent	Aorta
	Any pulmonary vein dilation	Pulmonary vein
	Pulmonary valvotomy (isolated)	Pulmonary valve
	Aortic valvotomy (isolated)	Aortic valve
	ASD or PFO closure (isolated)	ASD/PFO closure
	PDA device or coil closure	PDA closure
	Fenestration device closure (isolated)	Fenestration closure
2	Two or more proximal or distal right or left angioplasty and or stent (excluded RVOT intervention)	≥Pulmonary arteries
	RVOT dilation and or stent and proximal right or left angioplasty and or stent	RVOT + proximal PA
	RVOT dilation and or stent and two or more proximal or distal right or left angioplasty and or stent (excluded RVOT intervention)	RVOT ≥pulmonary arteries
	Pulmonary valvotomy and another intervention	Pulmonary valve+
	Aortic valvotomy and another intervention	Aortic valve+
	ASD or PFO closure and another intervention	ASD/PFO+
	Fenestration device closure and another intervention	Fenestration+

PA, pulmonary artery; RV, right ventricular; RVOT, right ventricular outflow tract.

TABLE 4 Patient and Procedure Characteristics (N = 3557)

Patient Characteristics	No. (%)
Age	
<1 mo	203 (6)
1 mo to <1 y	612 (17)
1–17 y	2122 (60)
≥18 y	620 (17)
Gender male	1899 (53)
Diagnosis[a]	
Complex defect with 2 ventricles	1399 (39)
Complex defect with 1 ventricle	606 (17)
Isolated defects	603 (17)
No structural heart disease[b]	873 (25)
Pulmonary hypertension	73 (2)
Genetic syndrome	477 (13)
Noncardiac comorbidity	1256 (35)
Procedural characteristics	
Procedure type	
Interventional	1953 (55)
Diagnostic	880 (25)
Biopsy	724 (20)
Admission type	
Elective	2849 (80)
Nonelective or emergent	708 (20)
Spontaneous respiration	1271 (36)
Risk category	
1	1354 (38)
2	901 (25)
3	822 (23)
4	480 (13)
Case duration[c]	76 [45, 114] (10, 761)
Any AE	514 (14)
Any high severity AE (level 3–5)	187 (5)

[a] Missing in 3.
[b] For example, myopathy or status post heart transplantation.
[c] Time from sheath insertion to removal.

be assigned a risk category, so the final sample size for analysis was 3557.

Case Groups

Cases were also grouped for this study according to technical skill required and number of interventions. Diagnostic catheterization and myocardial biopsy without additional interventions were designated group 0. Group 1 included interventional procedures with a single intervention, and group 2, interventional procedures with more than 1 intervention. Among the 3557 cases in the Children's Hospital Boston data set (2008–2010) with RVU values and designated risk category, 2982 case types (84%) could be assigned to 1 of these groups. The analysis by case type is limited to this subcohort (Table 3). Examples of case types performed infrequently and not captured in the subcohort (n = 575) include isolated distal pulmonary artery interventions, angioplasty or stenting in vessels or shunts other than the aorta, aorta stent redilation, intracardiac angioplasty or stenting, isolated coil occlusions, and mitral valvuloplasty.

Statistical Analysis

Cohort characteristics were summarized by frequency and percentage for categorical variables and by median and interquartile range for continuous variables. Comparisons of median case duration, radiation exposure, AE rates, and RVU across procedure risk categories were performed by using the Kruskal-Wallis test. RVU values were summarized for 18 case types and by the 3 groups and reported as mean, SD, median, minimum, maximum, and interquartile range.

AE rates, case duration, radiation exposure, and RVU values were also calculated and compared among diagnostic catheterization cases stratified by age group (neonates <1 month, infants 1 month to 1 year, children >1 year, and adults >18 years).

The 16 interventional case types were ranked from lowest to highest median RVU value, and the relationship between case ranking by median RVU value and the following characteristics were explored: median duration of case, median radiation dose, and median predicted probability of an AE. The predicted probability of an AE was calculated for each case using the Congenital Heart Disease Adjustment for Risk Method (CHARM) risk adjustment model, which is based on the assigned risk category, indicators of hemodynamic vulnerability, and age <1 year.[14] Associations between ranked interventional case types and each measure were quantified by using the Spearman rank correlation coefficient.

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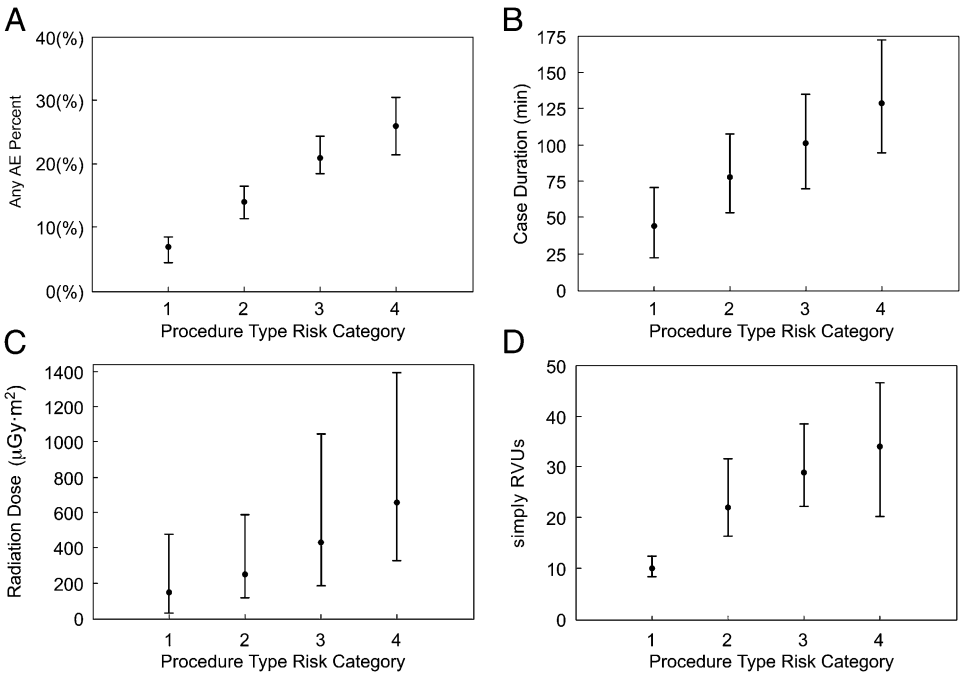


FIGURE 1

Proportion and 95% confidence interval for any AE (A) and median (interquartile range) for case duration (B), radiation dose (C), and RVU (D) by risk category; for all comparisons, $P < .001$.

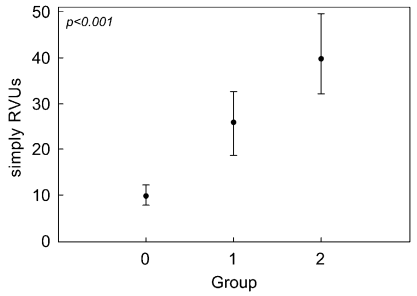


FIGURE 2

Median (interquartile range) RVU value for case groups 0, 1, and 2 as detailed in Table 3.

RESULTS

Patient and procedure characteristics for this population are summarized in Table 4. Most of the population had complex congenital heart disease, with either 2 ventricles (39%) or single ventricle physiology (17%). Most cases were scheduled electively (80%). The largest proportion of cases were classified as interventional (55%). Among the remaining, 25% were classified as diagnostic, which may have involved hemodynamic and/or angiographic assessment, and 20% as myocardial biopsy after heart transplantation. There was a wide range in case duration. At least 1 AE of any severity was recorded in 14% of cases, and high severity level 3, 4, or 5 events occurred in 5% of cases.

Risk Category

The largest proportion of cases were ranked in the lowest risk category (n = 1354 [38%]) and were composed mostly of diagnostic cases in patients >1 year of age, as well as those undergoing myocardial biopsy. The remaining cases were diagnostic cases in patients <1 year of age and cases involving single or multiple interventions in decreasing frequency by risk category (risk category 2 = 25%, 3 = 23%, and 4 = 13%). Procedure time, radiation dose, AE rates, and median RVU value increased by risk category (all $P < .001$) (Fig 1).

Case Group

The associated median RVU value for case group 0 (diagnostic catheterization and myocardial biopsy), 1 (interventional catheterization, single intervention), and 2 (interventional catheterization with >1 intervention) is shown in Fig 2. Median RVU increased according to groups with broader interquartile ranges among more complex and heterogeneous groups 2 and 3 (Table 5). Isolated interventions, such as closure of an ASD, PDA, or fenestration and aortic or pulmonary valvuloplasty, had similar median RVU values to one another compared with those involving multiple interventions ($P < .001$ for the 3-group comparison).

Diagnostic Cases

Diagnostic procedures composed 25% of the cohort in 885 patients over a wide age range from infants to adults (Table 6). Radiation dose per unit of time increases as a function of body surface area; thus, older patients had higher radiation doses during similar length procedures. But although case duration was similar among age groups, there were significant differences in AE rates, the surrogate used for stress in this study ($P < .001$). Despite this difference in risk associated with the procedure, all the diagnostic cases were assigned similar RVU values (Table 6, Fig 3).

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Interventional Cases

The largest proportion of patients (55%) in this cohort underwent interventional procedures with varied case types and associated RVU values. Interventional cases were ordered from lowest to highest median RVU value, and procedure characteristics are summarized (Table 7). Among these different types of procedures, no correlation existed between ranked RVU value and median procedure time, radiation dose, or the predicted probability of an AE as calculated for each case type using the CHARM method (Fig 4).

DISCUSSION

The relative value of physician work is determined through consensus methods by considering the time associated with the encounter, the amount of related stress, and the amount of required technical and cognitive skill.[3] In this study, we found that in the field of pediatric cardiac catheterization, RVU values did not capture intended elements of RVU (time, skill, and stress) among interventional cases or discriminate among important differences by patient age. Thus, the established RVU system does not reflect all the intended elements of work for patients undergoing catheterization for congenital heart disease. We propose that either new RVUs are generated or additional metrics be considered when measuring the complexity of work in this pediatric specialty care service.

After widespread adoption of the RVU scale, and to address inadequacies of the RVU system, the Society for Thoracic Surgeons recommended to the AMA CPT Editorial Panel several new codes to more correctly describe congenital heart surgery procedures. Once these were adopted for CPT, the Society for Thoracic Surgeons conducted surveys to establish work values for the entire group of congenital heart surgery codes and presented these recommended work values to the RUC. These codes were then given value by using standard methods based on consensus and relative value compared with other established procedures; later the utility of these codes was supported by work showing correlation with mortality, length of stay, and charges in congenital heart surgery.[9]

In catheterization for congenital heart disease, CPT codes (93530–93533) and associated RVU values for basic diagnostic cases without intervention have been established and were reviewed and revised by the RUC in 2010. Codes have also been established for a few common predictable and well-circumscribed procedures for placement in interatrial communications, including ASD, PFO, and Fontan fenestrations (CPT 93580). Nevertheless, due to the complexity and diversity of procedures performed in congenital cardiac catheterization and the sparse number of codes specific to the treatment of congenital heart disease, values for many of the interventional procedure codes have been extrapolated from codes developed for procedures performed in adults by cardiologists and interventional radiologists. For example, CPT codes 92997 and 92998 (transcutaneous pulmonary artery balloon angioplasty) are used for both angioplasty and stent redilation at multiple sites, including proximal pulmonary arteries, distal pulmonary arteries, aortopulmonary collaterals, and conduits. Despite a common procedural code, there is considerable variation among these interventions and potentially the expected complexity by site.

TABLE 5 RVU Values by Group (N = 2982)

Group	Case Type	N	RVU		
			Mean ± SD	Min–Max	Median [IQR]
0	RV biopsy	696	10 ± 2	6–18	9 [9,10]
	Diagnostic catheterization	880	10 ± 4	1–59	11 [9,12]
1	Proximal right or left PA	172	38 ± 28	14–202	28 [22,44]
	RVOT only	126	30 ± 12	16–111	29 [23,36]
	Aorta	127	28 ± 16	14–117	21 [19,30]
	Pulmonary vein	83	28 ± 27	14–164	19 [17,24]
	Pulmonary valve	100	27 ± 2	24–33	28 [25,29]
	Aortic valve	85	33 ± 2	29–37	33 [33,34]
	ASD/PFO closure	154	20 ± 5	18–41	18 [18,19]
	PDA closure	89	30 ± 4	22–50	29 [29,30]
	Fenestration closure	16	22 ± 2	20–26	22 [21,23]
2	≥2 Pulmonary arteries	309	43 ± 15	18–108	40 [33,50]
	RVOT + proximal PA	46	35 ± 10	23–81	32 [29,38]
	RVOT ≥2 pulmonary arteries	50	45 ± 12	30–108	44 [38,50]
	Pulmonary valve +	8	50 ± 18	38–92	44 [40,49]
	Aortic valve +	5	52 ± 5	46–57	54 [48,55]
	ASD/PFO +	6	57 ± 35	27–124	42 [40,64]
	Fenestration +	30	46 ± 19	23–121	40 [33,49]

IQR, interquartile range; PA, pulmonary artery; PFO, patent foramen ovale; RV, right ventricular; RVOT, right ventricular outflow tract.

TABLE 6 Diagnostic Case Characteristics by Age

Age Group	No. (%)	AE,%	Case Duration		Dose (μGy · m^2)		RVU Median [IQR]
			Mean ± SD	Median [IQR]	Mean ± SD	Median [IQR]	
<1 mo	92 (10)	21%	62 ± 31	57 [38, 86]	120 ± 83	101 [63, 160]	11 [9, 12]
1 mo to <1 y	175 (20)	11%	79 ± 63	71 [49, 90]	450 ± 125	126 [75, 173]	11 [9, 12]
1–17 y	451 (51)	6%	69 ± 34	63 [44, 87]	355 ± 488	190 [100, 412]	11 [9, 12]
> 18 y	167 (19)	12%	77 ± 38	73 [53, 103]	1528 ± 1434	1185 [461, 2114]	11 [9, 12]

IQR, interquartile range.

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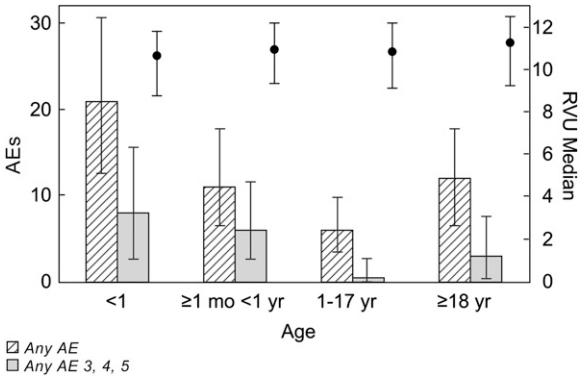


FIGURE 3
Median (interquartile range) RVU value and AE rates with 95% confidence interval shown for neonates (<1 month), infants (≥ 1 month, <1 year), older children (≥1 and <17 years), and adults (≥18 years) for diagnostic catheterization cases.

TABLE 7 Interventional Case With Characteristics Sorted by Median RVU

Case Type	Median RVU	Case Duration Median [IQR]	Dose (μGy · m^2) Median [IQR]	Predicted Probability of Any AE	Predicted Probability of High AE
ASD/PFO	18	64 [51, 84]	577 [292, 1148]	0.12 [0.12, 0.12]	0.04 [0.04, 0.04]
Pulmonary vein	19	140 [116, 172]	466 [340, 689]	0.27 [0.25, 0.29]	0.11 [0.10, 0.13]
Aorta	21	80 [67, 118]	446 [152, 1659]	0.18 [0.17, 0.22]	0.08 [0.06, 0.10]
Fenestration	22	117 [99, 128]	329 [242, 564]	0.12 [0.12, 0.12]	0.04 [0.04, 0.04]
Pulmonary valve	28	61 [45, 89]	103 [67, 251]	0.17 [0.13, 0.25]	0.06 [0.05, 0.12]
Proximal right or left PA	28	114 [88, 142]	496 [306, 1060]	0.22 [0.18, 0.25]	0.09 [0.08, 0.11]
RVOT no PA	29	110 [91, 136]	796 [284, 1833]	0.18 [0.13, 0.20]	0.08 [0.05, 0.09]
PDA closure	29	61 [46, 78]	167 [111, 300]	0.12 [0.12, 0.13]	0.04 [0.04, 0.05]
RVOT + Prox	32	122 [89, 158]	914 [304, 2746]	0.18 [0.18, 0.23]	0.08 [0.08, 0.10]
Aortic valve	33	79 [63, 105]	243 [137, 461]	0.22 [0.18, 0.25]	0.09 [0.08, 0.12]
≥2 Prox R/L	40	132 [100, 168]	722 [433, 1473]	0.25 [0.21, 0.27]	0.10 [0.09, 0.11]
Fenestration +	40	127 [98, 172]	572 [360, 897]	0.12 [0.12, 0.16]	0.04 [0.04, 0.05]
ASD/PFO +	42	97 [61, 189]	778 [394, 1250]	0.16 [0.15, 0.18]	0.06 [0.05, 0.08]
RVOT + ≥2 prox	44	149 [117, 172]	853 [436, 2183]	0.23 [0.20, 0.26]	0.10 [0.08, 0.11]
Pulmonary valve +	44	101 [90, 181]	329 [255, 555]	0.17 [0.13, 0.22]	0.06 [0.04, 0.09]
Aortic valve +	54	173 [108, 182]	356 [302, 665]	0.27 [0.22, 0.29]	0.11 [0.09, 0.13]

IQR, interquartile range; PA, pulmonary artery; PFO, patent foramen ovale; RVOT, right ventricular outflow tract.

This variability in intervention types and patient populations may partially explain why assigned RVU values did not correlate with case duration, radiation dose, and anticipated AE occurrence (Fig 4). As an example, pulmonary vein dilation cases, designated in risk category 4, include some of the most ill and vulnerable patients encountered in the field and require one of the most technically challenging procedures performed in congenital cardiac catheterization. However, ASD closure (risk category 2), which is a single isolated, short, and often predictable intervention in a relatively healthy patient population, has a similar RVU value. Despite these important shortcomings, some aspect of risk was captured by the RVU designations, which showed a median increase according to the 4 risk category designations (Fig 1).

A distinction in the complexity and work of performing a diagnostic procedure for congenital heart disease has been recognized and a relatively higher RVU applied compared with populations without congenital heart disease. In this study, we also considered potential age-related differences in the risk associated with performing diagnostic procedures and found statistically significant differences in AE occurrence according to age despite equivalent RVU designations. Thus, in pediatric catheterization and perhaps other pediatric disciplines, age adjustment may need to be considered in assigning the relative value of work.

Recently, the American College of Surgeons published a new risk adjustment model for the National Surgical Quality Improvement Program. This model considered new risk categories and found additional independent explanatory value beyond just RVU for procedural measures of stress, skill, and procedural complexity.[15] This finding lends additional credence to the consideration of factors other than or in addition to RVU when comparing and evaluating physician work output and outcomes in pediatric and congenital catheterization. In this analysis, we have demonstrated how RVU does not capture all the intended elements; however, additional work is necessary to determine measures that better evaluate and measure the procedural time commitment, complexity, and stress associated with performing procedures in congenital cardiac catheterization.

The measures used in this study were from a sample of convenience and not variables specifically developed to capture the components of RVU. There are no published billing standards in catheterization for congenital heart diseases. Because this analysis is limited to the experience at a single center, it does not allow for variation in the interpretation and valuation of a subset of interventional procedures for which there are no specific CPT codes. Although the risk categories and CHARM risk model were developed and validated in a multicenter dataset, the opportunity to test the categories and models in other data sets remains to be achieved. In addition, in this analysis we make the assumption that a higher anticipated AE occurrence is associated with physician stress,

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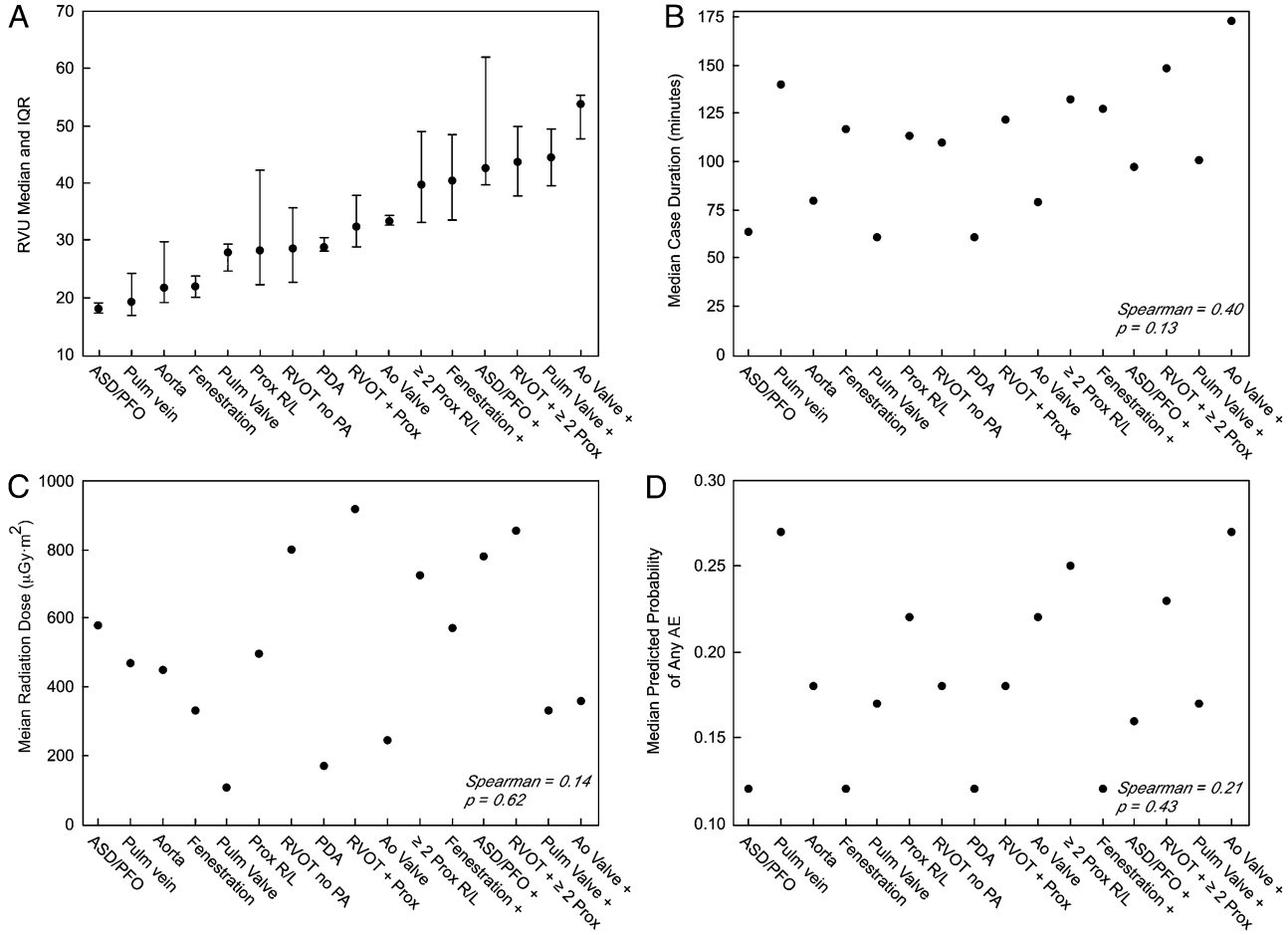


FIGURE 4

Interventional case types ranked from lowest to highest median RVU value (A). The relationship between (B) median case duration, (C) median radiation dose, and (D) probability of an AE according to case types ordered from lowest to highest ranked median RVU value. Ao, aorta; IQR, interquartile range; PA, pulmonary artery; PFO, patent foramen ovale; Prox R/L, proximal right or left pulmonary artery; Pulm, pulmonary, RVOT, right ventricular outflow tract.

whereas other personal or systems factors may be important.

CONCLUSIONS

RVUs are intended to assign value to the physical, technical, and cognitive skills possessed by a physician, as well as emotional stress endured while performing a service. In this analysis of catheterization procedures for congenital heart disease, we have demonstrated some of the weaknesses of the RVU system in capturing the complexity or risk involved with performing a diversity of procedure types in a population with a wide age range undergoing catheterization at a pediatric institution. It is therefore important to consider additional factors such as age and validated measures of case mix complexity. In addition, an expanded set of CPT codes for types of interventional cases to describe cardiac catheterization procedures in different age groups could be created and then valued through the RUC valuation process. Additional analyses are warranted to explore the explanatory value of RVU in other pediatric populations and validate measures that are intended to capture elements of work unique to these populations.

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TO DINE OR NOT TO DINE: *We have a small farm with numerous sheep. Despite our best efforts, too many of our ewes deliver lambs in the middle of the winter, which means we often have to help the mothers care for them. My children wind up naming the lambs and calling for them when we bring them grain in the summer. Although they are farm animals, and not pets, what to do with them as they get older is a hot family issue. I like to eat lamb, but my wife and most of the kids find the idea abhorrent – although they seem happy enough to eat all kinds of purchased meat. Amazingly, a similar dilemma has burst onto the national stage. As reported in* The New York Times *(U.S.; October 28, 2012), a small environmental college in rural Vermont is at the center of a national debate. Green Mountain College, which supports and promotes sustainable farming, has for years had two oxen named Bill and Lou. Students learned to drive them, and they pulled carts around the college farm and into town. However, Lou is in failing health with a bad leg injury and can no longer work. Bill, also elderly, is unlikely to work if not teamed with Lou. The college could euthanize the animals, allow them to die of their illnesses or old age, or slaughter them. After surveying the students, the college opted to slaughter the animals and serve them as food in the college dining hall. The decision prompted outrage by local and national animal groups, which argue that slaughtering the animals is tantamount to animal cruelty. Thousands of petitions and complaints flooded the college's Facebook page. The school, with strong support from the student population, responded that the purpose of the college farm is to produce food in a humane and sustainable way. The farm is not designed to be an animal shelter. While I support Green Mountain College's decision, I suspect I will be overruled at home and will spend my winter mornings dragging hay out to Houdini, Lambchops, and the rest of our sheep.*

Noted by WVR, MD

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Capture of Complexity of Specialty Care in Pediatric Cardiology by Work RVU Measures

Lisa Bergersen, Kimberlee Gauvreau, Doff McElhinney, Sandra Fenwick, David Kirshner, Julie Harding, Patricia Hickey, John Mayer and Audrey Marshall

Pediatrics 2013;131;258
DOI: 10.1542/peds.2012-0043 originally published online January 21, 2013;

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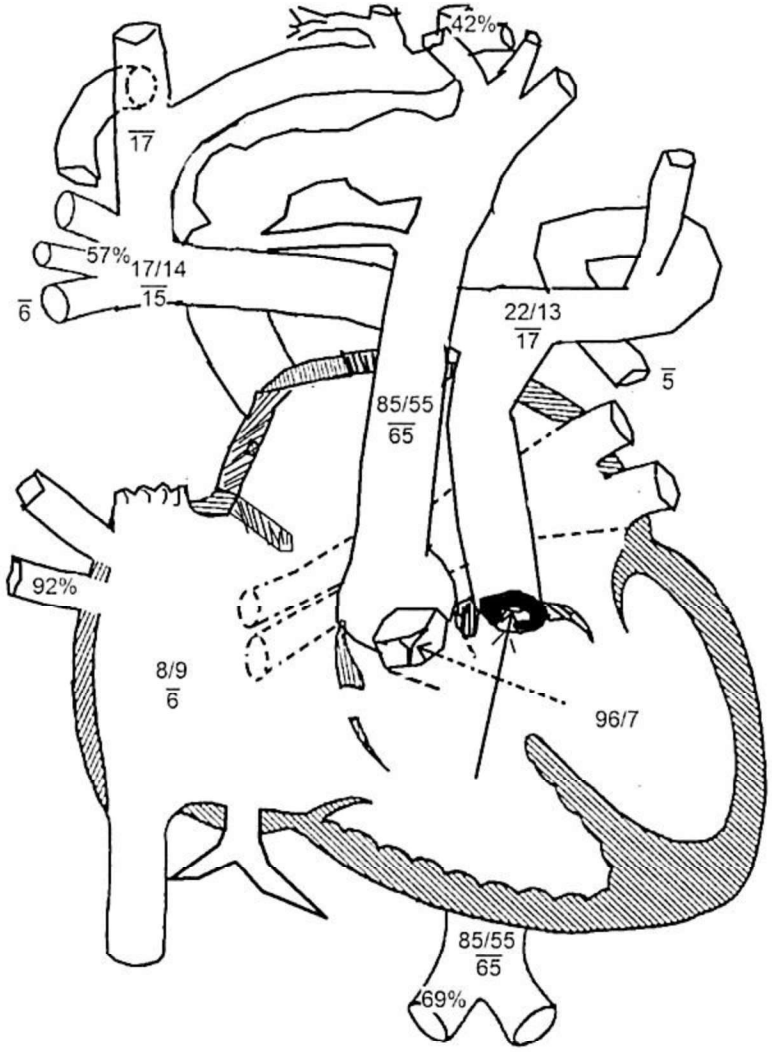
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[redacted]



Arrows indicate catheter course.

[redacted]

Birth Date: 07/08/2003
Cath Date: 08/27/2018
Cath #: 18P-60
Age at cath: 15 years
Gender: Female

Attending: [redacted]
Referring: [redacted]
Technician: [redacted]
X-Ray Tech:
Assistant Physician:

Height: 131.0 cm Weight: 25.0 kg
BSA = 0.97 m2

Fluoro: 66.00 min Contrast: 92.00 mL
Radiation Dose: 339.50 mGy
Vein: Right jugular 6fr, R
Artery: Right femoral 4fr

Set 1

Qp = 1.73 L/min (1.79 L/min/m2)
Qs = 4.04 L/min (4.17 L/min/m2)
Rp = 5.48 units (5.32 units x m2)
Rs = 14.60 units (14.16 units x m2)
Qp/Qs = 0.43 : 1 | Rp/Rs = 0.38
Qep = 1.44 L/min (1.49 L/min/m2)

Heart Rate: 80 bpm
VO2: 170 ml/min/m2
Hemoglobin: 20.0 gm/dL

Inspired O2: 21%
pH:
pCO2:
pO2:
HCO3:

Thermo CO:

%O2	Site	Sys/A	Dias/V	Mean
57	SVC			17
	RA	8	9	6
	RV			
	PA			
	RPA	17	14	15
58	LPA	22	13	17

Right		Left
6	Wedge Mean	5

%O2	Site	Sys/A	Dias/V	Mean
	LA			
	LV	96.0	7	
	aAO	85	55	65
65.0	dAO	85	55	65

RLPV: O2%: 92

LIJ: O2%: 42

[redacted]

[redacted]

[redacted]

Cath Date: 08/27/2018 Cath #: 18P-60

[redacted]

[redacted]

Cardiac Catheterization Report

Patient Name: [redacted] **DOB:** 7/8/2003 **MRN:** [redacted] **DOP:** 8/28/2018
Performing Physician: [redacted] **Referring Physician:** [redacted]

HISTORY:

[redacted] is a 15 year old girl with reported history of somewhat unbalanced AVSD and congenital hypoplastic aortic arch. She was said to have had an initial aortic jump graft placement with PA banding in infancy, followed by eventual removal of the PA bands and jump graft, arch reconstruction, and bi-directional Glenn palliation. This was all performed in Arkansas and she was then apparently lost to follow up for some long period of time. She has had 2 prior cardiac catheterizations; one in Arkansas, and a more recent one in Alabama. Overall, she has been felt to not be an operative candidate for Fontan completion, 2 ventricle repair, or transplantation due to her cardiac anatomy and hemodynamics which are all complicated by her sever scoliosis. She is referred to the cardiac catheterization lab for further evaluation of anatomy and hemodynamics and possible intervention if needed.

PROCEDURES PERFORMED:

1. [93531] Congenital right and retrograde left heart catheterization.
2. [37241] Embolization venous
3. CARDIAC ANGIOGRAPHY:
   - A. [+93567] Supra valvular aortogram
   - B. [75825] Inferior vena cava
   - C. [75774, x5] Left lower wedge, right upper wedge, right lower wedge, right lower pulmonary vein, left neck cervical spinal vein
   - D. [75820] Left innominate vein
   - E. [75827] Superior vena cava
   - F. [+93568] Pulmonary artery

PATIENT INFORMATION

Height:	131 cm	Weight:	25 kg	BSA:	0.97 m2

PROCEDURE:

Total intra-procedure time:	4 hours 25 minutes	Total fluoroscopy time:	66 minutes
Total contrast:	92 ml	Total mGy:	339.5

CARDIAC CATHETERIZATION PROCEDURE:

Written informed consent was obtained prior to the procedure, explaining the risks, benefits, and alternatives. The patient was brought to the cardiac catheterization laboratory, Intubated, and placed under general anesthesia. The catheterization sites were prepared and draped in the usual sterile fashion. Using a modified Seldinger technique, and under continuous ultrasound guidance,, a 6 French

[redacted]

sheath was inserted in the right internal jugular vein. A 4 French sheath was then placed in the right femoral vein, and a 4 French sheath in the right femoral artery. The patient was Heparinized and maintained to an ACT > 200 for the remainder of the case.

A 4 French Pigtail catheter was inserted in the RFA and advanced into the proximal descending aorta, however would not advance further around the aortic arch with catheter or wire. An angiogram was performed to the pigtail in order to further delineate the aortic arch anatomy due to the severe scoliosis. 4 French glide catheter was then used with the Wooly wire access ascending aorta further into the left ventricle, where the glide was then exchanged over the wire for the pigtail catheter. This was then used to perform a retrograde left heart pullback, in standard fashion. A 4 French glide catheter was then reinserted through the femoral venous sheath along with the Wooly wire and used to perform hand-injection angiogram of the inferior vena cava. Catheter and wire were then used in an attempt to selectively cannulate pulmonary veins from the left sided atrium, however unsuccessfully. The glide catheter was removed and a 6 French wedge catheter inserted through the right internal jugular venous sheath and used to evaluate the Glenn anatomy, including the right and left pulmonary arteries, and perform selective wedge angiograms a in various segments to help delineate the pulmonary veins in levo phase. Now that the veins were identified the glide catheter was reinserted through the right femoral venous sheath and used to selectively sample the right lower pulmonary vein which proved to be entering the right sided atrium, as were the remainder of the pulmonary veins.

A JR 1.5 catheter and Wooly wire were then used from the right to access left innominate vein. The JR catheter was used to perform hand-injection angiogram within the innominate vein as well as further up the left internal jugular. Catheter and wire were then manipulated to selectively cannulate an additional large venous structure that was entering the innominate vein rightward of the left internal jugular vein, and perform additional angiograms in this position. The JR catheter was then used to secure wire position in the venous collateral with an 0.014 Iron Man wire. A 4 French Flexor sheath was then passed through the 6 French sheath in the neck and advanced into position within the inniminate vein, at the base of the internal jugular. 1 6mm Tyshak balloon was advanced over the wire, positioned within the distal stump of the large vessel and used to gently occlude the vessel, while at the same time monitoring Glenn pressures and systemic arterial pressure. We waited for a full 30 minutes in an attempt to determine if the Glenn was being decompressed by these vessels. During this time a PA angiogram was performed through the right neck. After 30 minutes, the pressures in the Glenn were actually a mean of 2 mmHg lower, systemic arterial pressure slightly improved, and the patient saturations a few points better. With these findings, we decided to possibly occlude the collateral vessels to help with oxygenation. The balloon was removed and as I was attempting to gain better position with the wire, it was noted to pass much more superior (and posterior) than it had previously. Further angiography identified a large vein, as large as the left IJ, to be coursing from the posterior fossa, high in the cranium, and draining down into this spinal plexus of vessels. With that, finding, I decided not to occlude the main stump off the left innominate as that would only force all the blood through all those vessels, down to the IVC, further desaturating the patient and taking a substantial amount of flow away from the Glenn. In retrospect, I suspected this was why the Glenn pressure actually decreased with test occlusion. I then tried to selectively cannulate the numerous spinal plexus vessels that were draining this large vessel posterior to the spine. I was able to successfully cannulate one of the larger branches and deliver a single 0.035-7-5 coil. The remainder of the "branches" would not allow for any of a variety of 0.014 wires to enter, so this was further abandoned. The "vessels" did not behave like true vessels, rather as a collection of extremely small venules that coalesced together.

Attempts were then made to cannulate the large Azygous vein seen decompressing the Glenn, however, as the takeoff was quite high from the neck, this was not possible as the sheath was coming

out of the skin before allowing to be high enough to enter the vessel. Also, throughout the case, was not tolerating much manipulation of the sheath or even touching the right side of the neck without severe vagal reflex, causing her heart rates to drop as low as into the 20-30 bpm range and dropping pressures. I suspect this may have something to do with the severe scoliosis and excessive vagal stimulation.

Finally, I went back to the arterial side and used the pigtail to perform LV and AO angiograms.

The procedure was complete. All catheters and sheaths were removed and hemostasis achieved by direct pressure.

HEMODYNAMICS:

Please see the diagram for more detail. Pertinent findings are a Qp:Qs of only 0.43. Rp is elevated at 5.3 woods units x m2, as is the trans-pulmonary gradient of 11 mmHg, which is a more appropriate measure of pulmonary vascular resistance in patients with passive circulation. The cardiac index is normal at 4.1 L/min/m2. Mixed venous saturations were mostly in the mid 40s in most locations with a step up in the pulmonary arteries to the mid 50s. ***The systemic arterial saturations were consistently in the mid 60s% and always seemed to be about 10% lower than whatever the pulseoximeter was reading.*** The atrial pressure had an A-wave of 8 mmHg, with a dominant V wave pattern of 9-10 mmHg and a mean pressue of 6 mmHg. The ventricular pressure was 96 mmHg with an EDP of only 7 mmHg. The pressure in the aortic root is 85/55 mmHg with the 10 mmHg gradient being from the sub-valvar region rather than the valve itself. Despite the severely tortuous appearance of the arch, there was no gradient to the descending aorta, also at 85/55 mmHg. The mean pressure in the SVC is 17 mmHg with a slight gradient into the RPA at a mean of 15 mmHg. Whereas the RPA tracing was a normal, phasic, venous pattern, the LPA had a purely pulsatile tracing with a pressure of 22/13 mmHg and a mean of 17 mmHg. Wedge pressures were 6 and 5 mmHg on the right and left, respectively. Pulmonary venous saturation obtained directly from the right sided veins was only 92% ad with a pAO2 of only 62.

- WIth test occlusion of the large left sided venous colalteral network, the mean SVC pressure dropped from 17 to 15 mmHg, the systemic arterial saturations improved slightly, though equivocal, and the systemic pressures went up by about 10 mmHg.

ANGIOGRAPHY: (not necessarily in order imaged)

1. **Inferior vena cava:** Straight PA and Lateral. Performed through the Glide catheter by hand injection. Showed the IVC to be left of the spine in the abdomen and would likely cross to the right as it enters the floor of the right atrium if it were not for the severe scoliosis which keeps the IVC to the left of the severe rightward curvature. There are no hepatic vessels that join the IVC. Although this angiogram does not demonstrate their position, they were selectively cannulated with wire and catheter entering the floor of the atrium slightly leftward of the IVC entrance.

2-4. **Left lower, right upper and lower pulmonary wedge angiograms:** Overall the wedge angiograms do NOT demonstrate any pruning of the vasculature and have a fairly normal pulmonary capillary blush. Of note, on the left lower injection, the catheter course from the RIJ courses to the proximal LPA. At this point the left upper lobe is immediately at the terminal end of the straight portion of the vessel on the PA projection, after which, the vessel takes a 270 degree loop cranial, posterior, then caudal to course to the lower lobe. This is likely secondary to the extreme torsion of the scoliosis

pulling the left lung and vessel rightward. **On levophase, all of the pulmonary veins are noted to be widely patent and enter the right sided atrium.**

5. **Right upper pulmonary vein:** Hand injection into the RUPV, demonstrating the course as the catheter was manipulated from the IVC straight up and dorectly rightward into the pulmonary vein.

6-8. **Left innominate vein:** Hand injection through the JR catheter into the proximal left innominate vein. Demonstrates the left internal jugular as well as another large vessel immediately adjacent to the right of it which is draining posteriorly to the spinal vessels via numerous smaller branches. There is no apparent stenosis of the left innominate vein, its connection to the SVC, or the Glenn anastomosis. The antegrade flow across the pulmonary valve prevents any contrast from coursing to the left pulmonary circulation.

- Additional hand injections were performed within the LIJ as well as the adjacent vessel in attempt to clearly determine the drainage pattern from the brain. The final angiogram, immediately following the balloon test occlusion clearly shows this large vessel which originates from somewhere in the posterior fossa and draining down into the innominate vein as not being the internal jugular. The additional vessels which drain to the spine appear to somewhat steal from the drainage of this vessel into the innominate vein whereas the LIJ itself appears to drain into the innominate without any major collaterals.

9. **Superior vena cava:** Performed through the 6 French sheath in the RIJ, during balloon occlusion of the left sided venous collateral system. Shows the Glenn to be widely patent. COnfluent and adequate sized pulmonary arteries. All of the contrast once again courses only to the right pulmonary circulation and none to the left lung. There is clear evidence of the right sided azygous system to remain patent and decompressing the Glenn. The vessel is very large and draining below the diaphragm, then back to the heart.

10. **Left ventricle: Straight PA, Lat 20 cran / 60 LAO, 25 ml @ 17 ml/second at 900psi, 0.4 rise.** This angiogram was performed through the 4 French pigtail catheter placed in the left ventricle. The side by side relationship of the two outflow tracts and aortic and pulmonary valves can be seen on the LAO projection (clip 27 for RV-PA and clip 31 for LV-AO). There is a significant amount of contrast flow across the native pulmonary valve into the pulsatile Glenn circulation. This angiogram also demonstrates the mild subvalvular AS from the dynamic LVOT as compared to the larger diameter valve. The tortuosity of the aorta is seen and described subsequently.

11. **Aortogram: PA 0/0, Lateral biplane 0/90, 25 ml @ 17 ml/s, no rise 900 psi.** This angiogram was performed through the 4 French Pigtail catheter positioned in the aortic root. It demonstrated a very abnormal right sided aorta. There are two aneurysmal areas of the transverse aorta, best appreciated on the frontal projection. **The jump graft is seen on both projections clearly and continues to remain patent and non divided. This is seen causing significant anterior torsion of the proximal descending aorta which is seen as a kinking of the aorta on the lateral projection.** The coronary arteries are seen and appear to originate normally. The right coronary artery is best appreciated on the lateral projection and has at least two large marginal branches. The left coronary artery is seen on both projections and branches normally into the LAD and circumflex arteries.

COMPLICATIONS: Intermittent severe bradycardia with slow ectopic atrial escape as well as ventricular ectopy with manipulations of the sheath in the RIJ. This also occurred simply during holding pressure for hemostasis after the case end. No significant hemodynamic compromise. Although the blood pressure would drop, we simply let up pressure periodically before she would need resuscitation and she would fairly quickly return to sinus rhythm

DIAGNOSES:

1. Heterotaxy with reportedly asplenia
2. Somewhat unbalanced, type C, AVSD currently remains palliated with a pulsatile Glenn
3. Normally related great arteries though side by side angiographically
4. Independent hepatic venous drainage from IVC to the rightward atrium
5. Total anomalous return of the pulmonary venous return to the rightward atrium
6. S/p initial aortic jump graft placement with PA bands and subsequent band takedown, reportedly graft removal, and arch reconstruction, with BDG
7. **Patent and intact jump graft causing anterior deviation and distortion of the distal transverse and proximal descending aorta.** No aortic arch gradient in setting of persistently patent graft.
8. MIld sub valvar aortic stenosis
9. Large network of veno venous collaterals from junction of left IJ to left innominate vein. There is also presence of a large vein draining to this "collateral" connection which originates from the back of the head.
10. Persistently patent and large azygous vein decompressing the Glenn corculation. No stenosis of the Glenn or pulmonary arteries.
11. Persistent antegrade flow across the native pulmonary valve with abundant antegrade flow angiographically.
12. Severe scoliosis. Right edge of spine essentially makes contact with right lateral chest wall.
13. Pulmonary venous desaturation, likely secondary to pulmonary hypoplasia

Assessment/Plan:

Very unfortunate findings in this child today. Evaluating all the information, I do NOT believe her to have a significant amount of pulmonary vascular disease, rather, her elevated trans-pulmonary gradient and borderline PA pressures are believed to be due to the severe scoliosis and pulmonary hypoplasia. She is one of the best examples of bad Glenn physiology I have seen in a long time. The only way to have any estimation of what the true PA pressures is would be for simultaneous test occlusion of 1) the large azygous (which may not be possible as it appears that it may not be a direct connection, rather collaterals that come from higher in the neck and have reconnected), 2) the left sided venous collaterals, and 3) occlusion of the pulmonary valve. All of this would still not be a true reflection of the Glenn as the left sided venous collateral network actually has venous flow from above which needs to be part of the Glenn circulation. All of this would have to be performed through the neck with 3 catheters and today, she did not tolerate even 1 sheath with 1 catheter.

I believe her scoliosis has a large part to play in her hemodynamics as well as her very sensitive vagal reflex in her neck. I would think it would be beneficial to repair her spine initially, though would advise extreme caution in attempting this due to the persistent jump graft which is kinking the aorta. Her cardiovascular structures have had 14 years to slowly adjust to the extreme curvature. Straightening of the spine and forcing cardiovascular structures leftward may cause further kinking of the jump graft insertion site and possibly even intraoperative total obstruction. It is difficult to make a guess on if there would be any aortic gradient if the jump graft were initially divided as it is currently continuing to contribute to antegrade flow. This could possibly be offset by improved curvature of the aorta with release of the tension caused by it, but is only a guess.

[redacted]

Check for updates

REVIEW

Recent advances in cardiac catheterization for congenital heart disease [version 1; referees: 2 approved]

Sok-Leng Kang[1,2], Lee Benson [1]

[1]Department of Pediatrics, Division of Cardiology, The Hospital for Sick Children, The Labatt Family Heart Center, The University of Toronto School of Medicine, Toronto, Canada
[2]Department of Pediatric Cardiology, Bristol Royal Hospital for Children, Bristol, BS2 OJJ, UK

v1 **First published:** 26 Mar 2018, **7**(F1000 Faculty Rev):370 (doi: 10.12688/f1000research.13021.1)
Latest published: 26 Mar 2018, **7**(F1000 Faculty Rev):370 (doi: 10.12688/f1000research.13021.1)

Abstract

The field of pediatric and adult congenital cardiac catheterization has evolved rapidly in recent years. This review will focus on some of the newer endovascular technological and management strategies now being applied in the pediatric interventional laboratory. Emerging imaging techniques such as three-dimensional (3D) rotational angiography, multi-modal image fusion, 3D printing, and holographic imaging have the potential to enhance our understanding of complex congenital heart lesions for diagnostic or interventional purposes. While fluoroscopy and standard angiography remain procedural cornerstones, improved equipment design has allowed for effective radiation exposure reduction strategies. Innovations in device design and implantation techniques have enabled the application of percutaneous therapies in a wider range of patients, especially those with prohibitive surgical risk. For example, there is growing experience in transcatheter duct occlusion in symptomatic low-weight or premature infants and stent implantation into the right ventricular outflow tract or arterial duct in cyanotic neonates with duct-dependent pulmonary circulations. The application of percutaneous pulmonary valve implantation has been extended to a broader patient population with dysfunctional 'native' right ventricular outflow tracts and has spurred the development of novel techniques and devices to solve associated anatomic challenges. Finally, hybrid strategies, combining cardiosurgical and interventional approaches, have enhanced our capabilities to provide care for those with the most complex of lesions while optimizing efficacy and safety.

Open Peer Review

Referee Status: ✓ ✓

	Invited Referees 1	2
version 1 published 26 Mar 2018	✓	✓

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Corresponding author: Lee Benson (lee.benson@sickkids.ca)

Author roles: Kang SL: Conceptualization, Validation, Writing – Original Draft Preparation, Writing – Review & Editing; **Benson L**: Conceptualization, Supervision, Validation, Writing – Original Draft Preparation, Writing – Review & Editing

Competing interests: Lee Benson is a proctor for Medtronic (the manufacturer of the Melody™ valve). Sok-Leng Kang has no competing interests to declare.

How to cite this article: Kang SL and Benson L. **Recent advances in cardiac catheterization for congenital heart disease [version 1; referees: 2 approved]** *F1000Research* 2018, **7**(F1000 Faculty Rev):370 (doi: 10.12688/f1000research.13021.1)

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Grant information: The author(s) declared that no grants were involved in supporting this work.

First published: 26 Mar 2018, **7**(F1000 Faculty Rev):370 (doi: 10.12688/f1000research.13021.1)

Introduction

Over the last three decades, the pediatric cardiac catheterization laboratory has undergone a transformation from primarily a diagnostic tool to a modality for therapy. While this is an ongoing process, a variety of signature advances have taken place, altering management strategies. In the next few pages, we hope to highlight a few of those advances, which have improved the outcomes of children born with congenital lesions of the heart.

Advances in imaging

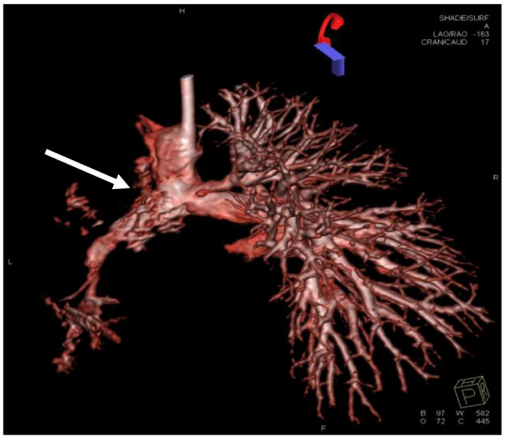
Three-dimensional rotational angiography and fusion imaging techniques

Three-dimensional rotational angiography (3DRA) is an emerging imaging modality that provides tableside, real-time acquisition of 3D volume rendered and cross-sectional images to aid the visualization of complex cardiac anatomy and navigation during diagnostic or interventional procedures[1–4]. Image acquisition is performed by rotation through an arc around the patient of the C-arm of the angiography system, equipped with flat-detector computer tomography (CT)[1,4]. The volume set is used to reconstruct the 3D structures of interest. These images can then be overlaid onto live fluoroscopy for road mapping during therapeutic procedures[2,4]. The so-registered 3D space can also be integrated with 3D datasets from magnetic resonance imaging (MRI) or CT studies.

Diagnostically, the advantage of 3DRA is its ability to profile the complexities of the cardiac anatomy from multiple projections, enhancing the appreciation of the spatial vascular relationships. To this end, several recent studies have reported the additive yield of using 3DRA compared to standard 2D biplane angiography[2,3,5]. For example, in children with cavopulmonary connections, 3DRA can facilitate an understanding of the mechanisms underlying pulmonary artery (PA) stenosis and identify additional discrete proximal lesions at the anastomosis site[5]. Additionally, the relationship of the trachea and bronchi to surrounding cardiovascular structures allows the assessment of airway anomalies and vascular compression frequently encountered in this population with significant implications for clinical management (Figure 1)[6,7].

In the interventional setting, 3DRA is useful for planning and guiding stenting for aortic coarctation and complex PA anatomies, percutaneous pulmonary valve implantation, interventions in the Fontan circulation, or after an atrial switch repair[8–12]. Image fusion from disparate modalities and image overlay during fluoroscopic procedures can provide continuous visualization of the target lesion in any angulation and guidance for catheters, wires, and device placement, enhancing procedural efficiency[1]. As such, shortened procedural time reduces radiation exposure not only to the child but also to laboratory personnel and total contrast dose[13,14]. Current challenges, however, include the inability to gate for cardiac and respiratory motion and the potential for misalignment of multi-modality image registration and distortion of anatomy by rigid interventional equipment. Innovations to address these concerns, including non-rigid registration techniques to compensate for translational motion, and the "triple overlay" technique, allow co-registration of pre-procedural CT or MR angiography and intra-procedural 3DRA and transesophageal echocardiography with live fluoroscopy[2,11].

Panel A



Panel B

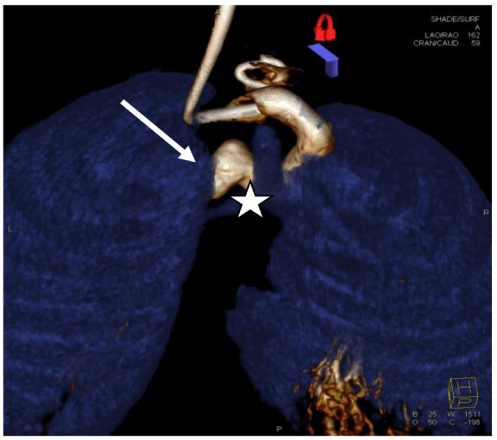


Figure 1. Rotational angiograms. Panel A: a three-dimensional (3D)-rotational angiogram in a child with severe left pulmonary artery stenosis related to the retained ductal stent (arrow). The injection was in the bidirectional cavopulmonary connection. Panel B: this reconstruction from a 3D-rotational angiogram shows the relationships between vascular structures; in this case, left bronchial stenosis (star) is due to vascular compression (arrow) following previous arch reconstruction.

Three-dimensional printing, holography, and stereoscopic imaging for the interventional laboratory

Over the last two decades, catheter-directed interventions for congenital heart lesions have taken on a significant role in patient management. Indeed, many transcatheter interventions have become the standard of care for a number of abnormalities of heart valves, cardiac chambers, and proximal vessels[15]. In this regard, children with complex congenital heart lesions, especially after complex operations, represent a challenge owing to their wide variation in complex morphology. One limiting factor in understanding and planning a percutaneous intervention is the limits of available 3D imaging modalities (MRI and CT) using

images viewed on 2D screens. As such, these 2D representations make it inherently more difficult to appreciate the 3D relationships of cardiac structures unique to a particular intervention. Three-dimensional printing (also known as rapid prototyping, stereolithography, or additive manufacturing), while not a new technology, has only recently been used to fabricate physical models from 3D computerized imaging datasets[16]. While the first medical applications were to produce surgical implants for oral and maxillofacial surgery and prosthetics for orthopedic surgery, the ability to generate a 3D model of complex cardiac anatomy has made this a tool for education, procedural planning, and device testing in both structural and congenital heart disease interventions (Figure 2)[17,18]. The use of these constructed models representing true anatomical relationships has been a promising adjunct in planning a number of interventional procedures allowing for virtual device implantation[19–27]. However, expertise is required to generate these 3D models and the investment in resources is required to establish a 3D printing lab. As such, this technology has been limited thus far to teaching hospitals and research centers. In addition to the creation of physical models to view 3D anatomy, several augmented viewing modalities, using holography or stereoscopic imaging, are being evaluated.

Radiation safety

Radiation safety awareness and techniques to reduce radiation exposure are essential for all procedures but have a special role in children with complex congenital cardiac lesions who often require long, and at times multiple, procedures during their lifetimes[28]. A recent systematic review noted that radiation dose during pediatric cardiac catheterization remains varied and potentially substantial despite a downward trend in recent years[29]. The observed decline in exposure estimates is attributed to improvement in physician awareness of dose optimization in tandem with technological advances[29–31]. However, the variation in radiation exposure amongst centers suggests that further initiatives towards minimizing radiation dose in children to "as low as reasonably achievable" (the ALARA principle) and standardization of practice are warranted[29]. Comparisons between centers also highlight the inadequacy of fluoroscopy time alone as a metric of radiation dose estimate because of differences in programmed fluoroscopy modes, pulse rates, and cine acquisition frame rates[32,33]. Instead, recognition and comparison of actual radiation energy exposure such as dose area product and air kerma in relation to procedure types are more appropriate.

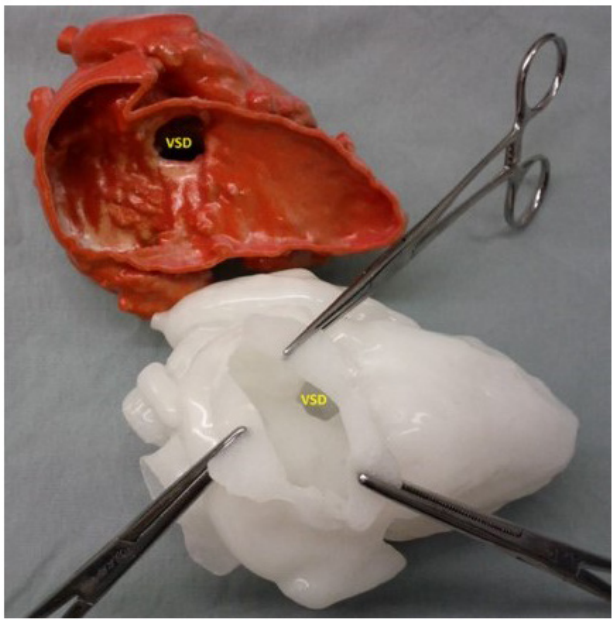


Figure 2. Three-dimensional modeling. The upper image is a three-dimensional model obtained from a magnetic resonance angiogram with the free wall of the right ventricle cut away revealing the location of the ventricular septal defect (VSD); the lower model, made from a soft pliable material, shows the appearance of the VSD as seen through a virtual incision in the right atrium, as would be seen by the surgeon.

Several technical developments have impacted positively on the reduction of radiation exposure, notably the transition to flat panel detector (FPD) technology, which converts X-ray photon energy to digital signals more efficiently than image intensifiers[30,34–36]. Innovation in FPD including increased pixel bit depth and usage of crystalline silicon rather than amorphous silicon combined with novel flat emitter X-ray tubes offers further reduction in radiation dose owing to better digitalization and lower detector noise[37]. Additionally, alternative imaging techniques, such as transesophageal and/or intracardiac echocardiography or fusion of MRI/CT imaging with fluoroscopy, have been successfully used to reduce radiation exposure in various interventional procedures[32,33].

Specific applications

Patent ductus arteriosus in preterm and low-birth-weight infants

A persistent patent ductus arteriosus (PDA) in the preterm newborn is often associated with important comorbidities (ventilator dependence, congestive heart failure, and failure to thrive) and increased mortality[38,39]. Definitive treatment strategies in this group remain debated, as both medical and surgical therapies have attendant risks[40,41]. Percutaneous ductal closure in these small newborns is generally limited by delivery sheath size, procedure-related hemodynamic instability, and the anchoring and retrievability characteristics of current devices[42]. Although manufacturer recommendations for the most commonly used Amplatzer ductal occluders are a weight of 6 kg or more, there is no consensus on the minimum weight limit in practice.

Recently, there has been a growing body of evidence supporting the feasibility and efficacy of percutaneous PDA closure in the premature or small infant under 6 kg. The procedural success rates range from 88 to 94% in those with a median weight of between 2.5 and 6 kg[43–47]. Technical feasibility has also been demonstrated in extremely preterm (under 28 weeks) or very preterm (28 to under 32 weeks) infants under 2.5 kg, with the smallest noted in the literature weighing 755 g, having an uncomplicated closure with a 4 mm Amplatzer vascular plug II device[44,48–52]. The adverse event rate was higher in the under 4 kg group, which was not unexpected given that premature infants

are medically fragile[45,53–55], in keeping with the known inverse event rate related to patient weight at the time of catheterization[56]. The increased risk of embolization is also noteworthy in low-weight and premature infants; hence, the retrievability of the occluder and duct morphology needs careful consideration[46,47]. There were no deaths attributable to the procedure reported in these studies.

Access-related complications, in particular acute arterial injury leading to vascular compromise of the extremity, is a significant concern when catheterizing these low-weight infants[57,58]. Some centers have avoided arterial access by adopting a transvenous-only approach guided by fluoroscopy and echocardiography[33]. The risk of device-induced obstruction to the descending aorta or left PA (LPA) was low in these studies, and the majority tended to resolve over time with growth of the vessels[43–45,52]. However, the severity of LPA stenosis may be underestimated because of outflow diversion to the right lung. Studies using scintigraphic perfusion imaging have shown evidence of decreased perfusion of the left lung after PDA occlusion, but the long-term clinical impact is unknown[59,60]. More recently, the introduction of a new microvascular plug (MVP™, Medtronic Inc.) for PDA closure in the extremely premature infant has shown promising results[61,62]. Advantages of the device include delivery through a microcatheter (<3 F), a flexible delivery cable, and diskless device design which minimizes the risk of device protrusion to the aorta or LPA.

The role of right ventricular flow tract stenting in symptomatic neonates with Fallot's tetralogy

Primary repair in infants with tetralogy of Fallot (TOF) with good-sized confluent central PAs is the standard of care with excellent outcomes. However, the ideal management strategy for the symptomatic (cyanotic) neonate with TOF and one or more adverse risk factors, such as prematurity, low birth weight, unfavorable PA anatomy, or pulmonary atresia or non-cardiac co-morbidities, remains debated[63,64]. Conventional palliation with the Blalock–Taussig (BT) shunt in this high-risk group can result in complications such as shunt stenosis or occlusion, distortion and differential growth of the PAs, and pulmonary overcirculation[65–67]. Balloon dilation of the pulmonary valve alone has inconsistent benefit owing to frequently associated muscular obstruction in the infundibulum. Stent implantation to enlarge the right ventricular outflow tract (RVOT) is now increasingly used as a bridging procedure to palliate the cyanosis and promote PA growth (Figure 3).

Several small studies have documented favorable outcomes of RVOT stents in isolation since 2008, focusing on technical aspects and acute outcomes[65,67–72]. More recently, Sandoval and colleagues provided comparative data on 180 infants with TOF who underwent RVOT stenting, early primary repair, or standard repair over 3 months of age[63]. While the RVOT stented group had worse PA anatomy and clinical factors compared to the early intervention group, final clinical outcomes were comparable to

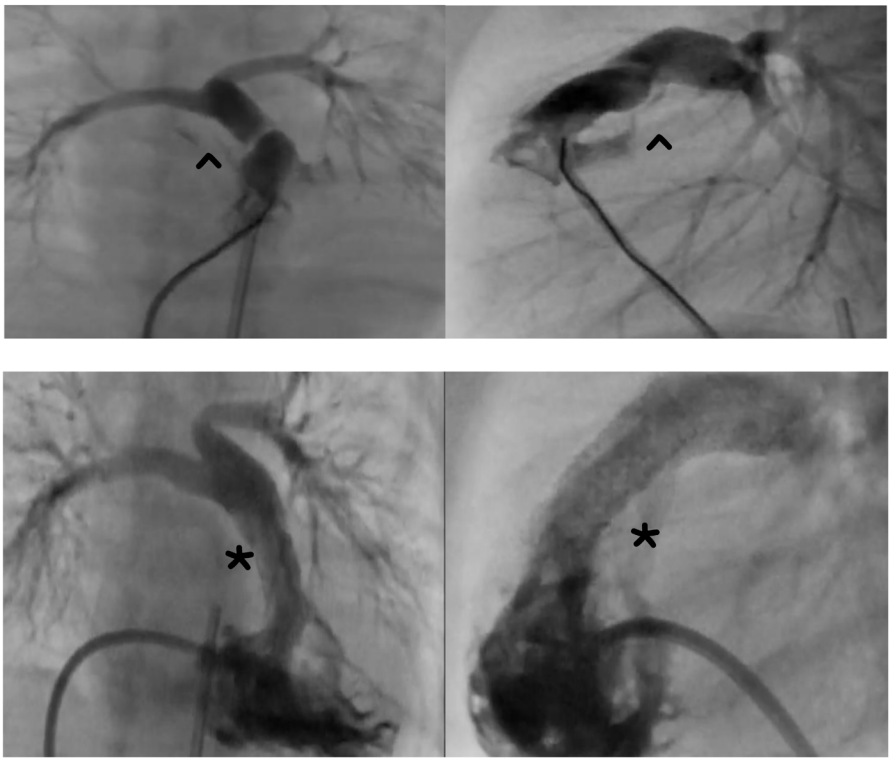


Figure 3. Hypoplastic pulmonary arteries and outflow stent. Upper panels from right ventricular angiograms show the obstructive right ventricular outflow tract (^) in a newborn with Fallot's tetralogy. The lower panels show stent implantation (*) to enlarge the outflow and improve pulmonary blood flow, relieving the cyanosis.

infants who underwent standard repair. RVOT stenting resulted in relief of cyanosis and PA growth, allowing time for somatic growth and resolution of non-cardiac comorbidities until definitive repair[63,71]. Quandt and colleagues compared outcomes of RVOT stenting and BT shunts, reporting better PA growth and hence shorter duration of palliation before complete repair after stenting. The RVOT stent group also had a shorter intensive care unit (ICU) and hospital stay, whilst mortality until surgical repair was similar in both groups[73,74].

Several disadvantages of RVOT stenting exist, notably the technical complexity and risk of inadvertent perforation of the RVOT in low-weight infants with membranous pulmonary valve (PV) atresia, who undergo radiofrequency perforation to open the RVOT prior to stenting[63]. A hybrid perventricular route may offer a more controlled approach to PV perforation and RVOT stent placement while avoiding cardiopulmonary bypass and femoral vessel complications and has been reported in a few case series, including a neonate as small as 1.3 kg[75,76]. There is a high re-intervention rate for additional stent implantation (if the initial implant did not cover the full extent of the outflow tract) and PA dilation, although in this subset of infants the PAs are hypoplastic and require repeat procedures to encourage growth[72].

Previous retrospective comparisons of early primary repair versus a staged repair with a BT shunt in symptomatic neonatal TOF showed equivalent mortality and outcomes, although shunted patients had a greater likelihood of avoiding a transannular patch at the time of repair[66]. However, there are currently no published data comparing the outcomes of early primary repair, BT shunt, and RVOT stent. Ultimately, the preferred palliative option, whether surgical or percutaneous, is likely to depend on local expertise, patient factors, and clinical condition at the time of intervention.

The role of ductal stenting in the duct-dependent pulmonary circulation

While ductal stenting (DS) has been applied for well over two decades, the procedure has gained a wider acceptance as a palliative option for the cyanotic infant with a duct-dependent pulmonary circulation deemed unsuitable for primary repair (Figure 4)[77,78]. The technique has been applied in various lesions, either leading to a biventricular repair or destined for univentricular palliation[77,79,80]. Apart from avoidance of surgery and shunt-related adverse events, maintaining duct patency has been shown to promote significant and uniform PA growth compared to a BT shunt alone[77,81,82]. The effective patency of the stented duct or PA growth potential was not significantly different between cases with a single source (ductal) of pulmonary blood flow or those with multiple sources of pulmonary blood flow[77,81]. In a few retrospective reports, DS has performed favorably and offered early survival advantage with improved hemodynamic stability compared to a BT shunt but with an increased likelihood of re-intervention prior to next-stage surgery[78–80,83].

One major disadvantage of DS is progressive neointimal proliferation and consequent endoluminal narrowing with an unpredictable timecourse[82]. The adequacy of palliation provided by DS, however, depends on the clinical setting. When DS is performed after RVOT intervention for critical PS or PA, short-term patency is usually adequate. In other conditions, such as univentricular palliation prior to a Glenn procedure or biventricular repair of complex anatomy, a longer lifespan of the stented duct from 6 to 12 months is desirable to allow somatic growth[82]. The impact of drug-eluting stents used in adult coronary artery disease has been investigated in this setting. Sirolimus-eluting stents implanted in the porcine arterial duct had higher patency rates compared with bare-metal stents with anti-proliferative action on ductal smooth muscle[84]. Early trials of drug-eluting stents in neonates showed no clinically significant

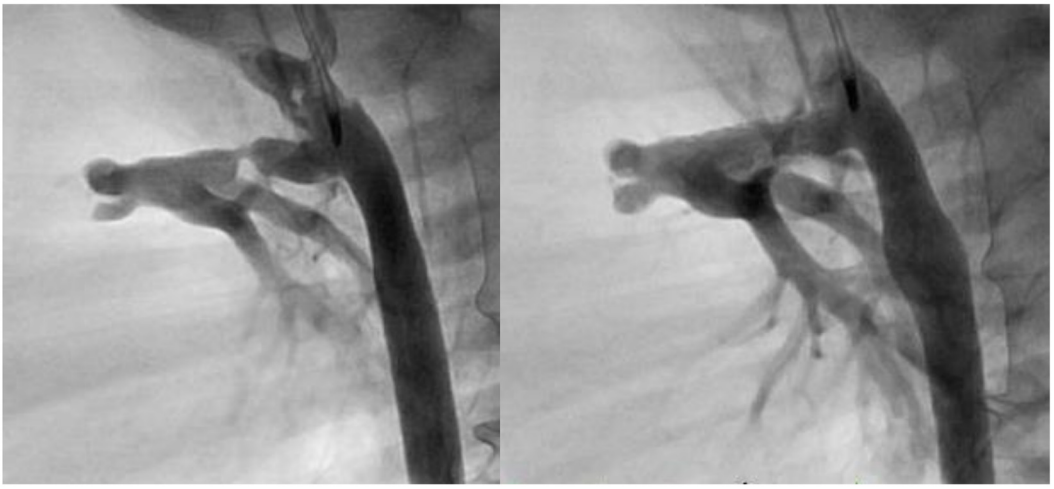


Figure 4. Ductal stent. The left panel details a stenotic arterial duct as it connects with the main pulmonary artery in a child with ductal-dependent pulmonary circulation. The right panel shows the appearance of the duct after the placement of a ductal stent to support the pulmonary blood flow.

adverse outcomes; however, their clinical efficacy has yet to be evaluated[85].

Percutaneous pulmonary valve implantation in the right ventricle to pulmonary artery conduit and native outflow tract

Percutaneous pulmonary valve implantation (PPVI) is a recognized alternative to surgical pulmonary valve replacement in selected patients with dysfunctional synthetic right ventricle-to-PA (RV-PA) conduits, bioprosthetic pulmonary valves, or homografts. Currently available percutaneous pulmonary valves include the Melody™ valve (Medtronic, Minneapolis, MN), which has a maximum outer diameter of 24 mm, and the Edwards Sapien™ valve system (Edwards Lifesciences Corp), with outer diameters of up to 29 mm.

Multiple studies have reported excellent procedural success and clinical efficacy of the Melody™ valve with thus far up to 7 years of follow up[86–89]. Published experience on the Sapien™ valve in the pulmonary position is comparatively less, although there are robust data supporting its use in the aortic position in high-risk or elderly patients with acquired aortic stenosis[90,91]. Early results of the COMPASSION (COngenital Multicenter Trial of Pulmonic VAlve Regurgitation Studying the SAPIEN Interventional THV) trial reported a good safety and efficacy profile, and several small studies have demonstrated comparable results to the Melody™ valve in the medium term[92–95]. With both the Melody™ and the Sapien™ valve, primary valve failure was rare and overall complication rates were low (0–5%) with reported mortality rates of up to 2%[86–89,92–95]. Coronary compression due to expansion of the implant occurred in less than 1% of cases and was significantly associated with an abnormal coronary artery course. Pre-implantation coronary artery compression testing is mandatory to avoid this potentially catastrophic complication[51,96]. Stent fractures which occurred with the Melody™ valve in the early experience have been addressed with routine RVOT pre-device implant stenting. The incidence of infective endocarditis after PPVI is estimated at approximately 3% per year with the Melody™ valve, whilst a lower incidence with the Sapien™ valve is suggested[97].

More recently, the application of both Melody™ and Sapien™ valves in the so-called "native" RVOT have been described in case reports and case series[98–101]. "Native" refers to the non-operated RVOT or one having a previous balloon pulmonary valvuloplasty/valvectomy for pulmonary stenosis or previous transannular patch repair for correction of TOF, which constitutes the vast majority of patients with a dysfunctional RVOT. The potentially distensible tissue in the contractile "native'" RVOT and the absence of a pre-existing "scaffold" such as in a conduit or bioprosthetic valve presents potential problems with implant valve stability, a paravalvular leak, or framework fracture. To overcome such issues, several techniques of pre-stenting the RVOT have been developed to create a "landing zone" for the selected transcatheter valve[11]. Implantation of the Melody™ valve in the branch PAs has also been described[102].

For the dilated "native" RVOT often encountered after a transannular patch repair for TOF, hybrid approaches of RVOT plication through a limited sternotomy or thoracotomy and subsequent percutaneous or perventricular delivery of the Melody™ valve have been explored[103–105]. Paralleling the limited application of these first-generation PPVIs in the "native" RVOT is the development of self-expanding percutaneous valves such as the Harmony™ valve (Medtronic Inc, Minneapolis, USA), the Venus P™ valve (Medtech, Shenzhen, China), and a rendezvous Alterra™ stent (Edwards Lifesciences) as a landing zone for a Sapien™ valve[106–111]. The flared ends of these systems are designed to provide stability in the large pulsatile outflows, whilst the self-expanding nitinol frames adapt to various outflow anatomies (Figure 5). Other concepts in development (in animal studies) include implantation of expandable conduits in the RVOT that can be dilated sequentially with growth or replaced with a percutaneous valve[112–114].

Transcatheter tricuspid and mitral valve replacement

The rapidly expanding transcatheter heart valve technology has been applied to the treatment of atrioventricular valve dysfunction with a growing experience in the tricuspid valve position. Implantation of percutaneous valves into degenerated bioprostheses (valve-in-valve, VIV) or into annuloplasty rings (valve-in-ring, VIR) is an attractive alternative to surgery in the high-risk and often-debilitated patient with acquired or congenital cardiac disease[115–118]. A large multicenter experience of tricuspid VIV implantation has recently been published, using both the Melody™ and the Sapien™ valves with favorable outcomes at more than a year follow up[117]. The majority of patients were relatively young (median age 40 years), and over half had tricuspid valve disease associated with congenital heart disease including Ebstein's anomaly, intrinsic tricuspid valve (TV) abnormalities, or TV injury related to previous surgery or catheter intervention. There was an excellent procedural success of 99%, with significant improvements in the degree of regurgitation or stenosis and symptomatic improvement. The 30-day mortality was 3.3%, and estimated freedom from tricuspid re-intervention at 1 year was 83%. The extension of the tricuspid VIV concept to VIR is considerably more challenging owing to larger diameters and geometric variability of surgically placed rings. Although this approach is technically feasible and clinically effective in reducing tricuspid regurgitation, paravalvular regurgitation has been common[119,120].

Transcatheter mitral valve replacement remains in its early clinical stages[121]. Mitral VIV implantation is more difficult to accomplish owing to difficulty in coaxial alignment of the percutaneous valve within the existing valve. The majority of implantations are performed using a direct transapical approach with the larger diameter Sapien™ valves[122–124]. A transvenous, transseptal technique utilizing an apical rail to facilitate the delivery of Melody™ valve into the dysfunctional mitral prosthesis has also been described[118]. To date, the results of mitral VIV implantations within a high-pressure hemodynamic environment have shown

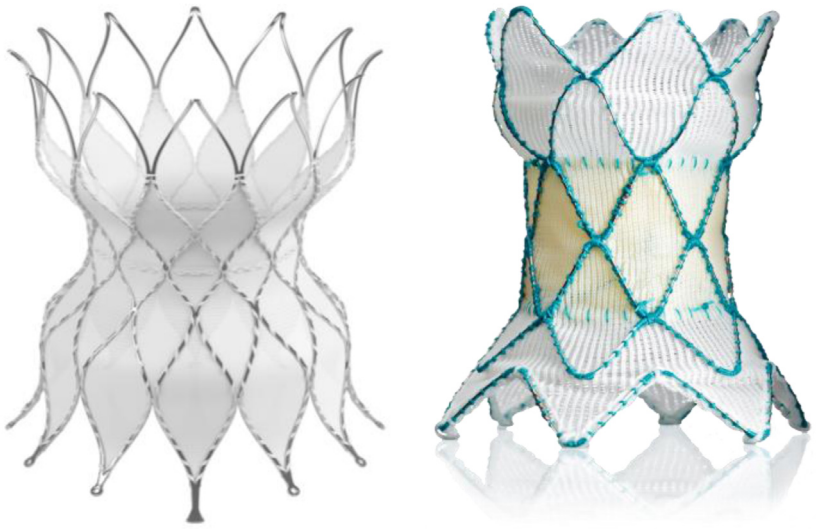


Figure 5. Percutaneous pulmonary valves for the large outflow tract. The left panel is a picture of the Edwards Alterra™ stent, designed to be placed in the right ventricular outflow tract in patients after transannular patch repair for Fallot's tetralogy. The nitinol stent hosing (seen in the photo) provides a landing zone for a 29 mm Sapien™ valve. The right panel is a photo of Medtronic's Harmony™ valve. This valve stent design has porcine pericardial valve leaflets sewn into the nitinol framework.

good valve performance with low transvalvular gradients and low rates of paravalvular regurgitation in the short term[122–125]. Applying the Sapien™ valve to surgically implanted ring (VIR) is even less appealing because of incomplete sealing of the variable and D-shaped annuloplasty rings and the risk of causing left ventricular outflow tract obstruction. Recent successful case reports of the Melody™ VIR technique, however, offer significant promise[126,127]. Compared to Sapien™ valves, the Melody™ valve has a longer stent that is covered throughout its length, which provides good sealing at the subvalvar level[128]. Transcatheter valve-in-native-ring for calcified native mitral stenosis has also been reported in high-risk adult patients[129–131].

In infants and children with severe mitral stenosis or regurgitation associated with congenital heart disease, the Melody™ valve as a surgical implant has shown promising results after failed attempts at primary mitral valve repair[132,133]. The Melody™ valve has the potential for future expansions with child growth and is a viable option in the lack of appropriately sized mitral valve prostheses in these small children; however, further study is required to determine longer-term durability and safety.

Conclusion

Recent years have seen the rapid development of imaging and device technologies as well as percutaneous interventions in a variety of congenital cardiac lesions, with an increased application of percutaneous therapies to a broad range of patients. It is important, however, to remember that long-term outcomes for many such novel interventions are lacking, and rigorous prospective studies and data surveillance are required to determine safety and efficacy profiles before these become standard of care. Future innovations and growing experience in this field, in addition to increased collaboration between surgeons and interventionists, will undoubtedly continue to expand transcatheter options in the management of congenital heart disease, further improving the quality of life for the child and adult with congenital heart disease. This short review touches on some of the highlights that have been developed over the last decade. A number of percutaneous procedures (not mentioned) have become standard of care in many centers, and with continued diligence we can anticipate the continued application of such therapies.

Competing interests

Lee Benson is a proctor for Medtronic (the manufacturer of the Melody™ valve). Sok-Leng Kang has no competing interests to declare.

Grant information

The author(s) declared that no grants were involved in supporting this work.

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Version 1

1 **Lourdes Prieto** Nicklaus Children's Hospital, Miami, FL, USA
Competing Interests: No competing interests were disclosed.

1 **Shyam Sathanandam** Invasive Cardiac Imaging and Interventional Catheterization Laboratory, LeBonheur Children Hospital, University of Tennessee Health Science Center, Memphis, TN, USA
Competing Interests: No competing interests were disclosed.

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Review article
Korean J Pediatr 2017;60(8):237-244
https://doi.org/10.3345/kjp.2017.60.8.237
pISSN 1738-1061•eISSN 2092-7258

Korean J Pediatr

Recent advances in pediatric interventional cardiology

Seong-Ho Kim, MD, PhD
Department of Pediatrics, Sejong General Hospital, Bucheon, Korea

During the last 10 years, there have been major technological achievements in pediatric interventional cardiology. In addition, there have been several advances in cardiac imaging, especially in 3-dimensional imaging of echocardiography, computed tomography, magnetic resonance imaging, and cineangiography. Therefore, more types of congenital heart diseases can be treated in the cardiac catheter laboratory today than ever before. Furthermore, lesions previously considered resistant to interventional therapies can now be managed with high success rates. The hybrid approach has enabled the overcoming of limitations inherent to percutaneous access, expanding the application of endovascular therapies as adjunct to surgical interventions to improve patient outcomes and minimize invasiveness. Percutaneous pulmonary valve implantation has become a successful alternative therapy. However, most of the current recommendations about pediatric cardiac interventions (including class I recommendations) refer to off-label use of devices, because it is difficult to study the safety and efficacy of catheterization and transcatheter therapy in pediatric cardiac patients. This difficulty arises from the challenge of identifying a control population and the relatively small number of pediatric patients with congenital heart disease. Nevertheless, the pediatric interventional cardiology community has continued to develop less invasive solutions for congenital heart defects to minimize the need for open heart surgery and optimize overall outcomes. In this review, various interventional procedures in patients with congenital heart disease are explored.

Key words: Congenital heart disease, Intervention, Catheterization

Corresponding author: Seong-Ho Kim, MD, PhD
Department of Pediatrics, Sejong General Hospital, 28, 489-gil, Hohyeon-ro, Sosa-gu, Bucheon 14754, Korea
Tel: +82-32-340-1121
Fax: +82-32-340-1236
E-mail: shkim24926@hanmail.net

Received: 1 May, 2017
Revised: 1 July, 2017
Accepted: 9 July, 2017

Introduction

Cardiac catheterization and intervention in pediatric cardiac diseases have evolved significantly since the publication of previous review articles on this subject in 1992, 1993, 2003, and 2006 in Korea[1-4]. During the last 10 years, there have been major technological achievements in pediatric interventional cardiology. There have also been substantial advancements in cardiac imaging modalities, such as intracardiac echocardiography (ICE), real-time 3-dimensional (3D) transesophageal echocardiography (TEE), cardiac computed tomography (CT) and magnetic resonance imaging (MRI), rotational angiography with 3D roadmap, holography, 3D printing, and EchoNavigator and VesselNavigator systems. As a result of such technological advances, more types of congenital heart diseases (CHDs) can be treated in the cardiac catheter laboratory today than ever before. Therefore, the possibility exists that many surgical procedures will be replaced by catheter-based procedures. Furthermore, lesions previously considered resistant to interventional therapies can now be managed with a high success rate, including peripheral pulmonary artery (PA) stenosis, obstructive surgical conduits, and acute postoperative stenosis[5]. The hybrid approach[6-15] has enabled overcoming the limitations inherent to percutaneous access, expanding the application of endovascular

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therapies as adjunct to surgical interventions to improve patient outcomes and minimize invasiveness. Some technologies that were considered far-off have actually came into being and emerged as alternative successful therapies, such as percutaneous pulmonic valve implantation[16-22]. However, most of the current recommendations[23] (including class I recommendations) refer to off-label use of devices that are approved for other coronary, peripheral vascular, or noncardiovascular (typically adult) indications[24]. Of 126 recommendations[23], 56% were based on level C evidence (consensus opinion), 42% were based on level B evidence, and <2% were based on level A evidence. Unfortunately, studies testing the safety and efficacy of catheterization and transcatheter therapy are rare in the field because of the difficulty in identifying a control population, the relatively small number of pediatric patients with CHD, and the broad spectrum of clinical expression. This has resulted in the almost exclusively "off-label" use of transcatheter devices, initially developed for the management of adult diseases, in the treatment of CHD[23]. Nevertheless, the pediatric interventional cardiology community has continued to develop less invasive solutions for congenital heart defects to minimize the need for open heart surgery and optimize overall outcomes. For most such interventions, these efforts lead to more highly acceptable outcomes and lower complication rates than the alternatives of surgery or no intervention[5]. In the following sections, various interventional procedures in patients with CHD are reviewed, and current issues on challenges and limitations in pediatric cardiac interventions are explored.

Defect closure

1. Atrial septal defect

Atrial septal defect (ASD) is the second most common congenital heart defect in adults after bicuspid aortic valve disease. Although most patients with ASD show no significant symptoms, defect closure is recommended in patients with a pulmonary-to-systemic flow ratio of 1.5:1.0 or greater. However, in view of the almost nonexistent surgical mortality in patients with an uncomplicated defect, the potential cardiomyopathic effect of chronic volume overload, the potential risk of paradoxical embolization, and the possibility of a late increase in shunt size owing to the onset of left ventricular disease, even smaller defects may warrant closure.

Since King and Mill invented the first device for closing ASDs in 1976, several devices have been introduced for this purpose. However, only the Amplatzer septal occluder (ASO; St Jude Medical, St. Paul, MN, USA) has been widely used owing to its advantage of being a double disc with a self-centering mechanism. ASO is the first device to receive approval for clinical use in patients with ASD from the U.S. Food and Drug Administration (FDA)[25].

ASO can be used in any patient with an ostium secundum ASD with an adequate rim (>5 mm); however, the presence of an anterior rim is not essential. The procedure is usually done under general anesthesia if TEE is planned. However, only minimal sedation is needed under ICE guidance by using the AcuNav catheter (Biosense Webster Co., Diamond Bar, CA, USA).

Complications with the use of ASO are rare, and most of them occur in the immediate period after implantation. Arrhythmia such as atrial flutter or supraventricular tachycardia can be encountered; however, most of them are transient. The other major complication is device embolization, which was reported to occur in 1%, and the most serious complication is development of erosion, which was reported to occur in 0.1%. Amin et al.[25] initially suggested that a deficient anterior or superior rim and an oversized device might be risk factors that significantly increases the erosion risk; however, they later modified their proposed risk factors to the following: absence of an aortic rim in multiple views, poor posterior rim consistency, septal malalignment, and dynamic ASD[26]. Although the exact mechanism of erosion with the use of ASO is still unknown, it is interesting that erosion is very rare or absent with the use of Figulla Flex II (Occlutech Co., Helsingborg, Sweden), Cocoon ASD occluder (Vascular Innovations Co., Nonthaburi, Thailand), or several Chinese ASD occluders that have a similar shape to the original ASO but are softer.

2. Patent ductus arteriosus (PDA)

Since Porstmann first attempted transcatheter closure of patent ductus arteriosus (PDA) in 1967, many devices have been introduced for percutaneous PDA closure. However, the incidence of residual leakage was relatively high (3%–38%) and the use of those devices was technically challenging for large PDAs. The Amplatzer duct occluder (ADO, St Jude Medical) has shown excellent results for closing ductus of any size or any shape, except for large tubular ductus that can be closed with the Amplatzer muscular ventricular septal defect (VSD) occluder (St Jude Medical). PDAs may become markedly dilated and aneurysmal, and calcified and degenerative changes within their wall occur in elderly patients, increasing the risk for surgical PDA ligation. Short and wide PDAs present a somewhat higher intraoperative risk. Ligation and division of these PDAs should be performed with cardiac pump on standby. However, the most distinguishing advantage of ADO compared with surgery is that dilated, aneurysmal, calcific, or friable PDAs in older adults can be closed easily with ADO. Nowadays, the percutaneous closure method is the treatment of choice for PDA. Nevertheless, it is still challenging to percutaneously close PDAs in premature babies or small infants. Recently, Amplatzer vascular plug, ADO II, and ADO II additional sizes (St Jude Medical) have been tried for such purpose and showed acceptable results[27-31]. However, the risk of migration of the device is a problem. Another important issue is closing a large ductus that cannot be closed with a standard-sized ADO. Amplatzer muscular VSD occluder[32-36] has been used for this purpose. In some countries, devices similar to the ADO are available in larger sizes (up

to 26 mm)[37], which can be used to close PDAs >12 mm. There have been case reports of large PDAs with pulmonary hypertension that were closed with an ASO with acceptable results[37-42].

3. Ventricular septal defect

VSD is the most common CHD and perimembranous VSD (PMVSD) is the most common subtype. Surgical closure has been a standard treatment method for PMVSD. Transcatheter closure of PMVSD is a challenging procedure, and the use of an Amplatzer PMVSD occluder (APMVSDO) was first reported in 2003[43]. In several reports, the APMVSDO has been shown to be safe and effective in closing PMVSDs[44-49]. However, several studies reported a high incidence of complete atrioventricular block (CAVB). Researchers from Toronto reported a 22% rate (4 of 20 patients) of CAVB after percutaneous closure of PMVSD with APMVSDO, and most other reports demonstrated an around 5% rate of CAVB[50-54]. Concerning the mechanism of occurrence of CAVB after percutaneous closure of PMVSDs with APMVSDO, it was suggested that the device may cause direct compression trauma or provoke inflammatory reaction or scar formation in the conduction tissue[51]. In addition, as the APMVSDO itself has a high stiffness, use of an oversized device would give the appearance of "stenting" the VSD and may be more traumatic to the conduction tissue. Compared with the APMVSDO, the Chinese PMVSDO is less stiff and has a longer waist. Therefore, it would theoretically cause less squeezing and less trauma to the conduction tissue even with oversized devices. Liu et al.[55] reported a 1.9% (11 of 576) incidence of CAVB. Of these, nine patients recovered in 3 weeks and permanent pacemakers were implanted in 2 patients. Recently, the second-generation APMVSDO has been developed by Saint-Jude Company and clinical trials are being conducted[56]. Lee et al.[57] reported transcatheter closure of PMVSD with ADO in 20 patients with PMVSD. ADO has a short rim (2–3 mm) in the distal part, which is supposed to be implanted in the space between the right coronary cusp and the noncoronary cusp of the aortic valve; thus, it is not likely to touch the aortic valve and is safe from aortic regurgitation. Furthermore, it has less contact with the left bundle branch compared with APMVSDO owing to its shorter rim. The other crucial advantage of ADO is that it does not have a proximal disc and thus does not squeeze the His bundle. These are the reasons for the author's preference in using ADO in percutaneous closure of PMVSDs (Fig. 1). However, percutaneous closure of PMVSDs is not approved by the Korean FDA.

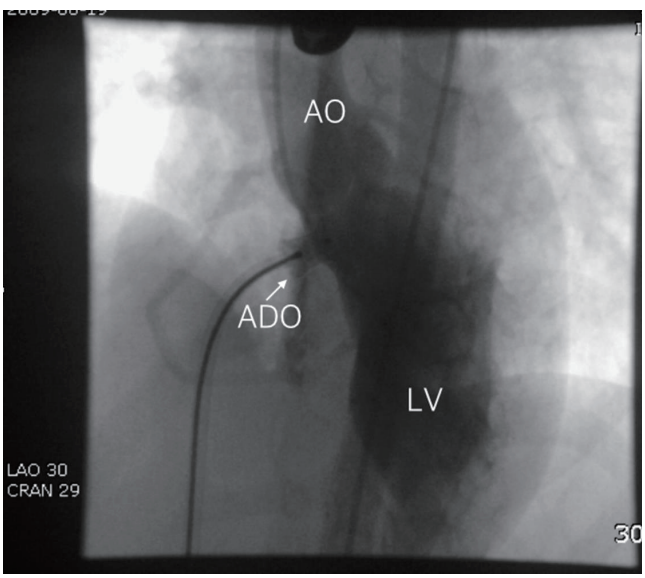


Fig. 1. Left ventriculogram taken after deployment of the Amplatzer ductal occluder in the perimembranous ventricular septal defect before releasing it. The image shows a well-positioned device and small residual leakage through it. AO, aorta; ADO, Amplatzer ductal occluder; LV, left ventricle.

Dilatation

1. Pulmonary valvular stenosis

Percutaneous transcatheter valvuloplasty is a treatment of choice for pulmonary valvular stenosis in both children and adults. It is reasonable to dilate valves with a peak gradient of at least 30 mmHg. Adult patients with pulmonary valvular stenosis have large valve annulus and sometimes require the double-balloon technique. The restenosis rates are low[58].

2. Aortic valvular stenosis

The congenital bicuspid aortic valve often becomes progressively stenotic; therefore, congenital aortic stenosis more commonly manifests clinically in old age. Balloon valvuloplasty can be a suitable palliation method for children with moderate to severe aortic stenosis (peak-peak gradient >50 mmHg) and mild aortic regurgitation at most, but not for adult patients because of high restenosis rates[59]. Infants with critical valvular aortic stenosis constitute a special group that needs a different approach. These patients usually show congestive heart failure early in life and rapidly progress to life-threatening conditions. The pressure gradient through the aortic valve is usually <30 mmHg because of poor left ventricular function. Urgent balloon valvotomy under ventilator care is crucial; however, its reintervention rate is high[60].

3. Percutaneous pulmonary valve implantation

Percutaneous pulmonary valve implantation (PPVI) is an established therapy for pulmonary regurgitation and right ventricular outflow tract (RVOT) obstruction in postoperative patients with tetralogy of Fallot and pulmonary atresia, the Ross procedure for aortic stenosis, truncus arteriosus, and the Rastelli procedure for transposition of the great arteries or double-outlet right ventricle, who had required surgical placement of valved conduits from the right ventricle to the PA[18,20,22,61-73]. With time, these conduits

become progressively stenotic and insufficient, and surgical replacement of the pulmonary valve has been needed in these cases. PPVI in both animals and humans has become a reality in the last decades[18,20,22,61-73]. A percutaneous stent-based expandable pulmonary valve, designed by Dr. Bonhoeffer[18], named Melody valve (Medtronic, Minneapolis, MN, USA), uses a glutaraldehyde-treated bovine venous jugular valve sewn into a balloon-expandable stent. This valve has been implanted in more than 10,000 patients; however, this procedure is limited by the conduit size (upper limitation <22 mm) and compliance, patient size (body weight >24 kg needs a 22F sheath), and uncertain long-term efficacy of the valve. In fact, an initial report showed a high incidence of stent fracture[22,62]. Nowadays, prestenting is a routine procedure before PPVI with the Melody valve to prevent stent fracture[68]. At present, because of its size, the use of the Melody valve is restricted to only approximately 15% of patients with CHD in whom pulmonary valve replacement is indicated. Extensive research and development are being conducted to design a suitable transcatheter device for patients with a dysfunctional native or patch-augmented RVOT that is too large for the current Melody valve. Further research and development of designs based on this model are under way. The Harmony valve (Medtronic)[74], Venus P-valve (Venus Medtech, Shanghai, China)[75,76], and Edwards SAPIEN XT valve (Edwards Lifesciences, Irvine, CA, USA)[77] were developed and have been used clinically for patients with a large (>22 mm) RVOT (Fig. 2).

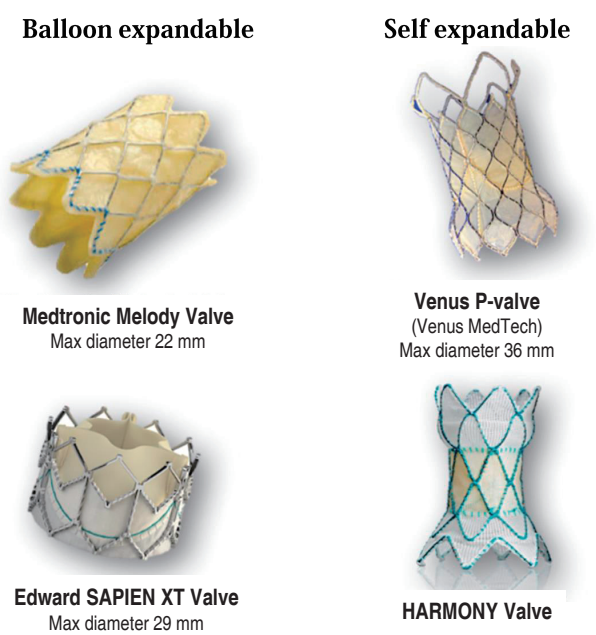


Fig. 2. Available valves for percutaneous pulmonary valve implantation.

Hybrid procedures

The hybrid approach involves the cooperation between surgeons and interventionists to maximize the outcomes and minimize the limitations of their respective approaches. It has enabled overcoming the limitations inherent to percutaneous access, expanding the application of endovascular therapies as adjunct to surgical interventions to improve patient outcomes and minimize invasiveness[6-15].

1. Hybrid procedure for hypoplastic left heart syndrome

The first hybrid palliative approach to hypoplastic left heart syndrome was reported in 1993 with surgical banding of the branch PAs and percutaneous stenting of the arterial duct[78,79], and modified by the Gissen group with the goal of achieving distal PA pressure <50% of the systemic pressure and a reduction in systemic oxygen saturation to approximately 80%[12], which showed 82% survival through stage II palliation[80]. Further modification by the Columbus group[13], who performed PA banding and stenting of the arterial duct through the PA with the surgeon and interventionist in the same hybrid room, showed 83% survival through stage III palliation[81].

2. Hybrid approach to VSD closure (perventricular closure)

The perventricular approach for closure of membranous and muscular VSDs in infants was reported in 1999[82]. The benefits of this approach were direct access to the heart after surgical sternotomy for direct placement of a closure device across the VSD under the guidance of TEE, without the need for cardiopulmonary bypass or radiation[8,9].

3. Other hybrid procedures

Hybrid pulmonic valve replacement[7,83], intraoperative stenting[6], and hybrid Fontan completion[10] have been used.

Fetal intervention

Fetal interventions for CHD have become important treatment modalities in the last 20 years, especially for severe aortic or pulmonary stenosis. Critical aortic stenosis in utero can progress into hypoplastic left heart syndrome, which has a high postnatal mortality rate. Fetal interventions may remodel cardiac morphology and function to such an extent that it may favorably alter the in utero natural history, resulting in improved prenatal and postnatal outcomes, including an increased likelihood of achieving biventricular circulation[84]. However, in a recent meta-analysis study [85], fetal aortic valvuloplasty had a live-birth rate of 65% with a neonatal death rate of 16%. In fetal pulmonary valvuloplasty, the live-birth rate was 56% and the neonatal mortality was 33%. Although the results of the meta-analysis are encouraging in terms of perinatal

survival, they should be interpreted with caution when comparing with procedures performed after delivery.

Advances in cardiac imaging

During the last 10 years, development of imaging software has facilitated major advances in cardiac imaging modalities such as ICE, real-time 3D TEE, cardiac CT and MRI, rotational angiography with 3D roadmap, holography, 3D printing, and EchoNavigator and VesselNavigator systems. Especially, fusion imaging with fluoroscopy and echocardiography (EchoNavigator) or fluoroscopy and tomography (VesselNavigator) further assist complex percutaneous interventional catheterization procedures. Cardiac imaging has to be done in real time with an excellent temporal resolution to ensure hand-eye synchronization and accurate positioning between the device and the target area[86]. As a result of recent technological advances, more types of CHDs than ever before are now possible to treat in the cardiac catheter laboratory. For example, VesselNavigator is a new fusion imaging modality that overlays a 3D CT image onto a live fluoroscopy image (Fig. 3). It provides an intuitive and continuous 3D roadmap by rotating overlaid CT images at any direction, and allows for both advanced diagnostic and interventional cardiac catheterization procedures in patients with CHD. Therefore, lesions previously considered resistant to interventional therapies can now be managed with a high success rate, such as peripheral PA stenosis[87].

Evolution and challenges

Several kinds of pediatric cardiac interventional procedures that were considered far-off in the last 2 decades have become standards of care owing to major technological advances, including PPVI. Therefore, the indications of pediatric cardiac interventions should be modified, and Feltes et al.[23] summarized the American Heart Association recommendations on the indications for cardiac catheterization and intervention in pediatric cardiac disease, which were endorsed by the American Academy of Pediatrics and Society for Cardiovascular Angiography and Intervention. However, even in the United States, most of the current recommendations about pediatric cardiac interventions (including class I recommendations) refer to off-label use of devices, because it is difficult to study the safety and efficacy of catheterization and transcatheter therapy in pediatric cardiac patients. This difficulty results from the challenge of identifying a control population and the relatively small number of pediatric patients with CHD. In Korea, many kinds of devices for interventional procedures are not available, such as several kinds of stents such as Genesis XD, Valeo, or covered stents. Furthermore, several kinds of interventional procedures are not approved by the Korean FDA, including percutaneous closure of PMVSD, although it has been performed since 2009 and reported by the author and coworkers[57]. Nevertheless, the pediatric interventional cardiology community has continued to develop less invasive solutions for congenital heart defects to minimize the need for open heart surgery and optimize overall outcomes.

Conclusions

As a result of recent technological advances, more types of CHDs than ever before are now possible to treat in the cardiac catheter laboratory. Furthermore, lesions previously considered resistant to interventional therapies can now be managed with high success rates. In addition, the hybrid approach, fetal cardiac intervention, and percutaneous pulmonic valve implantation have evolved significantly. However, most current recommendations for interventional procedures refer to off-label use of devices. Unfortunately, studies testing the safety and efficacy of transcatheter therapy in pediatric cardiac patients are rare because of the difficulty in identifying a

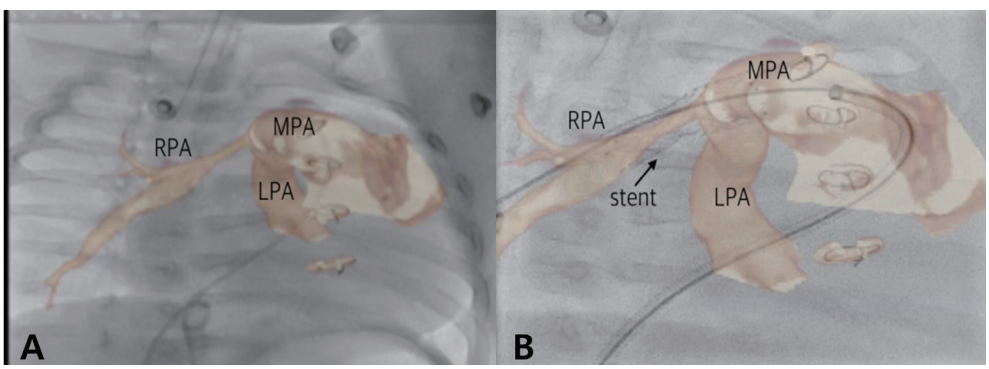


Fig. 3. Severe narrowing of the proximal right pulmonary artery is evident on live fluoroscopy with VesselNavigator (fusion imaging with computed tomography and fluoroscopy) (A), which offers a good 3-dimensional roadmap image for stenting without additional angiography (B). MPA, main pulmonary artery; RPA, right pulmonary artery; LPA, left pulmonary artery.

control population, the relatively small number of pediatric patients with CHD, and the broad spectrum of clinical expression. Nevertheless, the pediatric interventional cardiology community has made attempts to develop better solutions to minimize the need for open heart surgery and optimize overall outcomes.

Conflicts of interest

No potential conflict of interest relevant to this article was reported.

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Transcatheter Pulmonary Valve Implantation: A Comprehensive Systematic Review and Meta-Analyses of Observational Studies

Arka Chatterjee, MD; Navkaranbir S. Bajaj, MD, MPH; William S. McMahon, MD; Marc G. Cribbs, MD; Jeremy S. White, MD; Amrita Mukherjee, BDS, MPH; Mark A. Law, MD

***Background*—**Transcatheter pulmonary valve implantation is approved for the treatment of dysfunctional right ventricle to pulmonary artery conduits. However, the literature is limited because of a small patient population, and it does not reflect changing procedural practice patterns over the last decade.

***Methods and Results*—**A comprehensive search of Medline and Scopus databases from inception through August 31, 2016 was conducted using predefined criteria. We included studies reporting transcatheter pulmonary valve implantation in at least 5 patients with a follow-up duration of 6 months or more. In 19 eligible studies, 1044 patients underwent transcatheter pulmonary valve implantation with a pooled follow-up of 2271 person-years. Procedural success rate was 96.2% (95% confidence intervals [CI], 94.6–97.4) with a conduit rupture rate of 4.1% (95% CI, 2.5–6.8) and coronary complication rate of 1.3% (95% CI, 0.7–2.3). Incidence of reintervention was 4.4 per 100 person-years overall (95% CI, 3.0–5.9) with a marked reduction in studies reporting ≥75% prestenting (2.9 per 100 person-years [95% CI, 1.5–4.3] versus 6.5/100 person-years [95% CI, 4.6–8.5]; $P<0.01$). Pooled endocarditis rate was 1.4 per 100 person-years (95% CI, 0.9–2.0).

***Conclusions*—**Our study provides favorable updated estimates of procedural and follow-up outcomes after transcatheter pulmonary valve implantation. Widespread adoption of prestenting has improved longer-term outcomes in these patients. **(*J Am Heart Assoc*. 2017;6:e006432. DOI: 10.1161/JAHA.117.006432.)**

Key Words: endocarditis • Melody valve • reintervention • transcatheter pulmonary valve

Transcatheter pulmonary valve implantation (TPVI) was first performed by Bonhoeffer et al[1] in 2000. Bonhoeffer's work led to the development of the Melody Transcatheter Pulmonary Valve (Medtronic Inc, Minneapolis, MN). The Melody valve received US Food and Drug Administration approval under Humanitarian Device Exemption (HDE) in 2010 and Pre-Market Approval in 2015 for the treatment of right ventricular outflow tract (RVOT) conduit dysfunction. Use of the Melody valve has also been reported in off-label, nonconduit cases in both small series[2,3] and cohort studies including both conduit and native RVOT implantation. More recently, the ES-THV (Edwards Lifesciences LLC, Irvine, CA) has been implanted off-label in the pulmonary valve (PV) position, and the Sapien XT (Edwards Lifesciences LLC, Irvine, California) valve has been approved by the US Food and Drug Administration for use in dysfunctional right ventricle to pulmonary artery (PA) conduits.

In the last 16 years, multiple reports of outcomes of patients post-TPVI with the Melody valve and ES-THV have been published; however, the largest series is comprised of only 155 patients.[4] The longest duration of follow-up was a median period of 4.6 years.[5] In comparison, an estimated 50 000 adults underwent transcatheter aortic valve implantation between 2002 and 2012.[6] Randomized studies in various populations of adult degenerative aortic stenosis are feasible and have been performed comparing transcatheter aortic valve implantion to surgical aortic valve replacement.[7–10] Because of patient numbers and disease heterogeneity, randomized trials for TPVI are not feasible; therefore, to improve the body of knowledge of the short- and long-term

From the Division of Cardiovascular Diseases (A.C., N.S.B., M.G.C.), Departments of Pediatric Cardiology (W.S.M., M.G.C., M.A.L.) and Internal Medicine (J.S.W.), and School of Public Health (A.M.), University of Alabama at Birmingham, AL.

Correspondence to: Arka Chatterjee, MD, Division of Cardiovascular Diseases, University of Alabama at Birmingham, 1520 3rd Ave S FOT 920, Birmingham, AL 35294. E-mail: achatterjee@uabmc.edu

Received April 26, 2017; accepted June 15, 2017.

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Clinical Perspective

What Is New?

- Pooled data for >1000 patients suggest improving longevity for transcatheter pulmonary valve implantation, especially with universal adoption of pre-stenting and low rates of endocarditis.

What Are the Clinical Implications?

- The study provides updated estimates for procedural risk as well as medium-term outcomes which should facilitate decision making by physicians and patients/families alike.

outcomes post-TPVI, a systematic statistical review and meta-analyses of published observational reports is performed.

Methods

The study was reviewed and approved by the University of Alabama at Birmingham Institutional Review Board (Birmingham, AL).

Search Strategy

We queried the Medline and SCOPUS databases from inception until August 31, 2016 with the following MeSH terms: "Melody valve," "transcatheter pulmonary valve," "percutaneous pulmonary valve," and "transcutaneous pulmonary valve."

Study Characteristics

All observational studies, including case series and abstracts, were considered. Of these, studies that reported outcomes post-TPVI in at least 5 patients with a minimum of 6 months follow-up were included. There were instances of multiple publications from the same research group with overlapping patient populations. Caution was exercised in this scenario to carefully select only the publication with largest sample size and longest follow-up. Two authors (A.C., M.A.L.) independently reviewed studies with overlapping authors/institutions, and studies were included by mutual consensus. Figure 1 shows the relevant details of the study selection process.

Data Extraction

Two authors (A.C., J.S.W.) searched all titles and associated abstracts using the described search strategy. Full-text articles for all potentially relevant studies were extracted and reviewed with focus on inclusion criteria and outcome reporting. From these articles, studies were selected for inclusion. The data from these studies were extracted into prestructured forms and reviewed for accuracy and validity by 2 authors (A.C., M.A.L.). Disagreements were resolved with mutual consensus between authors.

Outcome Measures

We analyzed the data primarily to evaluate procedural success of TPVI and to estimate rate of reintervention post-TPVI. Definition of "success" was variable in the studies; however, it was most commonly defined as deployment of a transcatheter pulmonary valve (TPV) with acceptable gradient (<30 mm Hg peak to peak) and regurgitation (≤mild) without a need for surgical conversion before discharge. Reinterventions included catheter-based intervention (balloon angioplasty/valvuloplasty or TPVI) on the TPV or surgical right ventricle to PA conduit replacement.

Secondary outcomes evaluated included procedural complications, survival postprocedure, and incidence of endocarditis in follow-up. Endocarditis was defined as bloodstream

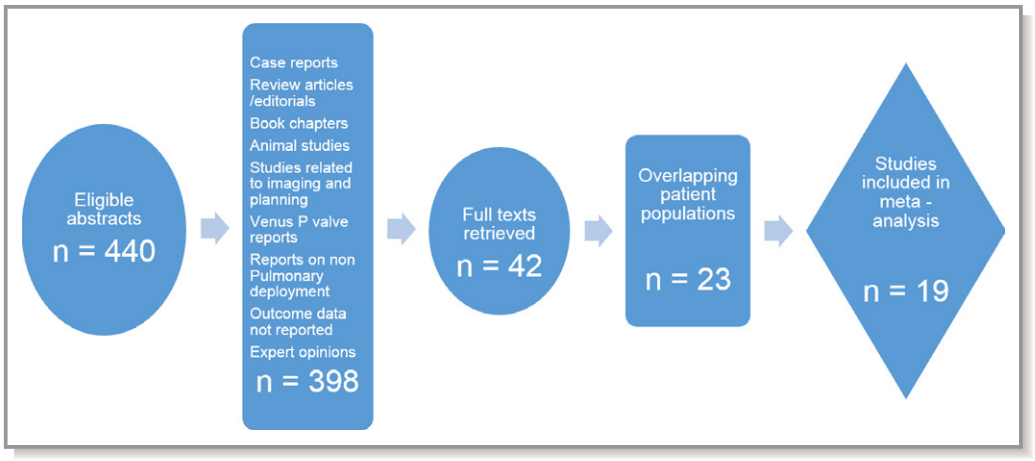


Figure 1. Flow diagram showing selection of studies for analysis.

infection classified in the respective study as possible or definite by the modified Duke criteria.[11] Endocarditis events were further analyzed as TPV-specific endocarditis (vegetation visualized on TPV or new dysfunction of TPV) and endocarditis leading to reintervention, explantation, or death. Additionally, a subgroup analysis was performed to ascertain relationship of prestenting with need for reintervention. To evaluate effect of prestenting, studies were divided into 2 groups—1 with ≥75% patients prestented before valve deployment and the other with <75% patients prestented. This cut off was chosen to reflect the change in practice in the United States pre- and post-HDE approval of the Melody valve as reported by Armstrong et al.[12]

Statistical Analysis

Systematic and statistical analyses were carried out with Comprehensive Meta-Analysis (version 3; Biostat, Englewood, NJ). Pooled event rates were computed using standard methods. Procedural outcomes are reported as percentages whereas follow-up outcomes are reported as events per 100 person-years (PY) of follow-up. Heterogeneity was assessed with the I^2 test (I^2 >50 and Q-statistic, P<0.05 implying substantial heterogeneity).[13] Random-effects modeling was utilized to account for studies' heterogeneity and observational nature. Publication bias was assessed using the funnel plot method (Figure 2). All of the P values were 2-tailed, with statistical significance specified at P<0.05 and confidence intervals (CI) computed at the 95% level. The analysis has been reported in accord with the PRISMA guidelines.[14]

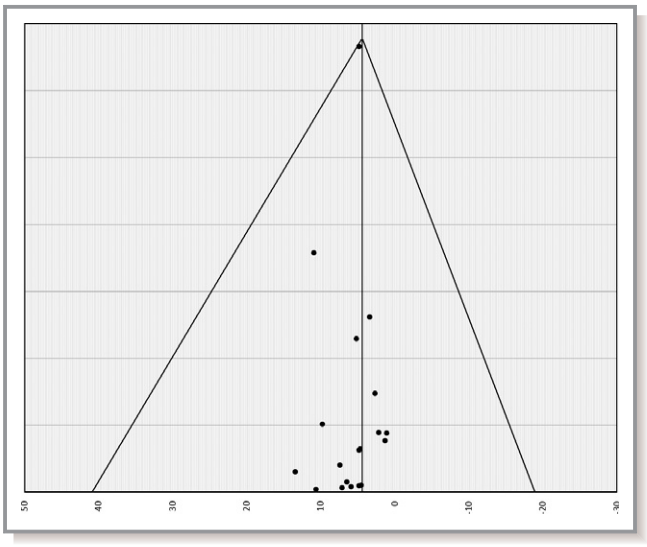


Figure 2. Funnel plot of rate of reinterventions using the SE method (95% CI).

Results

Nineteen observational studies[2–5,12,15–28] met inclusion criteria and were included in the final analysis. Table 1 illustrates the baseline characteristics of the included studies. A total of 1044 patients underwent attempted TPVI. The pooled analysis yielded a follow-up of 2271 PY. Thirteen studies solely used the Melody valve, 3 reported use of Edwards Sapien or Sapien XT THV, and 3 studies used both Melody and Edwards valve systems. Of the latter 3, Faza et al[21] reported separate outcomes for Melody and Edwards cohorts. The Edwards cohort had overlapping patients with the study reported by Kenny et al.[24] Hence, only the data for the Melody valve cohort were included for analysis from this article. Our data include TPVI attempted with the Melody valve system in 942 patients and Edwards THV system in 102 patients. Seven studies included at least 1 patient with a nonconduit RVOT whereas 2 studies reported solely on TPVI in patients with nonconduit RVOTs.

Patient Selection for TPVI

Eight studies[4,12,15,16,18,24,25,28] elaborated on the patient cardiac catheterization selection process before attempting TPVI. The pooled estimate of patients considered ineligible for TPVI was 7.7% (95% CI, 4.8–12.2%). In total, 52 of 623 patients were screened out as not suitable for TPVI. Reasons for exclusion included the following: coronary compression on balloon testing (n=18; 2.9%); conduit size not suitable for TPVI (n=18; 2.9%); conduit function better than anticipated on hemodynamic catheterization (n=8; 1.2%), branch PA stenosis (n=2; 0.3%) an exclusion criteria in early trials[29]; conduit stenosis adequately relieved by angioplasty alone (n=4; 0.6%); surgery needed for other congenital heart defects (n=1; 0.2%); and unspecified (n=1; 0.2%).

Procedural Outcomes

Success and procedural complications

Overall, 1019 of 1044 patients had a successful TPVI, yielding a pooled procedural success rate of 96.2% (95% CI, 94.6–97.4). Pooled procedural mortality was 1.5% (95% CI, 0.8–2.6%). There were a total of 5 procedural deaths. Two deaths were secondary to coronary compression or dissection whereas the other 3 patient deaths occurred when TPVI was utilized in a compassionate salvage procedure and mortality was likely not secondary to an adverse outcome of TPVI.

The adjusted pooled rate for total short-term complications was 10.1% (95% CI, 7.3–13.8). The most

Table 1. Studies Included and Demographic/Clinical Factors of Patients

First Author, Year (Ref)	Patients Considered/ Attempted	Age (y)	Median Follow-up (y)	Valve Used	Primary Pathology				Native RVOT (Yes/No/Only)	Indication		
					TOF/ PA/PS	Ross	TGA/ Truncus	Other		Stenosis	Regurg	Mixed
Wilson, 2015[27]	NA/25	34.0	3.5*	E	17	6	2	0	No	8	7	10
Cheatham, 2015[28]	167/150	19.0	4.5	M	80	31	31	8	No	39	80	31
Cools, 2015[19]	NA/111	19.3	2.4	M	71	22	18	0	Yes	49	36	26
Jalal, 2015[23]	NA/10	16.3	0.9*	M	7	0	2	1	Yes	3	2	5
Biernacka, 2015[16]	42/40	25.4	1.7*	M/E	30	5	4	1	Yes	19	21	0
Borik, 2015[17]	NA/51	20.2	4.2	M	35	5	10	1	No	NA	NA	NA
Berman, 2014[15]	25/24	8.0	1.3	M	18	2	5	0	No	5	7	13
Armstrong, 2014[12]	120/101	19.9	0.9	M	61	20	28	11	No	16	52	32
Fraisse, 2014[5]	NA/64	21.4	4.6	M	35	8	15	6	No	14	7	43
Meadows, 2014[3]	NA/31	24.0	1.3	M	28	0	1	2	Only	3	14	14
Malekzadeh-Milani, 2014[2]	NA/34	26.0	2.6	M	26	2	2	4	Only	18	16	0
Faza, 2013[21]	NA/13	20.9	0.5	M	9	0	2	2	No	7	3	3
Odemis, 2013[26]	NA/10	19.2	0.8	M/E	NA	NA	NA	NA	Yes	NA	NA	NA
Butera, 2013[18]	63/61	24.0	2.5	M	27	9	12	15	No	21	12	30
Haas, 2013[22]	NA/22	21.7	0.5*	E	13	2	4	3	Yes	2	11	9
Eicken, 2011[20]	NA/102	21.5	1.0	M	61	8	23	10	Yes	36	18	48
Kenny, 2011[24]	36/34	30.3	0.5	E	16	11	1	8	No	15	19	2
Martins, 2010[25]	7/6	19.0	0.7	M	3	0	4	0	No	0	0	7
Lurz, 2008[4]	163/155	21.2	2.4	M	94	12	31	18	Yes	61	46	44

E indicates Edwards; M, melody; NA, not applicable; PA/PS, pulmonic atresia/stenosis; Ref, reference number; RVOT, right ventricular outflow tract; TGA, transposition of great vessels; TOF, tetralogy of fallot.
*Mean follow-up.

frequent complication reported was conduit rupture: 4.1% (95% CI, 2.5–6.8). A total of 32 conduit ruptures were reported. The majority of ruptures were treated with covered stent and/or valve deployment. Only 5 required surgical repair. Other frequently observed complications were access-site complications requiring blood transfusion or vascular surgery: 2.8% (95% CI, 1.7–4.6) and dislodgement of stent/valve system: 2.5% (95% CI, 1.3–4.8). Table 2 lists rates of all procedural complications. Notably, despite prescreening for coronary compression in most protocols, 5 patients had a coronary complication from either the bare metal stent used for prestenting or the valve system itself (pooled incidence rate, 1.3%; 95% CI, 0.7–2.3).

Surgical conversion for the management of complications occurred in 3.4% of cases (95% CI, 2.3–5.2). Reasons for surgical conversion were stent/valve dislodgement in 9 cases, conduit rupture in 5 cases, coronary compression in 4 cases, obstructed branch PA in 1 case, and stent compression causing acutely elevated gradient in another case.

Follow-up Outcomes

Death

The adjusted pooled rate for death following discharge after a successful TPVI was 0.6 per 100 PY (95% CI, 0.3–0.9). There were a total of 17 deaths reported. Four of these were attributed to sepsis/endocarditis, 2 were secondary to progressive right ventricle dysfunction despite TPVI, 7 were considered to be unrelated to TPVI, whereas 4 were unexplained and may have been caused by arrhythmia.

Stent fractures

Reporting of stent fractures was not uniform across the studies included. Twelve studies reported on total and significant stent fractures, 2 reported total fractures only,

Table 2. Pooled Estimates for Short-Term Procedural Outcomes

	No. of Studies	Pooled Estimate (%)	I^2	*P* Value
Procedural success	19	96.2 (94.6–97.4)	0.0	0.48
Total complications	17	10.1 (7.3–13.8)	52.1	0.01
Death	19	1.5 (0.8–2.6)	0.0	0.98
Access complications	16	2.8 (1.7–4.6)	0.0	0.50
Coronary compression/dissection	17	1.3 (0.7–2.3)	0.0	1.00
Conduit rupture	17	4.1 (2.5–6.8)	43.6	0.03
Pulmonary artery perforation/laceration	17	2.1 (1.3–3.5)	0.0	0.85
Stent/valve dislodgement	17	2.5 (1.3–4.8)	38.5	0.05
Surgical conversion	18	3.4 (2.3–5.2)	7.8	0.36

whereas 2 others reported on significant stent fractures only (assumed to be either type 2 or 3 stent fractures per the Nordemeyer classification).[29] Pooled incidence of all stent fractures was 4.4 per 100 PY (95% CI, 2.4–6.3) whereas type 2/3 stent fractures were noted in 1.3 per 100 PY (95% CI, 0.5–2.0).

Reintervention

Overall, 4.4 patients required a RVOT reintervention per 100 PY of follow-up (95% CI, 3.0–5.9). Breaking these down, catheter-based reinterventions accounted for 2.7 events per 100 PY (95% CI, 1.7–3.7) whereas adjusted rate for surgical reinterventions was 1.7 per 100 PY (95% CI, 1.2–2.2). There is significant heterogeneity in the studies in this regard, which is negated once we analyze studies after adoption of prestenting (Figure 3).[2–5,12,15–28] In total, 77.5% of reinterventions were done for restenosis, 15.2% for endocarditis, only 1.8% for valve insufficiency, and 5.2% for other indications.

Effect of prestenting on stent fractures and reintervention

Studies with ≥75% prestenting had a much lower total rate of stent fractures (2.3 versus 7.2 per 100 PY; $P<0.01$). Reintervention was also less frequent in this group: 2.9 per 100 PY (95% CI, 1.5–4.3) as compared with 6.5 per 100 PY (95% CI, 4.6–8.5) for the studies with <75% prestenting ($P<0.01$). This difference persisted if we analyze catheter based or surgical reinterventions separately (Table 3).

Endocarditis

Pooled incidence rate of endocarditis in these 19 studies was 1.4 per 100 PY (95% CI, 0.9–2.0). TPV-specific endocarditis (vegetation involving TPV or new TPV dysfunction) and endocarditis requiring reintervention/TPV explantation or causing death occurred at a rate of 0.6 per 100 PY (95% CI, 0.3–0.9).

Discussion

Our meta-analysis is the first attempt to systematically pool high-quality observational studies to provide an estimate of procedural as well as follow-up outcomes. We report pooled outcomes of more than 1000 patients with a follow-up of 2271 PY. Because 20% of patients with congenital heart disease have RVOT or PV dysfunction,[30] many patients undergo surgical RVOT conduit or PV placements during their lifetime and will need revisions with age. TPVI is an attractive option to minimize the need for repeated cardiac surgery for these patients. Although several studies have reported on the safety and feasibility of TPVI with excellent short-term results[4,18,28] and improvement in cardiopulmonary exercise capacity and quality of life,[31,32] direct comparisons between surgical valve replacement and TPVI have not been made. European Society of Cardiology guidelines[33] do not distinguish between surgical and catheter interventions. American societies give TPVI a Class IIa recommendation.[34] The pooled data from this meta-analysis support TPVI as a highly successful intervention to treat RVOT dysfunction with an acceptable complication profile and low reintervention rate.

Procedural Success and Complications

The procedural success for TPVI is greater than 96%, with a complication rate of 10%. Our pooled estimate for procedural success is consistent with the high rates reported in the US IDE trial[28] and postapproval study[12] as well as the larger European studies.[4,19,20] Failed TPVI procedures were commonly associated with a complication requiring surgical conversion, which occurred in over 3% of cases. We believe

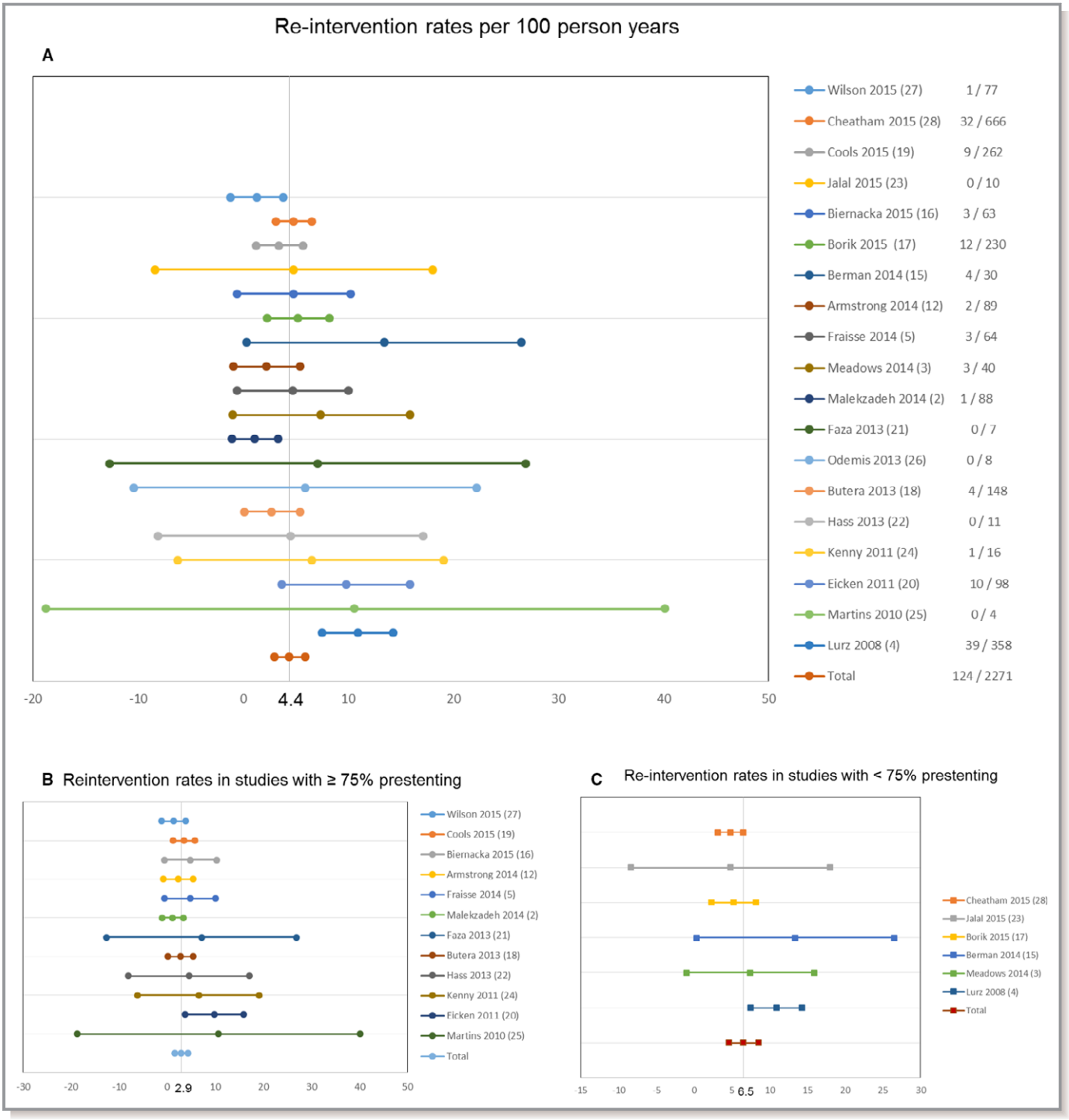


Figure 3. Forest plots depicting reintervention rates in the total pooled sample (A)—individual study event rates are noted in the right column (events/follow-up in person-years); reintervention rates contrasted among studies with <75% (B) and ≥75% presenting rates (C).

that procedural experience focusing on decreasing or treating these known complications will further increase TPVI success rates and decrease the frequency of surgical conversion.

Conduit rupture is a significant complication of TPVI. Berman et al[15] reported a very high rate of 20.8% conduit rupture, although this study solely reported on a specific patient population weighing <30 kg with stenotic homograft conduits. In another series of 99 RVOT interventions, which included 76 TPVI procedures, homografts had a higher frequency of rupture.[35] Interestingly, neither conduit size nor type/size of balloon used was associated with risk of rupture. This study classified conduit rupture severity as absent (grade 0), minimal rupture without extension (grade 1), moderate rupture with

Table 3. Pooled Estimates for Outcomes in Follow-up

Parameter	No. of Studies	Events/ 100 PY	Lower CI	Upper CI	I^2	*P* Value
Death	19	0.6	0.3	0.9	0.0	0.95
Stent fracture	14	4.4	2.4	6.3	79.7	0.00
Type 2/3 stent fracture	15	1.3	0.5	2.0	53.3	<0.01
Patients requiring reintervention	19	4.4	3.0	5.9	51.4	<0.01
Catheter re-interventions	19	2.7	1.7	3.7	44.7	0.02
Surgical reintervention	19	1.7	1.2	2.2	0.0	0.56
Endocarditis	19	1.4	0.9	2.0	11.9	0.31
TPV specific endocarditis	19	0.6	0.3	0.9	0.0	0.70
Endocarditis requiring explantation/ death/reintervention	19	0.6	0.3	0.9	0.0	0.88
Effect of prestenting						
Stent fracture						<0.01*
≥75% prestenting	8	2.3	0.8	3.7	57.7	0.02
<75% prestenting	5	7.2	5.0	9.3	26.9	0.24
Type 2/3 stent fracture						0.01*
≥75% prestenting	9	0.6	0	1.2	0.0	0.91
≤75% prestenting	5	2.3	1.4	3.2	60.5	0.04
Patients requiring reintervention						<0.01*
≥75% prestenting	12	2.9	1.5	4.3	0	0.46
<75% prestenting	6	6.5	4.6	8.5	56.5	0.04
Catheter reinterventions						<0.01*
≥75% prestenting	12	1.5	0.7	2.3	1.5	0.43
<75% prestenting	6	4.4	3.3	5.5	0.0	0.56
Surgical reinterventions						<0.01*
≥75% prestenting	12	1.3	0.5	2.0	0.0	0.81
<75% prestenting	6	2.2	1.4	3.0	35.7	0.17

PY indicates person-years; TPV, transcatheter pulmonary valve.
**P* value for subgroup analysis.

extension but contained and without hemodynamic instability (grade 2), and severe rupture with extension causing hemothorax or hemopericardium and with hemodynamic instability requiring blood transfusion (grade 3). Only 2 of 9 conduit ruptures reported were grade 3, and these were managed without surgery. Similarly, very few of the 32 conduit ruptures in our pooled analysis required surgical conversion, mostly managed with covered stents and/or valve implantation. The pooled rate of conduit rupture (4.1%) is comparable with Armstrong et al,[12] who found an incidence of 5.9%.

Notable other procedural complications with important implications for the TPVI procedure are dislodgement of the stent/valve apparatus and PA perforation. Although these complications can sometimes be managed with catheter techniques, this meta-analysis demonstrates that inability to retrieve or stabilize the dislodged/malpositioned valve or control PA bleeding results in surgical conversion. Six of the 9 valve dislodgements in our pooled sample were Edwards THV. Although determining whether this finding is significant is beyond the scope of this report, however, off-label implantation of the Edwards THV into patched or native RVOT may be related to increased risk of valve dislodgement. Similarly, we have insufficient information to conclude if nonconduit Melody implants carry a higher risk of the same. Reports of Sapien use for TPVI are from early use of the device and growing familiarity and technical expertise may obviate this difference.

Eligibility for TPVI

Not all patients needing PV replacement are candidates for TPVI. Our pooled estimate of 7.7% of potential TPVI candidates found at the time of the procedure to be ineligible

is comparable to both the US Melody IDE trial (10.2%)[28] and the largest European study by Lurz et al (4.9%).[4] The post–market approval study by Armstrong et al had a higher exclusion rate of 15.8%.[12] It is important to point out that studies elaborating on the patient selection details predominantly did not include native RVOT candidates, hence this estimate should not be extrapolated to nonconduit implants. Because surgical conversion or death are predictable outcomes of coronary compression, this finding during balloon testing is a contraindication to TPVI. As expected, this is the most common reason for patient exclusion from TPVI. The occurrence of coronary compression on balloon testing (raw, 2.9%; pooled estimate, 3.7%) was similar to the 5% reported by Morray et al.[36] They studied 404 patients considered for TPVI from 4 large-volume centers included in US IDE trial and found that a large proportion of patients with coronary compression on balloon testing had anomalous coronary artery anatomy (15 of 21). The finding in this meta-analysis supports the practice of careful preprocedural and procedural coronary artery imaging and balloon testing for coronary compression before prestenting or valve implantation.

Branch PA stenosis and unsuitable conduit size were other common reasons for exclusion. Two patients in our pooled sample were excluded because of distal PA stenosis, which would not have been an exclusion criterion in current clinical practice where concurrent intervention could be performed, if indicated. Unsuitable conduit size was another common reason for exclusion. Theoretically, the Melody valve mounted on a 24-mm balloon or the Edwards THV could be implanted in some patients who were excluded secondary to large conduit or RVOT size, potentially decreasing the patient exclusion rate.

Reintervention

There is lack of data on the longevity of the Melody valve. Cheatham et al recently published a rate of 76±4% freedom from reintervention at 5 years[28] in the US IDE trial cohort. They found higher rates of reintervention in patients with homografts, without prestenting, a higher post-TPVI RVOT gradient (>25 mm Hg) and preimplantation moderate-to-severe tricuspid valve insufficiency. Our pooled rate of 4.8 per 100 PY also reflects a similar outcome. However, implantation practices have changed over the last decade and now place significant emphasis on prestenting with bare metal stents. Only 10% of cases were prestented in the first tertile of the US IDE trial.[28] In comparison, the postapproval study by Armstrong et al observed prestenting in 76 of 101 patients.[12] Similarly, Cools et al and Fraisse et al report prestenting rates of 96.4% and 96.9%, respectively.[5,19] Schievano et al, in their in vitro modeling study, showed that a stent-in-stent technique decreased mechanical stress on the TPV stent struts.[37] There are increasing data to support that prestenting reduces stent fractures and hence reduces the need of reintervention. A recent meta-analysis investigated the relationship between prestenting and stent fractures pooling data from 5 studies.[38] Prestenting was associated with a 2-fold reduction in all stent fractures and a 6-fold reduction in type II/III stent fractures. However, the pooled sample only included 360 patients, of whom 207 were prestented. This study also showed a reduction in RVOT reintervention in prestented patients in a subgroup analysis including 191 patients only with 1 versus 6 reinterventions in prestented and non-pre-stented patients.

With a lack of clinical data regarding prestenting/stent fractures and reinterventions, we chose to analyze the pooled data in a different manner. Adopting Armstrong et al's postapproval study[12] as a reflection of common clinical practice, we divided the studies into 2 groups—≥75% prestenting and <75% prestenting. We found a markedly lower rate of stent fractures (in total and type 2/3) as well as reintervention rates. The reduction in reintervention rates persisted for both catheter and surgical reinterventions. The rates of reintervention in the first group are more comparable to rates reported for surgical conduits and homografts.[39] Thus, TPVI seems to be bridging the gap in longevity compared with surgical conduits as practice patterns have become more refined and standardized.

Endocarditis

Bloodstream infections have been recognized as a late complication post-TPVI. Varying rates for endocarditis have been reported in different cohorts of patients. McElhinney et al reported an annualized rate of first episode of endocarditis and TPV-related endocarditis of 2.4% per PY and 0.88% per PY, respectively.[40] This was derived from 3 patient cohorts in North America and Europe and had a cumulative follow-up of 687.1 PY. Malekzadeh-Milani et al, in their study of 86 patients followed for a mean duration of 23.6±15 months, reported a rate of 5.8% (5 cases).[41] Interestingly, all 5 of these cases could be classified as TPV-related endocarditis. Buber et al reported a rate of 9.5% (14 cases) in their 147 patient study over a median follow-up period of 19 months.[42] Whereas vegetations were only noted on 4 valves, all 14 cases had a new elevation in RVOT gradient. The pooled rates for endocarditis and TPV-specific endocarditis estimated in our study are considerably lower, with a cumulative follow-up of over 2200 PY.

It is thought that TPVI in a smaller conduit is a risk for endocarditis given a higher residual gradient.[40,43] Also, a majority of cases reported have been associated with predisposing conditions, including noncompliance with antibiotic prophylaxis regimen with dental or other invasive

procedures, and concomitant bacterial infection.[4,18,40] Role of aspirin discontinuation has also been reported.[41] In retrospective comparisons of Melody valve versus surgical RVOT conduits, Melody valves have been noted to have a higher rate of endocarditis.[44,45] The difference is pronounced when comparing Melody valves with homografts, but not for Contegra bovine valved conduit, suggesting possible tropism of micro-organisms to the bovine material used in making the Melody and Contegra valves.[45]

Limitations

The primary study limitations are inherent to the meta-analysis study design. Systematic pooling of different observational studies with differences in baseline characteristics, anatomic substrate, sample sizes, implantation techniques, valve type, and different follow-up durations introduce imprecision in the results because of heterogeneity. Many studies included have small sample sizes and follow-up durations and may lead to falsely low outcome rates, especially for endocarditis. There are variations in reporting how many patients were screened but considered ineligible for TPVI. Under-reporting of outcomes has to be taken into account given that all of the data included are observational. We concede that there is variability in how data are presented in each study, criteria for implant, and adverse event reporting are also nonuniform. There may be under-reporting of endocarditis, especially in the earlier studies. Moreover, there has been refinement of the procedure and improved outcomes as operators have become more experienced. It should be kept in mind that results from this analysis cannot be extrapolated to long-term outcomes.

Because TPVI is now considered standard of care, randomized controlled trials proving the safety and efficacy of TPVI versus surgical right ventricle to PA conduit or PV implantation are not feasible. Furthermore, small sample size limitations in congenital heart disease makes pooling of multiple observational studies a logical approach to increase the evidence to support interventional therapies and outcomes. Thus, in spite of the inherent limitations, this meta-analysis can clarify extensive and sometimes conflicting data by systematic organization and aggregation of available observational data. We hope that the pooled estimates can be used as a "worst-case scenario," especially given that it includes a significant number of patients from the early years of TPVI.

Conclusion

In our systematic review and meta-analyses pooling studies reporting TPVI outcomes on conduit as well as nonconduit RVOTs with Melody and Edwards THV systems, TPVI was found to have an outstanding procedural success rate with an acceptable complication profile and low need for surgical conversion. We also demonstrate corroborative evidence of decrease in stent fractures and RVOT reinterventions with increase in adoption of prestenting with bare metal stents. Our analysis reports lower rates of infective endocarditis and TPV-related endocarditis than previously reported; however, this finding should be evaluated with caution, given the chance of under-reporting of events in observational data and the potentially catastrophic effects of TPV endocarditis. More experience needs to be gained with nonconduit RVOT TPVI procedures as well as with using the newer generations of Edwards Sapien XT and Sapien 3 systems to draw concrete conclusions about the same.

Disclosures

None.

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Canadian Journal of Cardiology 30 (2014) 75–86

Review

Evolving Trends in Interventional Cardiology: Endovascular Options for Congenital Disease in Adults

William Wilson, MBBS, FRACP,[a] Mark Osten, MD, FRCPC,[a]
Lee Benson, MD, FRCPC, FACC, FSCAI,[b] and Eric Horlick, MDCM, FRCPC, FSCAI[a]

[a] *Toronto Congenital Cardiac Centre for Adults, Peter Munk Cardiac Centre, University Health Network and University of Toronto, Toronto, Ontario, Canada*
[b] *Hospital for Sick Children, Division of Cardiology, Toronto, Ontario, Canada*

ABSTRACT

As increasing numbers of patients with congenital heart disease enter adulthood, there is a growing need for minimally invasive percutaneous interventions, primarily to minimize the number of repeated surgeries required by these patients. The use of percutaneous devices is commonplace for the treatment of simple lesions, such as atrial septal defect, patent foramen ovale, patent duct arteriosus, and abnormal vascular connections. There is also substantial experience with device closure of membranous and muscular ventricular septal defects, as well as more complex shunts such as baffle leaks after atrial switch repair and ventricular pseudoaneurysms. An increasing use of covered stents has improved the safety of aortic coarctation, conduit, and branch pulmonary stenosis interventions. Percutaneous pulmonary valve implantation now has an established role in the setting of dysfunctional right ventricle-pulmonary artery conduits or failing bioprosthetic pulmonary valves. Many patients remain unsuitable for percutaneous pulmonary valve implantation because of large diameter "native" outflow tracts, however, various techniques have emerged and multiple devices are in development to provide solutions

RÉSUMÉ

Alors que de plus en plus de patients ayant une cardiopathie congénitale arrivent à l'âge adulte, le besoin d'interventions percutanées minimalement invasives se fait croissant, principalement pour minimiser le nombre de chirurgies répétées souvent requises par ces patients. L'utilisation de dispositifs percutanés est devenue fréquente pour le traitement des lésions simples, comme la communication interauriculaire, la persistance du foramen ovale, la persistance du canal artériel et les anastomoses vasculaires anormales. L'expérience concernant la fermeture des anomalies du septum membraneux et du septum musculaire par un dispositif, ainsi que les shunts plus complexes comme les fuites de la cloison après la détransposition auriculaire et les pseudoanévrismes ventriculaires est également non négligeable. L'utilisation croissante des endoprothèses recouvertes a amélioré l'innocuité des interventions liées à la coarctation de l'aorte, des sténoses du conduit et des branches pulmonaires. L'implantation percutanée d'une valvule pulmonaire a maintenant un rôle bien établi dans le cadre des conduits dysfonctionnels du ventricule droit et de l'artère pulmonaire défaillantes, ou des bioprothèses

The development and implementation of new surgical techniques in conjunction with improvements in medical care for patients with congenital heart disease has resulted in a significant reduction in childhood mortality rates from near 100% in the mid twentieth century to approximately 20% in the 1970s and 5% in the current era.[1,2] Increasing numbers of patients with congenital heart disease are now surviving to adulthood, such that there are now more adults than children with congenital heart disease.[3] Most patients with complex disease have had palliative surgery in childhood and many will require further interventions in adulthood, many of which can now be performed via a transcatheter approach, owing to improvements in transcatheter techniques and advances in equipment. Concurrent improvements in cardiac imaging have facilitated more accurate diagnosis and guidance of increasingly complex lesion sets.

In this article, the evolving trends in interventional procedures for congenital heart disease, including simple lesions such as ventricular septal defects (VSDs) and coarctation, and more complex interventions such as percutaneous pulmonary valve replacement and those used in patients with complex congenital heart disease are reviewed.

Imaging and the Cardiac Catheterization Laboratory

Intraprocedural imaging is of great importance in guiding structural and congenital interventions. Fluoroscopic imaging and angiography are employed universally and have been widely used since the 1950s. Over the past 20 years, there has been

Received for publication September 27, 2013. Accepted November 6, 2013.

Corresponding author: Dr Eric Horlick, 200 Elizabeth St, Room 6E-249, Toronto General Hospital, Toronto, Ontario M5G 2C4, Canada. Tel.: +1-416-340-3835; fax: +1-416-340-3000.
E-mail: Eric.Horlick@uhn.ca

See page 83 for disclosure information.

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http://dx.doi.org/10.1016/j.cjca.2013.11.006

for these unique anatomic challenges. Hybrid approaches involving use of surgical and transcatheter techniques are increasingly common, serving to optimize efficacy and safety of certain procedures; they depend on a collaborative and collegial relationship between cardiac surgeons and interventionalists that is primarily patient-centred.

valvulaires pulmonaires dé faillantes. L'implantation percutanée d'une valvule pulmonaire demeure inappropriée pour plusieurs patients en raison des voies d'éjection « natives » de grand diamètre. Cependant, des techniques variées sont apparues, et de nombreux dispositifs sont en développement pour offrir des solutions à ces particularités anatomiques. Les approches hybrides avec l'utilisation de techniques chirurgicales et par cathéter sont de plus en plus fréquentes, et servent à optimiser l'efficacité et l'innocuité de certaines interventions; elles dépendent d'une relation collégiale et de collaboration entre les chirurgiens cardiaques et les cathétériseurs interventionnels, qui est principalement axée sur le patient.

an increasing use of intraprocedural transesophageal echocardiography (TEE) and, more recently, intracardiac echocardiography (ICE). TEE and ICE are of particular use in assisting percutaneous device closure of septal defects (atrial and ventricular), paravalvular leaks and left atrial appendage occlusion. Familiarity with ICE is a useful skill for the interventionalist because it affords independence and obviates the need for an echocardiographer to be present during certain interventions, in particular, atrial septal defect (ASD) device closure. 3-D ICE might provide additional insight into complex lesions of the atrial septum and enhance our ability to guide intracardiac intervention. TEE (2-dimensional and 3-D) retains an important preprocedural role in this setting, in particular for definition of multiple ASDs. Rotational angiography with 3-D reconstruction capability and computed tomography aortography (CTA)/magnetic resonance aortography (MRA) 3-D fluoroscopic overlay are now commercially available; these can afford 3-D visualization and allow fusion of 3-D models with fluoroscopic images.[4] Potential benefits include improved image quality, improved interventional guidance, lower overall radiation exposure and, thus, improved patient safety. In the structural intervention arena, such 3-D imaging is of particular use for planning and guidance of coarctation stenting, percutaneous pulmonary valve implantation (PPVI) and complex interventions in the Fontan circulation or after atrial switch repair.[5,6] Imaging in the setting of a single ventricle is enhanced by cessation of respiration and manipulation of the heart rate and cardiac output (with adenosine or rapid pacing, for example[6,7]) to slow contrast transit time. Limitations currently include the inability to overlay in the lateral plane and the lack of "dynamic" overlay (current images are static with no adjustment for heart motion or respiration). Future advances should resolve these issues, allowing for the development of the "triple overlay" technique with coregistration of preprocedural CTA or MRA, intraprocedural 3-D rotational angiography, and echocardiography with live fluoroscopy.

Most structural interventions are currently performed in catheterization laboratories designed for coronary intervention. Ideally, delivery of valves and devices should be performed in a setting with operating room standards of air exchange and optimized imaging systems, including a biplane fluoroscopy system coregistered with intraprocedure TEE and preprocedure computed tomography (CT)/magnetic resonance imaging (MRI) scans. Furthermore, such procedures often require extra space to accommodate extra personnel (anaesthetic team, echocardiographer) and extra equipment. The "hybrid" laboratory has been designed to meet these requirements.

Simple Congenital Lesions

Shunts

ASDs. ASDs remain the most common congenital defect diagnosed in adulthood. Indications for ASD closure include a hemodynamically significant shunt, evidence of right atrial or right ventricular enlargement, paradoxical embolism, or platypnea-orthodeoxia syndrome.[8] Percutaneous treatment is well established as a therapy for secundum ASDs with appropriate anatomy, which includes diameter < 38 mm and adequate rims. The Amplatzer Septal Occluder device instructions for use[9] list the presence of any rim of less than 5 mm (other than the aortic rim) as a contraindication to device insertion, and a deficient aortic rim is listed as a warning. In our experience, however, it is possible to safely implant a device without long-term issues in those with shorter rims (as long as an indent is evident during balloon sizing). Other types of ASDs, including ostium primum and sinus venosus defects, remain unsuitable for device closure. Patients with coexisting secundum defects and anomalous pulmonary veins might be carefully evaluated using cardiac MRI[10] to define the relative flow from the anomalous vein vs the intracardiac shunt; in adults, especially of older age, closure of the defect without addressing the anomalous venous drainage might provide symptomatic relief (likely at the expense of mild residual right ventricle [RV] enlargement).

Improvements in the ASD occluder devices, delivery systems, and techniques have improved safety and efficacy of the procedure and have allowed for closure of larger, more complex defects. Two designs frequently used currently are (Supplemental Fig. S1): nitinol wire mesh-based double disk plugs (including the Amplatzer septal occluders [St Jude Medical, Plymouth, MN] and the Occlutech device [Occlutech International AB, Helsingborg, Sweden]) and the Gore Septal occluder (Gore Medical, Flagstaff, AZ). The Gore septal occluder uses a 5-wire frame covered with a polytetrafluoroethylene patch-like material and has a better design than its predecessor, the Gore Helex device. The Gore septal occluder has superior conformability, apposition, and closure performance[11] but is only suitable for defects smaller than 20 mm.

Several nonrandomized studies have compared percutaneous secundum ASD closure with surgical repair; in a recent retrospective study of 718 patients from a Québec database (1988-2005), 30-day mortality rates were similar (1.0% vs 0.3%; $P = 0.38$) and there was no difference in 5-year mortality rates.[12] Procedural success rates of more than 95%

have been documented with no differences in efficacy (defined as successful closure without major complications or need for surgical intervention) in the medium term in another study.[13] Percutaneous closure is, therefore, the procedure of choice where technically feasible.

Overall complication rates are low after transcatheter device occlusion of ASDs.[14] Medical Device Reporting-reported major adverse events for the on-label use of the Amplatzer Septal Occluder device (with associated rates based on world-wide reported events and sales) include: embolization (0.16%), erosion (0.04%), arrhythmia (0.02%), thrombus on device (0.005%), and stroke (0.003%).[15] Device erosion, when it occurs, usually does so in the region of the antero-superior wall and often involving the aorta. Conjecture exists regarding the exact mechanism for erosion; although an AGA expert panel recommended against device oversizing and avoidance of overstretching the balloon when balloon-sizing the defect to reduce erosion risk, many operators believe an undersized device with tip protrusion into the aortic root or excess motion of the device relative to the heart to be greater risk factors.[16,17] We avoid device oversizing relative to balloon size (ie, no more than 1 mm for devices less than 20 mm and no more than 2 mm for those more than 20 mm), but in the case of a deficient aortic rim, we prefer the device splay around the aorta, rather than causing an indent. Late erosions have not been reported with the flexible Gore septal occluder, however, there remains limited experience with this device.

Intracardiac echocardiography has emerged as a useful adjunctive tool for ASD device closure, and is particularly useful for defining the inferoposterior margin of the defect.[18]

Challenging subsets include:

- A fenestrated septum: options include use of a cribriform Amplatzer device or performance of a balloon septostomy to coalesce smaller defects into 1 large defect that is closed with a single device;
- Multiple defects: multiple devices can be inserted in the septum;
- Coexistent systolic and/or diastolic left ventricular dysfunction, where there is risk of decompensation with occlusion of the ASD. In this setting, test balloon occlusion to assess for a significant rise in left atrial pressure (of more than 10 mm Hg) should be performed, in which case, so-called "anti-congestive conditioning" or deliberate device "fenestration" has been discussed.[19] In our experience however, heart failure rarely, if ever, ensues in this scenario when diuretics are used for 2 weeks before ASD closure.
- Pulmonary hypertension (PAH): closure is contraindicated if there exists irreversible PAH (pulmonary artery [PA] pressure more than two-thirds systemic arterial blood pressure or pulmonary arteriolar resistance greater than two-thirds the systemic arteriolar resistance). Closure is possible if PAH is present with a net left-to-right shunt of greater than 1.5:1, or there is evidence of PA reactivity when challenged with a pulmonary vasodilator.[8] Evaluation of a patient with PAH and an ASD might involve pretreatment with a vasodilator or initiation of a loop diuretic, depending on the aetiology (the "treat and close" model). Involving experts in PAH in the multidisciplinary team responsible for the management of these patients is mandatory.

VSDs. VSDs amenable to transcatheter closure include postoperative residual defects, defects of the muscular septum (congenital or acquired after myocardial infarction), and membranous defects that are remote from the aortic and tricuspid valves with an adequate rim. Current indications for closure include a hemodynamically significant shunt (ie, symptomatic, left ventricular volume overload or dysfunction, or a shunt more than 2:1), recurrent endocarditis, or in the presence of more than mild aortic incompetence in the setting of a perimembranous or subarterial VSD. Closure of a VSD to prevent paradoxical emboli in the setting of transvenous pacing is controversial.[8] VSD closure should be avoided in the setting of PAH with Eisenmenger physiology. As with ASDs, pulmonary vasodilator challenge might be useful in patients with PA pressures more then two-thirds systemic arterial pressure and a pulmonary vascular resistance of more than two-thirds systemic arteriolar resistance.

The first successful percutaneous VSD device closure was reported by Lock et al. in 1987 using a Rashkind double umbrella device for a muscular VSD.[20] Multiple devices have since been developed including the Amplatzer muscular VSD occluder, the Amplatzer post myocardial infarction VSD occluder, and the Amplatzer membranous VSD occluder (St Jude Medical). A technique for VSD closure using the Nit Occlud coil (PFM Medical Ag, Koln, Germany) has also been described and is in use in other parts of the world.

The technical success rate for transcatheter closure of selected muscular and membranous VSDs is high (87%-97%) with a low mortality rate (0-2.7%).[21-24] A US prospective multicentre registry described an 87% procedural success rate for congenital muscular VSD closure with an 11% major complication rate (death, stroke, device embolization, or cardiac perforation).[23] Residual shunting after muscular VSD closure is commonly seen after device deployment but is uncommon at discharge and rare at long-term follow-up.[25]

Device closure of perimembranous VSDs is more complicated owing to proximity to the aortic valve and conducting system, and there are persistent concerns regarding the high rate of peri- and post-procedure complete heart block. Heart block and permanent pacing in younger patients is a significant issue with potential for many device-related complications over a lifetime, thus all efforts to avoid it should be made.

In a large European registry of 430 patients with a congenital VSD (119 muscular, 250 perimembranous, 45 residual after surgery), a success rate of 95% was described (85% were Amplatzer devices).[21] Complete atrioventricular block occurred more commonly with closure of membranous (5%) or post-operative VSDs (6.7%) compared with muscular VSDs (0.8%). Complete heart block in this setting might sometimes respond to corticosteroids or device explantation. When a ventricular septal aneurysm coexists with a perimembranous defect, device implantation within the aneurysm has been shown to be an effective technique to avoid complete heart block by avoidance of impingement on the conduction system.[26] A new version of the Amplatzer perimembranous VSD occluder, which has been designed to reduce the incidence of complete heart block, is under investigation (Supplemental Fig. S2).[27]

Other issues encountered in the published European experience included tricuspid regurgitation not requiring surgery in 6% and aortic regurgitation in 3.2%.

A very low complication rate after perimembranous device VSD closure has been reported in a large Chinese study of 848 subjects,[28] using either the asymmetric Amplatzer perimembranous occluder or the domestic symmetric Shanghai perimembranous occluder. Technical success was 98% with a major complication rate of only 0.9% at a median follow-up of 37 months. Complications in this series included complete heart block (2 patients), tricuspid insufficiency (3 patients), device embolization (2 patients), and endocarditis (1 patient). Many of these VSDs might not have been truly membranous in location, however, and might have been smaller than those closed in the US and European experience.

The long-term outcome of percutaneous device closure of VSDs remains unknown, hence close follow-up is warranted.

Patent ductus arteriosus. Patent ductus arteriosus (PDA) closure is indicated if there exists associated left cardiac chamber enlargement, if PAH is present (with evidence of pulmonary vascular vasoreactivity as for ASD or VSD), in the setting of previous endarteritis or in the presence of an audible continuous murmur regardless of endocarditis status. Closure is contraindicated in the presence of Eisenmenger physiology with right-to-left shunting. PDA was the first vascular anomaly to be successfully closed via a transcatheter approach in 1967 and early attempts at PDA closure required the creative use of coils or other devices. Dedicated PDA devices are now available and associated with excellent success rates and low complication rates.[29] Percutaneous closure is thus now favoured over surgical closure; small PDAs can be closed with coils or the Amplatzer PDA2 device (a double disc device that can be delivered from the aortic or venous side), and larger ducts are usually closed with the single-disc Amplatzer duct occluder device which is usually delivered from the venous side (Supplemental Fig. S3). Issues encountered in the pediatric population such as left PA or aortic isthmus obstruction are not apparent in adults. CTA is a useful tool to define the duct anatomy before intervention and can exclude other causes of a continuous murmur such as coronary fistulae, sequestered lung segment, or a mammary artery-to-PA connection. There is a paucity of high-quality long-term follow-up data after PDA closure in adults, and ongoing follow-up is therefore recommended.[8]

PA Stenosis and Aortic Coarctation

Branch PA stenosis

PA stenosis usually occurs in the setting of complex cardiac disease. It can be diffuse or focal and can occur in any segment of the pulmonary tree. Intervention for branch PA stenosis is recommended if there are attributable symptoms, if there is a $>$ 50% reduction in luminal diameter, or a subpulmonic ventricular systolic pressure $>$ 50 mm Hg. It is worth noting that pressure gradient per se across the lesion might be unreliable in this setting.[30] Other indications to treat an angiographically evident stenosis include: coexistent pulmonary regurgitation (branch PA stenosis might worsen pulmonic regurgitation); evidence of differential pulmonary perfusion; or in the presence of a Glenn anastomosis or Fontan circulation (given the reliance on passive forward flow). Options for treatment include balloon angioplasty, cutting balloon angioplasty, or endovascular stent insertion (in first- and second-order branches only) (Supplemental Fig. S4). Endovascular PA stents were first implanted in humans in the late 1980s and numerous studies have confirmed good short- and long-term outcomes.[31,32] Significant in-stent restenosis and stent fracture appear uncommon, although jailing of side branches has been associated with a high rate of abnormal side branch flow in 1 study,[32] the clinical significance of which remains unclear. Improved techniques (including management of bifurcation lesions for example) and better PA stents (more flexible with smoother edges), have improved the utility and success of the procedure,[33] however, insertion of stents in pulmonary arteries remains "off label" in the United States. Covered stents are usually reserved for management of complications, such as perforation.

PA angioplasty has been described as part of a hybrid approach when additional cardiac surgery is required. In this setting, intraoperative stenting using direct visualization can be performed instead of surgical arterioplasty, thus reducing procedural time and complexity.[34]

Aortic coarctation

Current indications for intervention for coarctation include the presence of hypertension with a catheter-derived simultaneous peak-to-peak pressure gradient of $>$ 20 mm Hg, or imaging evidence of coarctation with significant collateral formation in the absence of hypertension.[30] Arm-to-leg gradient measured clinically is a useful screen for the presence of a coarctation, however, the absolute value attained should not be used as evidence for the need for intervention. Intervention is performed with the intention to prevent complications including stroke and heart failure. The association of coarctation with accelerated atherosclerosis remains controversial, thus it remains unclear whether coarctation intervention modifies the risk for coronary vascular events.[35,36]

Percutaneous intervention was first reported in 1982, as an alternative to surgery in those with recoarctation after surgical repair,[37] however, it has emerged as a viable alternative to surgery in native and recurrent coarctations.[38-41] Stent implantation (Supplemental Fig. S5), first performed in 1991,[42] is associated with improved results compared with balloon angioplasty alone, with fewer complications (including aneurysm formation) and more durable results (less elastic recoil of the aorta).[43] Furthermore, the development of covered stents might possibly reduce the incidence of procedural complications such as rupture and aneurysm formation, but can be complicated by side branch occlusion, dissection, or residual gradients across the coarctation site (if the superior aspect protrudes into the arch, for example).[44-46] Covered stents have a role in certain situations, including complex coarctation anatomy, balloon/stent related aortic perforation, or aneurysm formation post surgery or intervention,[47] but there is a growing literature base supporting their use as a primary therapy in all patients undergoing coarctation intervention.[48]

Long-term outcome data for percutaneous intervention for coarctation are lacking, however, the prospective, multicentre, single-arm **Co**arctation of the **A**orta **St**ent (COAST) trial demonstrated coarctation stenting in 105 patients with native

or recurrent coarctations with a Cheatham-Platinum (CP) stent (NuMED, Hopkinton, NY) to be effective and safe (no deaths, low serious complication rate including small aneurysm formation [3 patients], stent migration [1 patient], and dissection [1 patient]) with medium-term follow-up complete.[49] The stent fracture rate at 2 years was 12% (none led to loss of stent integrity) and repeat intervention was required in 8% (5 redilation and 3 therapy for aneurysm formation). The COAST II trial to evaluate the covered CP stent is under way.[50]

The morbidity rate after surgical repair is greater than for primary stenting, however, the need for reintervention because of persistent hypertension appears to be greater after stent insertion. Approximately 30% of patients have residual hypertension after successful coarctation stent insertion, which might relate in part to deliberate stent undersizing at the initial procedure to reduce the risk of aortic dissection/rupture (with a view to staged elective repeat intervention).[51] These repeat procedures themselves impart risk, thus it might be that a definitive procedure with a covered stent is preferable, however, this is yet to be demonstrated. Ongoing trials to compare long-term results of coarctation stenting with surgical repair are warranted to ensure that late hypertension, in particular, is not an issue. Surgery might still be the preferred option in the setting of significant arch hypoplasia or long coarctation segments. Wall complications (including aneurysm formation), aortic dilatation, and stent recoil have been reported after coarctation angioplasty and/or stenting. Considering the potential for serious clinical sequelae relating to these issues, we believe that serial imaging after coarctation stent insertion is warranted. Guidelines suggest evaluation of the coarctation site using CT or MRI every 5 years or less.[30]

The development of bioabsorbable scaffolds might revolutionize the treatment of coarctations, presuming concerns regarding radial strength can be overcome.[52]

Valvular Interventions

Aortic valvuloplasty

Percutaneous balloon aortic valve dilation remains a low risk and effective treatment option for congenital aortic stenosis (AS) in children and young adults. The fibrocalcific valve of congenital AS responds well to valvuloplasty, which is usually performed with a balloon sized 0.9 to 1 to the aortic annulus measured using aortography at catheterization.[53,54] In young adults without significant aortic valve calcification and no aortic regurgitation, indications for balloon aortic valvuloplasty include: the presence of symptoms with peak-to-peak gradients at catheterization $>$ 50 mm Hg; or, in the absence of symptoms, a peak-to-peak catheter gradient greater than 60 mm Hg with ST or T wave abnormalities in the left precordial leads on electrocardiogram at rest or with exercise. Excellent long-term outcomes have been achieved in this setting with aortic valvuloplasty, thus avoiding a sternotomy and long-term anticoagulation that would be required if a mechanical valve was inserted.[54,55] This contrasts with the poor long-term results of valvuloplasty seen in elderly patients with degenerative, calcific AS.

Pulmonary valvuloplasty

Pulmonary stenosis can occur as an isolated lesion or as part of complex congenital heart conditions, such as Tetralogy of Fallot. Indications for treatment of isolated pulmonary stenosis include the presence of symptoms associated with a peak or mean gradient $>$ 50 mm Hg or 30 mm Hg respectively, or, if asymptomatic, peak/mean gradients of 60/40 mm Hg. Stenosis is usually due to commissural fusion, which is readily addressed by balloon angioplasty (balloon size 1.3 to 1 to the pulmonary annulus assessed angiographically), hence percutaneous intervention is preferred over surgery. The first transcatheter congenital intervention was indeed a pulmonary valvuloplasty performed in 1956 and, when performed for congenital pulmonary stenosis, has been associated with excellent early and late outcomes, in addition to low complication rates.[56-59] The dysplastic valve of Noonan syndrome usually require a larger balloon to annulus ratio and have less favourable results. Significant outflow tract obstruction or pulmonary regurgitation requiring intervention appear to be uncommon during long-term follow-up.[57]

Percutaneous pulmonary valve implantation

PPVI has now emerged as a viable alternative to surgery in certain patients with dysfunctional right ventricular outflow tracts (RVOTs). PPVI is mostly performed within dysfunctional synthetic right ventricle-to-PA (RV-PA) conduits, bioprosthetic pulmonary valves (xenografts), or pulmonary homografts (as part of the Ross procedure, for example), all of which can act as a framework to house the percutaneous valve. In these patients, PPVI effectively extends the longevity of the conduit or tissue valve, thus reducing the number of surgical procedures required over a lifetime. In general, PPVI is not currently suitable for use in patients with dysfunctional "native" RVOTs, however, we and others have performed PPVI in selected patients in whom the native outflow tract is of an appropriate diameter or can be made so using insertion of multiple stents.[60,61]

PPVI is currently recommended when the following criteria are met[62]:

1. Indication for surgical pulmonary valve replacement exists (such as: RVOT obstruction with symptoms and a right ventricular systolic pressure-to-aortic pressure ratio more than two-thirds; or free pulmonary regurgitation with significant RV dilatation [right ventricular end-diastolic volume $>$ 150 cm/m^2 according to cardiac MRI]);[10] or significant RV dysfunction in the presence of significant pulmonary regurgitation.
2. Suitable RVOT anatomy: RVOT diameter of $<$ 29 mm (in jurisdictions where the Sapien XT 29 mm valve [Edwards Lifesciences Corp, Irvine, CA] is available). The maximum feasible diameter depends, in part, on the compliance of the RVOT, which can be assessed using a sizing balloon. A 28 mm RVOT, for example, might be amenable to PPVI if it is a rigid conduit, but not if it is a "native" and very compliant RVOT.
3. Absence of contraindications with no evidence of: coronary occlusion with full-sized inflation with a noncompliant balloon inflation in the RVOT; infective endocarditis; central vein occlusion (can use jugular vein in setting of

inferior vena cava occlusion); need for concomitant procedures such as tricuspid annuloplasty, arrhythmia surgery, or coronary bypass surgery.

Over time, there has been a gradual lowering of the threshold for surgical pulmonic valve replacement in the setting of severe pulmonic regurgitation (lower right ventricular end-diastolic volume on MRI). The advent of a percutaneous alternative has shifted the risk/benefit ratio, such that patients might be considered for replacement at an earlier stage than they would have been for the more invasive surgical option. PPVI has also extended treatment to those considered high risk for conduit revision, and advances in other transcatheter approaches, such as percutaneous coronary intervention and ablation procedures for atrial and ventricular arrhythmias, have meant that PPVI has become applicable to patients who might have otherwise required surgery for concomitant issues (such as coronary bypass grafting or arrhythmia surgery). Furthermore, in high surgical risk patients with RVOT dysfunction and coexisting cardiac issues, such as severe tricuspid regurgitation, a less invasive but less "complete" strategy of pulmonary valve replacement only via PPVI can be effective in improving hemodynamics and affording clinical stability, which might allow for safer cardiac surgery for the coexisting lesions at a later stage should symptoms fail to resolve.

Currently available percutaneous pulmonary valves include the Medtronic Melody transcatheter pulmonary valve (Medtronic, Minneapolis, MN) and the Edwards Sapien Pulmonic Transcatheter Heart Valve (THV) (Edwards Lifesciences Corp) (Supplemental Fig. S6). The Melody Valve, first implanted by Bonhoeffer in 2000, is composed of a bovine jugular venous valve, which has been sutured into a balloon-expandable stent (CP Stent, NuMED) that needs to be crimped onto a custom-made delivery system. Only 1 size is available (stent is 34 mm in length when unexpanded and is expected to shorten with expansion), but the delivery system is available with an outer balloon diameter of 18, 20, or 22 mm. The competence of the valve is maintained at diameters of 16-22 mm and at 22 mm, the outer diameter of the valve is 24 mm. There are anecdotal reports of deploying the Melody valve on a 24-mm balloon-in-balloon system (NuMED) through a long sheath. The yield for harvesting bovine jugular veins is low, and a drought in 2012 has further limited the number of animals available with suitable jugular veins, thus creating a supply issue for the Melody valve.

The Sapien THV consists of 3 bovine pericardial leaflets hand-sewn to a tubular, stainless steel, balloon-expandable stent and is the same valve used successfully in the aortic position for transcatheter aortic valve implantation. The first-generation device is available in 2 sizes (23 and 26 mm), whilst the newer Sapien XT valve is available in the same diameters and 29 mm. The stent scaffold of the XT valve is made of cobalt chromium in an attempt to improve durability and reduce profile. The XT valve is designed for use in the aortic position and exits the sheath behind the balloon to further minimize profile; an alignment manoeuvre is then carried out such that the balloon is withdrawn into the stent. Experience in the pulmonary position is thus far favourable, despite initial concerns regarding valve orientation in this setting. The implantation technique for the 2 devices is similar and venous access is usually obtained through the femoral vein, but use of the jugular vein is possible. Supplemental Figure S7 depicts valve delivery via a Glenn shunt.

Complications encountered while the procedure was being perfected led to modifications in PPVI technique, in particular to avoid coronary compression, valve failure due to stent fracture, and the need for repeated surgery. Modifications include:

- Use of a full-size noncompliant balloon inflation within the conduit to exclude coronary compression, which was noted in 6% of patients in the pivotal United States Investigational Device Exemption (US IDE) trial (Fig. 1)[63,64];
- Prestenting: conduits are now routinely prestented to reduce the risk of fracture of the Melody valves and reduce the risk of premature valve failure.[65] Occasionally, multiple stents are required and it is common practice to insert additional stents until no stent recoil is identified upon balloon deflation;
- Post dilation to achieve a peak transvalvular gradient of less than 20 mm Hg has reduced the repeat intervention rate.
- Covered stents: a covered stent is preferred in some instances (eg, small calcified homografts). Covered stents are generally not necessary when a Melody valve will be placed but might be preferred for Sapien valve implantation to reduce the risk of paravalvular leak because of the relatively short stented segment with a circumferential skirt. This is especially so in irregular conduits or where the potential landing zone is short.

The implantation technique is the same for insertion into a degenerative homograft, conduit, or a failing pulmonary bioprosthesis. When performing PPVI in a bioprosthesis, one must be mindful of the different positions of radiographic markers in bioprosthetic valves. Furthermore, coronary compression testing and prestenting are not necessarily required for "valve-in-valve" PPVI.

Both Melody and Sapien valves appear to perform well in the early phase with a significant reduction in RV-PA gradient without significant pulmonary incompetence (more than trace pulmonary incompetence is unusual). Interestingly, delayed improvement in valve hemodynamic performance has been described and might relate to resolution of perivalvular edema/hematoma after valve implantation and long-term exposure to pulsatile transvalvular flow which might optimize valve configuration and valve opening kinetics.[66] Freedom from valve dysfunction at 1 year is high with both valves (> 95%).

More data are available for the Melody valve in the pulmonary position, with 4 published studies,[63,67-69] comprising 464 patients from the UK, US, German, and Italian registries, describing 1- to 5-year follow-up. The US Melody Valve trial[63] was a formal protocol-driven monitored study describing a high procedural success rate with excellent short-term valve function. There is less published experience with the THV Sapien valve (4 small studies, 72 patients),[70-73] although there is abundant positive experience with this valve in the aortic position with follow-up to 5 years.

Insertion of either valve is almost uniformally successful (92%-98%) with very low mortality rates (0%-2%). The

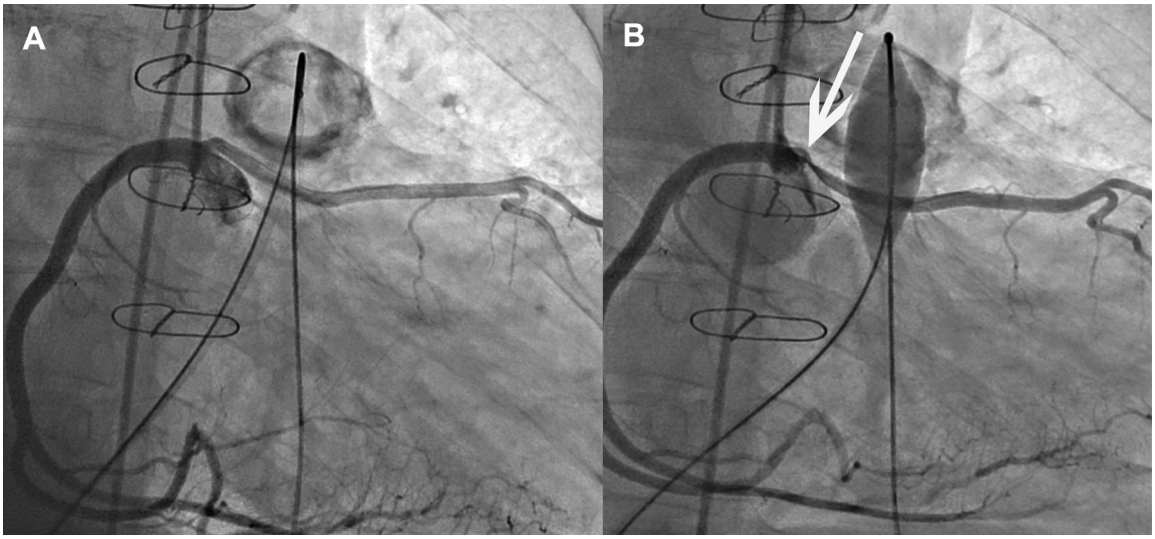


Figure 1. Cineangiogram in a potential percutaneous pulmonary valve implantation candidate showing compression of an anomalous LAD from the RCA during balloon inflation in the RVOT ([**A**] RCA angiography with anomalous LAD; [**B**] angiography during balloon inflation in the RVOT with **arrow** indicating compression of the proximal LAD). LAD, left anterior descending artery; RCA, right coronary artery; RVOT, right ventricular outflow tract.

overall complication rate of the procedure is low (approximately 5%). Specific complications include device embolization (< 1%), conduit rupture with hemodynamic compromise (1%), coronary compression after device deployment (< 1%), tricuspid valve injury (0.5%), or distal PA perforation (1%, mostly guide wire-related and usually well tolerated). Endocarditis rates are approximately 1%-3%. Stent fracture was an issue early in the experience with the Melody valve (up to 20% if no prestenting), however, is rarely an issue with routine prestenting.

The restriction of PPVI use to those with a pre-existing "scaffold," such as a dysfunctional conduit or bioprosthetic valve, significantly limits the applicability of PPVI. It is estimated that only 15% of dysfunctional RVOTs are currently amenable to PPVI, and a large population therefore exists with dysfunctional "native" RVOTs who could benefit from a transcatheter approach. A "native" outflow tract refers to: a RVOT with no previous surgery, previous balloon valvotomy for pulmonary stenosis, or previous transannular patch repair for anatomic correction of Tetralogy of Fallot. Common to these scenarios is the absence of a stable framework to anchor the valve and the presence of distensible tissue in the mobile and contractile "native" RVOT, which is associated with an increased risk of valve dislodgement, perforation, paravalvular leak, and stent fracture. PPVI in smaller native outflow tracts has, however, been described in case reports,[74,75] and case series (approximately 2.5% and 7% of published case series of Melody and Sapien valve implantations, respectively, were in "native" RVOTs).[67,68,73] Prestenting in this scenario is mandatory to provide a "conduit" to stabilize the valve. Other techniques used to facilitate PPVI in native outflow tracts include the "PA jailing" technique (a stent scaffold is created with overlapping stents from a branch PA that is < 25 mm, extending back into the RVOT), the "Russian dolls technique" (multiple stents with decremental diameters deployed within each other to reduce the RVOT diameter), or alternatively, implantation of a pulmonary valve in 1 or both branch pulmonary arteries.[76] In particularly challenging circumstances, implantation of a pulmonary valve in 1 branch might suffice, especially wherein there exists differential relative contribution of each PA to pulmonary regurgitation.[77]

Percutaneous implantable RVOT size reducers are in development to further expand the applicability of PPVI. A 35-mm diameter endovascular size reducer (Cormove, Ivry le Temple, France) has shown promise in animal studies,[78] and the Native Outflow Tract Transcatheter Pulmonary Valve Device (Medtronic) is currently approved for use in a phase 1 feasibility study in humans.

Future developments might centre on hybrid approaches, such as RVOT banding with radio-opaque rings via a left thoracotomy and subsequent percutaneous valved stent implantation,[79] or the implantation of an expandable conduit at the time of initial repair that can later be dilated or replaced with a percutaneous valve as it fails.[80,81]

Tricuspid Valve Dysfunction

Bioprosthetic valves are used for tricuspid valve replacement in certain congenital cardiac conditions, such as Ebstein anomaly. Dysfunctional bioprosthetic valves in the tricuspid position have been successfully palliated with transcatheter implantation of Melody[82] or Sapien valves.[83] Some operators advocate jugular vein access for improved stability in this setting.

Interventions in Complex Patients

Improved survival of patients with complex congenital heart disease means increasingly that interventionalists will be required to undertake interventions in patients with complex anatomy and unusual pathology. The heterogenous nature of lesions requiring treatment in this population demands that interventionalists are not only very familiar with congenital cardiac anatomy but are also flexible and creative in devising solutions for these patients. Examples include potential complications in patients who have been palliated with a Fontan circulation or in patients post atrial switch repair.

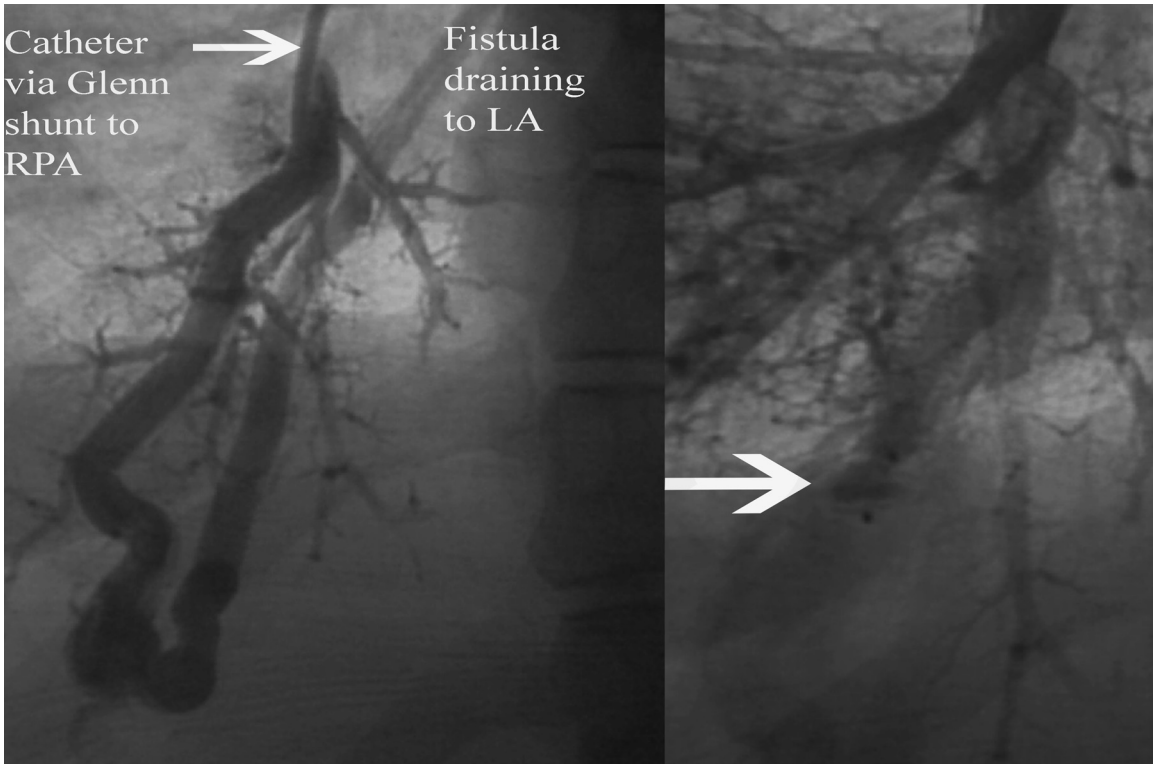


Figure 2. Pulmonary arteriovenous malformation closure with an 8-mm Amplatzer AVP4 device in a hypoxic patient with a classic Glenn shunt (a recognized complication of this procedure). LA, left atrium; RPA, right pulmonary artery.

Issues in the Fontan circulation

Fontan fenestrations. Fenestrations (between the systemic venous and pulmonary venous circulations) are commonly surgically created at the time of Fontan surgery to reduce Fontan circuit pressure and improve cardiac output perioperatively. Closure might be desired in the setting of cyanosis or paradoxical embolism, and can be achieved with septal occluders or covered stents.

Fontan baffle puncture. Creation of fenestrations, in contrast, might be required to treat protein-losing enteropathy, for example, and requires familiarity with techniques for transseptal puncture.

The inferior vena cava to PA conduits are often made of stiff Goretex, thus can be difficult to puncture; use of a standard transseptal puncture kit might suffice, but often more aggressive strategies might be required, such as use of steerable sheaths, filing of the back end of a wire for sharpness, electrocautery, and balloon dilatation of the puncture.[84]

Despite a significant reduction in arrhythmia burden with the "newer" Fontan circuits (lateral tunnel and extracardiac),[85] arrhythmias still occur in many patients; electrophysiology/ablation procedures in this setting have thus become complex interventions, requiring Fontan circuit baffle puncture to afford catheter access to the atria.[86] Structural interventionalists have needed to work closely with electrophysiologists to resolve this issue.

Expertise with the transseptal puncture kits has also been exploited in other scenarios pertaining to the Fontan circulation, such as percutaneous conversion of a classical Glenn shunt to a bidirectional cavopulmonary anastomosis using a radiofrequency wire.[87]

PPVI on Bjork Fontans. PPVI has been described in the setting of a failing Fontan circulation because of right ventricular inflow obstruction in a patient with a Bjork modification Fontan (Supplemental Fig. S8).[88]

Fistulae and collaterals. A variety of other abnormal connections commonly seen in patients with congenital cardiac conditions are amenable to transcatheter closure including:

- right-to-left shunts including systemic venous-to-pulmonary venous collaterals (especially in Fontan patients) and pulmonary arterial-to-pulmonary venous malformations, which can cause cyanosis and allow passage of paradoxical emboli (Fig. 2);
- left-to-right shunts such as systemic arterial-to-pulmonary arterial collaterals (in conditions associated with pulmonary hypoperfusion) can pose a volume load on the systemic ventricle;
- coronary artery fistulae, which can arise from either coronary artery and drain into a right cardiac chamber or systemic vein, thus causing a coronary steal phenomenon (Supplemental Fig. S9)[59];
- previously created surgical shunts, which might no longer be useful.

Coils have traditionally been used to occlude such structures, however, a range of vascular plugs are now available and

have proved to be useful in facilitating these interventions.[89] Device oversizing is recommended in these interventions to prevent embolization (for example, plug devices should be 20%-50% larger and coils 50% larger than the target vessel).

Baffle leaks or stenosis after atrial switch surgery

The arterial switch procedure is the current surgery of choice for patient with d-transposition of the great arteries, however, a large population has now entered adulthood having survived a Mustard or Senning operation. Atrial switch surgery relies on creation of "baffles" (from native atrial tissue in the Senning procedure and with pericardium or synthetic material in the Mustard procedure) to separate the pulmonary venous and systemic venous circulations at the atrial level. As many as 25% of atrial switch surgery patients have been shown to have a baffle leak, but most are not hemodynamically significant.[90] Most leaks occur at the suture line of the superior limb of the systemic venous baffle, and when hemodynamically significant, can be closed using Amplatzer septal occluders or covered stents (especially when baffle stenosis coexists).

Baffle stenosis can also occur at either baffle location and indications to intervene include exercise intolerance attributable to baffle obstruction (usually the inferior baffle), a caval syndrome or before transvenous pacemaker insertion in the superior baffle. Stent insertion has been reported to be feasible with satisfactory medium-term outcomes and is clearly superior to balloon angioplasty alone (Supplemental Fig. S10).[91,92]

Conclusions

There has been a rapid expansion of percutaneous interventions for adult congenital heart disease patients over the past few decades, which have improved the quality of life of these patients and reduced the number of surgical procedures required. Limited data exist, however, for long-term outcomes for many such interventions, in part because of the rarity of certain conditions, thus caution is required and data surveillance/reporting are important to ensure appropriate future use. Collaboration between interventional cardiologists, cardiac surgeons, and imaging specialists is paramount to facilitate appropriate treatment and further development of newer interventional techniques.

Disclosures

Dr Horlick is a consultant for St Jude Medical, Edwards, and Medtronic. Drs Benson and Osten are consultants for Medtronic. Dr Wilson has no conflicts of interest to disclose.

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Supplementary Material

To access the supplementary material accompanying this article, visit the online version of the *Canadian Journal of Cardiology* at www.onlinecjc.ca and at http://dx.doi.org/10.1016/j.cjca.2013.11.006.

Review Article

Innovative interventional catheterization techniques for congenital heart disease

Jeffrey D. Zampi, Wendy Whiteside

University of Michigan Congenital Heart Center, C.S. Mott Children's Hospital, Ann Arbor, MI, USA

Contributions: (I) Conception and design: All authors; (II) Administrative support: All authors; (III) Provision of study materials or patients: All authors; (IV) Collection and assembly of data: All authors; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Correspondence to: Jeffrey D. Zampi, MD. Interventional Pediatric Cardiology, Pediatric Cardiology, University of Michigan Congenital Heart Center, C.S. Mott Children's Hospital Floor 11, Room 715Z, 1540 E. Hospital Drive, Ann Arbor, MI 48109-4204, USA. Email: jzampi@med.umich.edu.

Abstract: Since 1929, when the first cardiac catheterization was safely performed in a human by Dr. Werner Forssmann (on himself), there has been a rapid progression of cardiac catheterization techniques and technologies. Today, these advances allow us to treat a wide variety of patients with congenital heart disease using minimally invasive techniques; from fetus to infants to adults, and from simple to complex congenital cardiac lesions. In this article, we will explore some of the exciting advances in cardiac catheterization for the treatment of congenital heart disease, including transcatheter valve implantation, hybrid procedures, biodegradable technologies, and magnetic resonance imaging (MRI)-guided catheterization. Additionally, we will discuss innovations in imaging in the catheterization laboratory, including 3D rotational angiography (3DRA), fusion imaging, and 3D printing, which help to make innovative interventional approaches possible.

Keywords: Innovation; congenital heart disease; cardiac catheterization

Submitted Oct 14, 2017. Accepted for publication Dec 01, 2017.
doi: 10.21037/tp.2017.12.02
View this article at: http://dx.doi.org/10.21037/tp.2017.12.02

Transcatheter valve implantation

The first report of successful transcatheter pulmonary valve implantation was in 2000 (1). After a successful multi-center United States Investigational Device Exemption trial, the Melody™ Transcatheter Pulmonary Valve (Medtronic, Inc., Minneapolis, Minnesota, USA) became the first FDA approved transcatheter pulmonary valve in 2010 (2,3). Results from the United States Post-Approval Study and several international Melody valve implantation registries, led to the quick adoption of this therapy in patients with congenital heart disease as these valves exhibited excellent reduction in both right ventricular outflow tract stenosis and insufficiency (4-6). The initial indication for Melody valve implantation was for use in dysfunctional right ventricle-to-pulmonary artery conduits. However, off-label use of the device quickly expanded to dysfunctional bioprosthetic pulmonary valves (now an on-label use of the Melody valve), as well as implantation in non-pulmonary positions, including the mitral valve, tricuspid valve, and aortic valve, as well as implantation in the bilateral branch pulmonary arteries (7-10).

While the Melody valve, and its delivery system, were specifically designed for use in the pulmonary position, the Edwards Sapien valve (Edwards Lifesciences, Irvine, CA, USA) originally designed as a transcatheter aortic valve, also expanded its market into the pulmonary space (11). The next generation device, Edwards Sapien XT valve (Edwards Lifesciences, Irvine, CA, USA) received FDA approval in 2016 for the use in dysfunctional right ventricle to pulmonary artery conduits. The COMPASSION Trial (COngenital Multicenter trial of Pulmonic vAlve regurgitation Studying the SAPIEN InterventIONal THV COMPASSION Trial) is completing data collection and the COMPASSION Post-Approval Study is currently underway. A newer version of the Sapien valve, the S3 valve,

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has also been implanted successfully in the pulmonary position and non-pulmonary prosthetic valves (12-14).

A recent meta-analysis of implanted transcatheter pulmonary valves, including both Melody and Sapien valves, confirms what has been shown in multiple smaller studies: a very high rate of implantation success (96.2%) in over 1,000 reported implants in the literature (15). Further, after accounting for the practice of pre-stenting conduits, which has drastically lowered the incidence of stent fracture in the Melody valve population, re-intervention rates were quite low (2.9 per 100 patient years, compared to 6.9 per 100 patient years in patients without pre-stenting).

Despite the excellent success of transcatheter pulmonary valve therapies, patients with dysfunctional conduits or bioprosthetic valves comprise the minority of patients with right ventricular outflow tract dysfunction. It is estimated that the currently available therapies will only effectively treat ~15% of patients with severe pulmonary insufficiency (16). Of the remaining 85% of patients, the majority have severe pulmonary regurgitation secondary to surgical right ventricular outflow tract patch augmentation, typically in the setting of Tetralogy of Fallot. Over time, chronic pulmonary regurgitation leads to right ventricular dilation, decreased exercise tolerance, and increased risk for arrhythmia and sudden cardiac death (17-21). These patients, however, often have severe dilation of the outflow tract making pulmonary valve replacement with currently available transcatheter valves not feasible and therefore making surgical pulmonary valve replacement the only option. Now with the availability of larger diameter S3 valves, as well as several creative ways to reduce the size of the right ventricular outflow tract to allow for the safe implantation of currently available transcatheter valves (22,23), treatment of so-called "native" outflow tracts is possible but remains limited. Therefore, this patient population represents a significant unmet need in the field of congenital heart disease.

Several newer valves are currently being developed to expand our ability to treat patients with severe pulmonary insufficiency and right ventricular outflow tracts too large for currently approved devices. The first of such devices, which is now better known as the Medtronic Harmony™ Transcatheter Pulmonary Valve (Medtronic, Inc.), was successfully implanted in 2010 (16). This self-expanding nitinol covered stent with a porcine pericardial valve sewn at the center has shown promising results in animal models, with improved right ventricular size on follow-up volumetric imaging (24). More recently, the Harmony early feasibility study showed a high rate of implantation success (95%) with few procedural complications (25). Furthermore, 100% of patients had mild or less pulmonary regurgitation at 6-month follow-up, compared to 95% with severe and 5% with moderate pulmonary regurgitation at baseline (25). The Pivotal Trial for the Harmony valve is currently underway in the United States with successful implantation in the first patient in September 2017. Other devices being implanted outside the United States include the Venus P valve (Venus Medtech, Shanghai, China) (26-29), as well as the self-expanding device by the TaeWoong Medical Company (Gyeonggi-do, Republic of Korea) (30). All devices have shown promising early results but further longitudinal study is necessary to understand how each of these devices will change the landscape of pulmonary valve replacement.

Transcatheter valve implantation—conclusions

Transcatheter valve implantation is one of the fastest growing areas of innovation in our field. Current devices have allowed us to treat a large number of patients who previously required surgical re-operations and future technologies promise to grow the patient population that we can serve. A critical next step will be refining when we intervene, particularly in the setting of chronic pulmonary regurgitation, and understanding if earlier intervention improves long-term patient outcomes, especially compared to surgical valve replacement.

Hybrid procedures

A "hybrid procedure" refers to any procedure where interventional catheterization and surgical techniques are used in tandem. In congenital heart disease, hybrid procedures are often synonymous with the hybrid stage I palliation for infants with hypoplastic left heart syndrome (HLHS), however hybrid procedures are utilized in many other situations extending beyond infants with HLHS. In fact, in the era of increasingly complex interventions on increasingly high-risk patients, hybrid procedures offer many potential advantages over traditional interventional catheterization and surgical techniques because, during hybrid procedures, we are able to combine the best parts of each specialty. Often, performing a procedure with a hybrid approach allows for more direct access with larger bore equipment in smaller patients while avoiding cardiopulmonary bypass. More importantly, hybrid

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procedures are an example of using cross-discipline innovation, collaboration, and group-thought to solve complex problems.

The first "hybrid" procedure was described in 1972 (31). Although never referred to as a hybrid procedure, what we would now refer to as hybrid techniques were utilized to facilitate patent ductus arteriosus closure. Interestingly, the authors comment that they were "impressed by the simplicity and quickness of the procedure," which is often a main advantage of hybrid procedures over more traditional surgical and transcatheter techniques (31). Since that time, hybrid procedures have been used for a myriad of purposes (*Figure 1*). Here we will highlight two of these hybrid procedures; the hybrid approaches for hypoplastic left heart syndrome and pulmonary atresia with intact ventricular septum.

Common Current Uses of Hybrid Procedures in Congenital Heart Disease
Muscular ventricular septal defect closure
Intra-operative pulmonary artery stent placement
Transcatheter pulmonary valve implantation (esp. small children and large native outflow tracts)
Hypoplastic left heart syndrome
Pulmonary atresia with intact ventricular septum
Any procedure where small patient size may prohibit a transcatheter approach

Figure 1 Common current uses of hybrid procedures in congenital heart disease.

HLHS

Probably the most commonly discussed hybrid procedure in the field of pediatric cardiology is the use of a hybrid procedure for patients with HLHS. This alternative to the standard surgical Norwood palliation involves stenting of the ductus arteriosus, bilateral pulmonary artery band placement, and atrial septostomy, and was first described in 1993 (32,33). Now commonly referred to as the hybrid stage I palliation, or the hybrid Norwood, the procedure has undergone some modifications with time but the three main objectives of the hybrid stage I palliation for infants with HLHS are the same as the surgical approach: create unobstructed pulmonary return across the atrial septum, create unobstructed systemic arterial blood flow, and create restricted pulmonary blood flow (*Figure 2*).

From a technical standpoint, the hybrid stage I palliation can be completed by a surgeon and interventional pediatric cardiologist with minimal additional equipment or training. Several techniques have been developed to help ease the learning curve associated with the procedure, like the appropriate tightness when placing the pulmonary artery bands (34). Some centers across the country have adopted a strategy of using the hybrid Norwood in all single ventricle patients, while other centers use the hybrid Norwood only in high-risk patients, or patients felt to be at a higher risk of morbidity or mortality after the surgical Norwood palliation (35-42). In these high-risk patients, avoiding cardiopulmonary bypass during the neonatal period may

Objective	Surgical Norwood	Hybrid Norwood
Unobstructed return of pulmonary venous blood	Atrial septectomy	Atrial septostomy, atrial septoplasty, or atrial septal stent implantation
Unobstructed systemic arterial blood flow	Aortic arch reconstruction	Ductus arteriosus stent implantation
Restricted pulmonary blood flow	Systemic-pulmonary artery stent	Pulmonary artery band placement

Figure 2 Comparison of the surgical and hybrid Norwood palliation for patients with hypoplastic left heart syndrome.

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lower mortality and morbidity during the staged single ventricle palliation (43-48). Our center is currently examining the impact of utilizing the hybrid approach in high-risk single ventricle patients when compared to a similar high-risk cohort prior to the advent of the hybrid procedure.

Importantly, the hybrid stage I palliation has also been used successfully in the non-single ventricle population. For example, in patients with factors which might place them at higher risk of morbidity or mortality after major complex congenital heart repair during infancy, the stage I hybrid palliation can be used to stabilize the circulation and post-pone definitive anatomic repair until later in childhood (49,50).

There are some anatomic and potential pathophysiologic complications uniquely associated with the hybrid stage I palliation, including recurrent atrial septal restriction, reverse coarctation of the aorta, and pulmonary artery stenosis. Additionally, several studies comparing the hybrid to standard surgical Norwood approaches using computational flow modeling have found some important differences in systemic and cerebral oxygenation as well as ventricular mechanics which may favor the standard surgical approach (51,52). Therefore, as with any novel approach to a complex problem, careful and longitudinal analysis will be important as we identify which patients will most benefit from the hybrid palliation.

Pulmonary atresia with intact ventricular septum

A subset of patients with pulmonary atresia with an intact ventricular septum will be anatomically suitable to undergo a biventricular repair. This involves opening the right ventricular outflow tract, typically in the neonatal period. Traditionally, this could be done via a surgical approach (pulmonary valvotomy) or via a transcatheter approach (percutaneous pulmonary valve perforation and balloon valvuloplasty). The hybrid procedure in this lesion is a great example of how taking advantage of the benefits from each approach facilitates a procedure while minimizing procedural complications and long-term deleterious effects.

The hybrid approach to pulmonary atresia with intact ventricular septum typically involves periventricular access via a midline sternotomy with needle perforation of the atretic pulmonary valve followed by balloon pulmonary valvuloplasty (53,54). In many patients, a systemic-pulmonary artery shunt is performed due to persistent (typically muscular) subvalvar right ventricular outflow tract obstruction. Fortunately, this shunt can be placed without the use of cardiopulmonary bypass. Surgical exposure to the right ventricle allows for direct access to the pulmonary valve with much lower risk of right ventricular outflow tract perforation, a risk of the transcatheter approach to pulmonary valve perforation. Combining the use of transcatheter techniques, the entire procedure can be performed without cardiopulmonary bypass with nearly identical high procedural success, low procedural complication rates, and mid-term outcomes compared to the surgical approach (53). Proponents of the transcatheter approach frequently site the need for a midline sternotomy as a major downfall of the hybrid approach. However, up to 76% of patients (range, 33–76%) who undergo the transcatheter approach ultimately require a midline sternotomy either to augment pulmonary blood flow (typically with placement of a systemic-pulmonary artery shunt) in the setting of post-procedure hypoxia, or due to inadvertent perforation of the right ventricular outflow tract (55-61). A comparison of the various approaches for right ventricular decompression in patients with pulmonary atresia with intact ventricular septum is detailed in *Figure 3*.

Hybrid procedures—conclusions

As we continue to develop less invasive ways to treat complex congenital heart disease, hybrid procedures will undoubtedly continue to help shape the interventional landscape. We must continue to both push the boundaries of these procedures, while continuing to study the outcomes to assure we are providing acute results better than standard transcatheter and surgical approaches alone, or acute results equivalent to standard approaches with better overall long-term patient outcomes. For some types of hybrid procedures, like intra-operative pulmonary artery stent placement, fairly long-term patient follow-up is available (62). Only by directly comparing hybrid approaches to other standard approaches will we be able to choose the best options for our patients.

Biodegradable technologies

Through years of innovation, interventional pediatric cardiologists have been afforded a wide array of devices to palliate and treat patients with congenital heart disease. These include stents of various diameters, lengths, and

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	Surgery	Transcatheter	Hybrid
Procedural Success	100%	75-95%	100%
Procedural Complications	58.8%	15-75%	57.1%
Procedural mortality	0%	0-16.7%	0%
Re-operation (within 2 years)	47.1%	62-77%	28.6%
Eventual biventricular circulation	82.3%	58-87%	85.7%
Cardiopulmonary bypass duration (minutes)[1]	80 (69-108)	0	0

Figure 3 Comparison of the various approaches for right ventricular decompression in pulmonary atresia with an intact ventricular septum. Adapted from Zampi, *et al.* (34). [1], data presented as median (interquartile range).

physical properties, coils and vascular occlusion devices, and devices designed to close atrial septal defects, ventricular septal defects, and the patent ductus arteriosus. However, a significant drawback of all these devices is their permanence. Outside of surgical excision, these devices are implanted permanently. For some patients, there are potential benefits to permanent implantation. For example, left pulmonary artery stenosis secondary to compression by the aorta likely will require a permanent stent to maintain patency. But a major consideration for the majority of patients with congenital heart disease undergoing cardiac catheterization procedures early in life is somatic growth. A stent placed in the aorta or pulmonary artery at 8 years of age will undoubtedly require further dilation in adulthood. And besides somatic growth, many heart lesions would be much better treated with a temporary implant. For example, at the current time closure of a patent ductus arteriosus or atrial septal defect requires implantation of a device (coil, vascular occlusive device, septal occlude, etc.) which generally results in immediate and complete occlusion. But in a relatively short time period, endothelialization forms a permanent "natural" covering over the defect. At this point, the implanted device, which really served as a scaffold to facilitate the endothelialization process, is an unnecessary remnant of the procedure. So how can we get the excellent results we expect from our current medical devices but limit the negative consequences related to their permanence? One possible solution may come in the form of biodegradable technology. Biodegradable materials have been used for years in medicine (for example, absorbable sutures), however, more recently, there has been tremendous effort by several research teams to develop these materials for use in patients with congenital heart disease. This includes development of vascular stents and occlusion devices, which can be applied across a wide variety of cardiovascular diseases.

Grossly, current biodegradable materials can be broken into two major categories based on their composition: bioabsorbable polymers and biocorrodible metals (63). Each material has advantages and limitations and each may have an important role in various devices. Polymers, for example poly L-lactic acid, break down by hydrolysis. The material strength and rate of bioabsorption can be altered by engineering the composition of the individual monomers and how they are inter-connected (63,64). Because bioabsorption occurs by hydrolysis and the monomers are commonly occurring and/or inert substances, these are likely to be very safe. One drawback, especially from the perspective of the interventional cardiologists, is that these materials are completely radiolucent unless modified. In contrast, biocorrodible materials, like zinc or magnesium, break down by biocorrosion. Biocorrosion is potentially inflammatory or toxic at the cellular or tissue level, although some research indicates Zinc may actually suppress inflammation at the cellular level. For the development of stents, this may be beneficial in lowering rates of neointimal proliferation, which is problematic for current small and medium diameter bare metal stents (65,66). Being metallic, there are radio-opaque and may have more similar physical properties, including radial strength and deployment characteristics, to currently commercially approved medical devices.

Many biodegradable stents and occlusion devices are in various stages of development with potential applications within the congenital heart disease space (63,65,67). The first commercially approved bioabsorbable stent became

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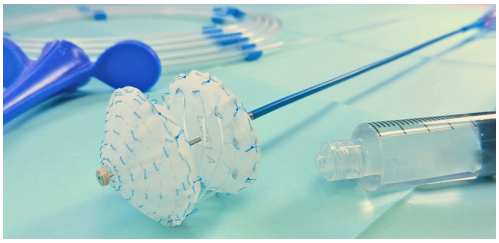


Figure 4 Careg bioresorbable septal occluder (image courtesy of Careg AG).

available in the United States in July 2016. The Absorb GT1 Bioresorbable Vascular Scaffold (BVS) stent (Abbott Vascular, Abbott Park, IL, USA), showed promise for use in coronary artery disease during the initial ABSORB trials (68). This bioabsorbable polymer stent made of poly L-lactic acid, was compared directly to a commercially available bare metal coronary stent through a series of first in man, then prospective and randomized clinical trials (68). Unfortunately, the stent is no longer commercially available. Although the company cites low sales, the device was removed from the market in mid 2017 due to a higher incidence of late stent thrombosis, in addition to evidence of higher rates of target lesion failure during long-term follow-up from the ABSORB III clinical trial (69). Although this is certainly a major set-back for biodegradable technologies, hopefully this early failure does not hinder future research and development of what will surely be an important part of the pediatric interventionalists' armamentarium in the near future. Most recently, in Europe a new device for atrial septal defect closure has received CE mark. The Carag bioresorbable septal occluder (CBSO) (Carag AG) was approved for use across Europe in mid-September 2017 (*Figure 4*). With time, we hope that this device and other devices of its kind will continue to improve the care we provide to patients with congenital heart disease.

Biodegradable technologies—conclusions

Biodegradable technologies represent an important merger between materials scientists and clinicians as we strive to improve the care we deliver with both excellent short-term, and long-term outcomes for our patients. In congenital heart disease, accounting for growth potential is crucially important as we perform interventions on increasingly small children and strive to minimize re-interventions on devices implanted during childhood.

Magnetic resonance imaging-guided cardiac catheterization

X-ray fluoroscopy has traditionally provided guidance for cardiac catheterization procedures, however fluoroscopy is limited by 2-dimensional projections, limited soft tissue definition, and necessary exposure to ionizing radiation. In patients with congenital heart disease, early and multiple exposures to ionizing radiation over the course of their lives puts them at higher cumulative risk associated with ionizing radiation exposure (70-73). Practices and techniques to minimize radiation exposure in this vulnerable group of pediatric patients, therefore, is of particular focus in pediatric interventional cardiology. One emerging technology that allows for minimal or no radiation exposure is magnetic resonance imaging (MRI)-guided cardiac catheterization.

Cardiac MRI (CMR) provides excellent soft-tissue definition and provides important information about structure, function, and perfusion/flows. However, measurement of intracardiac hemodynamics still requires cardiac catheterization, which is invasive and exposes patients to radiation. The guidance for this catheterization can be modified to include no radiation through the use of real-time CMR. Clinical CMR was first reported as an adjunct to X-ray fluoroscopy in adults over 10 years ago (74) and has continued to evolve since that time, with many small studies evaluating the feasibility and outcomes of radiation free CMR-guided cardiac catheterization. This includes both animal and adult pilot studies for both diagnostic and limited interventional procedures (75-77). In their pilot study comparing X-ray and CMR-guided right heart catheterization in 16 adult patients, Ratnayaka and his colleagues found that CMR-guided catheterization was able to be safely and successfully performed, and had a total procedure time similar to that of X-ray guided catheterization (76). In their patients, CMR-guided catheterization has now become the preferred modality for adult patients referred for a right heart catheterization. They have since published on 50 radiation-free transfemoral CMR-guided right heart catheterizations in children (78). All catheterizations were successful with no complications, and given the short procedure time with a realistic workflow, they hope to be able to offer this technology routinely in the pediatric population in the near future (78).

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Figure 5 Combined fluoroscopy and cardiac MRI suite (Image courtesy of Dr. Elena Grant, Children's National Medical Center).

CMR-guided catheterization requires an elaborate set-up, which has limited its widespread use. A combined fluoroscopy/CMR suite with biplane X-ray fluoroscopy and adjoining CMR rooms, separated by X-ray and radiofrequency shielded doors, are fashioned with special mobile tables that can transfer a patient from the fluoroscopy lab to the MRI scanner while maintaining sterility (*Figure 5*). The other challenge with CMR-guided catheterization is that all equipment used in the MRI room must be MRI compatible, including all catheters, guidewires, and potential devices. At this time, visualization of catheters on MRI is limited to the tip only, where a commercially available balloon tipped catheter is inflated with gadolinium to allow localization of the catheter tip. There are currently no commercially available guidewires to aid manipulation of catheters into specific locations or over which balloons and stents can be delivered, and this remains the biggest hurdle to the expansion of CMR-guided interventional catheterization. The added superiority of real-time MRI imaging, however, has the potential to allow for safer performance of complex interventions. Recently, Ratnayaka *et al.* published their experience with MRI-guided transcatheter cavopulmonary shunt creation in 15 swine (79).

Magnetic resonance imaging-guided cardiac catheterization—conclusions

The ability to offer transcatheter cardiac procedures more safely and without ionizing radiation is particularly relevant for patients with complex congenital heart lesions who require multiple catheterization procedures over their lifetime. Although eliminating exposure to ionizing radiation, and continuing to expand the scope of transcatheter interventions, seems like a pipe dream, it may soon become a reality with CMR-guided catheterization.

Innovative imaging and modeling techniques

No transcatheter intervention would be possible without appropriate imaging to plan, guide, and assess the impact of a procedure. The development and more widespread use of innovative imaging techniques is paramount in the interventional cardiologist's ability to perform increasingly complex interventions on complex anatomy, broadening the scope of procedures that can be performed via a transcatheter rather than surgical approach. Three-dimensional (3D) imaging and advanced visualization techniques have allowed for superior imaging with lower radiation doses and have allowed for the understanding of more complex anatomy and anatomic relationships.

3D rotational angiography (3DRA)

Originally designed for use in interventional neurovascular procedures (80,81), over the last 10 years, angiographic computed tomography (CT), or 3DRA, has become an integral part of the modern day cardiac catheterization lab. This technology uses cross-sectional CT images created from a rotational angiogram to display a volumetric data set. The angiogram is performed over a slow, multiple second injection of dilute contrast (typically 50–60% strength) while a standard C-arm mounted flat panel detector rotates ~190 degrees around the patient. This rotational angiogram provides a robust data set, which can be post-processed into a 3D reconstruction within minutes. The source images obtained are identical to that of a cross-sectional CT scan, therefore in addition to post-processing into a 3D reconstruction, the cross-sectional CT images may also be viewed and are particularly useful for visualizing soft tissue structures, allowing for the operator to appreciate relationships and interactions between vascular/cardiac structures and other soft tissue structures within the chest (82,83).

Respiratory and cardiac motion over the duration of the rotational angiogram make the cardiac applications of this technology understandably more difficult than the neurovascular applications for which they were originally designed. However 3DRA can provide diagnostic quality images in the majority of cases with comparable overall

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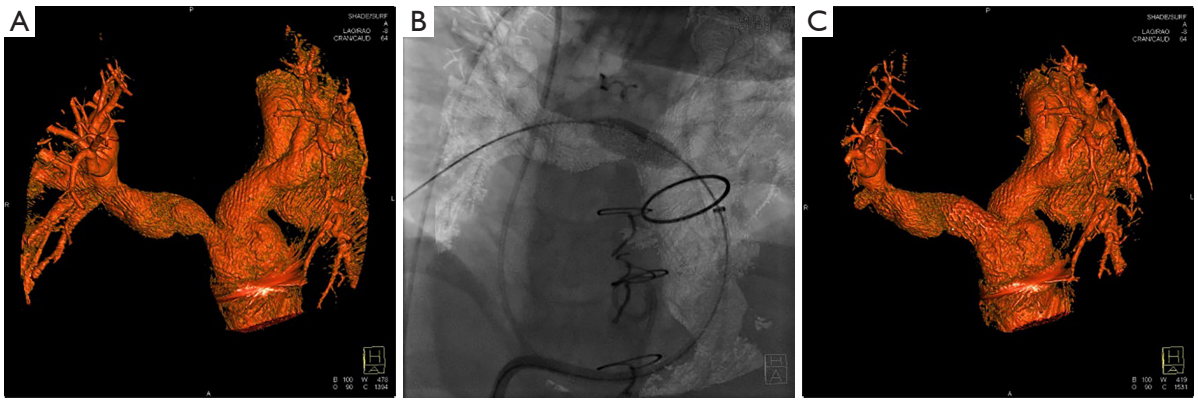


Figure 6 3D reconstruction of branch pulmonary arteries at baseline (A), use of 3D image overlay during stent placement in the right pulmonary artery stenosis (B), and 3D reconstruction post-stent (C).

radiation and contrast doses to standard cineangiography (84-87). The 3D reconstructions are particularly useful in understanding complex pulmonary artery or aortic arch anatomy and the relation of these vascular structures to soft tissue structures such as the airway (82,83), frequently providing additional, clinically relevant data when compared with standard biplane angiography (87). While dependent in part on the structure being visualized, quantitative measurements of structures made by 3DRA are comparable to those by 2D angiography (88). The reconstruction can also be manipulated on the workstation to visualize areas that are difficult or impossible to profile by standard 2D angiographic views and can be more sensitive for detection of some stenotic lesions (88). "Ideal" camera angles for viewing a particular lesion can also be easily identified, standard fluoroscopic C-arms moved to these angles, and the lesion of interest viewed at optimal working 2D angles. This can potentially lower the number of angiograms needed to visualize a lesion, which may result in lower radiation exposure and contrast dose. An overlay of the reconstruction can also be projected on the fluoroscopic image to allow for real time guidance of catheters and interventional equipment and can assist with complex catheter manipulations (*Figure 6*).

3DRA—conclusions

The use of 3DRA in congenital heart disease allows for a more robust understanding of complex anatomic relationships compared to standard biplane angiography. The ability to create and manipulate 3D volumetric data sets in real time allows for facile evaluation of both cardiac and non-cardiac lesions and procedural guidance. These attributes make 3DRA an important adjunctive imaging modality for the treatment of complex congenital heart disease in cardiac catheterization procedures.

Multimodality image fusion

While 3DRA allows for acquisition of a new CT dataset during the catheterization, if a pre-existing cross-sectional dataset derived from CMR or CT scan is available, these images can be fused with live fluoroscopy to provide additional anatomic guidance during a cardiac catheterization. Particularly appealing, the use of X-ray magnetic resonance fusion (XMRF) allows a 3D dataset with soft tissue definition obtained without ionizing radiation to be used to guide a live catheterization. Various methods can be used to fuse these images with fluoroscopy by using internal (bone, airway, artifact, calcium) or external fiducial markers (89,90). Once fused, these overlays can be used similarly to those obtained with 3DRA, and function to guide catheter manipulation, choose optimal working camera angles, and guide interventions. Multiple small studies have shown that use of XMRF can reduce radiation and contrast dose and reduce fluoroscopic time for select interventional procedures (89,91,92)

The multimodality fusion techniques described above have the downside that they do not provide real-time imaging to account for cardiac and respiratory motion and changes in patient position. A newer fusion technique, initially approved for use in 2012, is a software called EchoNavigator (Philips Healthcare, Best, The Netherlands), which allows for fusion of real-time

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echocardiographic images onto live fluoroscopy (93). This technique takes the wide field of view and excellent visualization of bony structures, devices, and catheters provided by fluoroscopy, and couples it with the excellent soft tissue visualization provided by echocardiography (standard 2D or 3D). These images are then displayed in the same orientation as a single fused image viewable by the operator (93). Areas of interest, such as a baffle or paravalvular leak, can be marked on the echo image and then viewed on the fused fluoroscopy image to help with localizing structures not visible by fluoroscopy alone. This modality has found wider use in adult structural heart disease, with multimodality guidance utilized for left atrial appendage occlusion, transcatheter mitral valve repair, and paravalvular leak closure (93-96). It has started to find a place within the realm of congenital heart disease as well, with proposed uses for atrial and ventricular septal defect closure, Fontan fenestration closure, and transseptal puncture (97,98). Compared to a historical control group of patients undergoing atrial septal defect closure, use of EchoNavigator was shown to provide superior procedural guidance compared with standard echocardiography alone in the majority of cases, with lower overall fluoroscopy time and radiation dose (97).

Multimodality image fusion—conclusions

Fusion of CT or MRI derived volumetric data sets, and 2D/3D echocardiographic data sets with fluoroscopy allows for improved understanding of anatomic relationships and enhanced procedural guidance. While the use in congenital heart disease is in its infancy, we anticipate continued growth in this area as we continue to look for ways to lower radiation doses and await application of additional technologies, like 3D TEE, in the pediatric space.

3D printing and 3D modeling

Over the last decade, advances in 3D imaging techniques have allowed the ability to translate cross sectional imaging data into interactive, real-life modeling through the use of 3D printing (99). Also known as rapid prototyping or additive printing, 3D printing has been used since the 1980s. More recent advances in imaging and printing technology have allowed for 3D printing to be more readily accessible (cheaper and faster) and used in dynamic cardiac structures (100). Non-invasive imaging datasets (CT, MRI, and more recently 3D echocardiography) can now be used to create patient-specific 3D printed heart models of complex cardiac anatomy and provides an innovative approach to pre-procedural planning, communication, and patient and trainee education (99,101) (*Figure* 7).

Historically, cross sectional imaging in the form of contrast-enhanced CT images were used most frequently to create 3D models. Free-breathing 3D whole heart MRI has become increasingly popular with complex congenital heart lesions (102). More recently, 3D echocardiography has also been utilized for the creation of 3D printed models. This modality offers a more accessible and cost-effective option and is particularly beneficial when visualization of structures not well seen by cross-sectional imaging, such as the atrial septum and valve leaflets, are the area of interest (103-105). Hybrid imaging, which combines a cross sectional dataset with an ultrasound dataset to take advantage of the best components of multiple modalities, is also evolving and is a promising avenue for production of a complete heart model with imbedded valve leaflets (106,107).

Once created, these models have been used successfully in the understanding of intracardiac and extracardiac lesions including complex intracardiac relationships, aortic arch anomalies, pulmonary artery branches, and aortopulmonary collaterals. These models can then facilitate pre-procedural planning both for transcatheter and surgical interventions. Multiple studies have shown the feasibility and accuracy of 3D printed models for reconstruction of complex cardiac lesions, with excellent correlation (within millimeters) of 3D models to the anatomic details visualized by cross-sectional imaging or by direct visualization in the operating room (104,105,108-110). In interventional cardiology, these models can be used in pre-procedural planning, in order to better understand complex anatomy (104,111-114) and to allow for mock-implants of a device or stent within a 3D printed model to better understand device fit in a particular patient (113,115,116). Additionally, there is the potential for patient specific 3D models to be used for education of patients and families, improving patient satisfaction, and improving communication between providers and between providers and their patients.

While there is endless potential for the use of 3D printing within congenital heart disease, there are a number of limitations. There is currently a lack of a standardized approach to imaging, segmentation, and processing which results in wide variation in the models produced. While the cost and time associated with segmentation and printing

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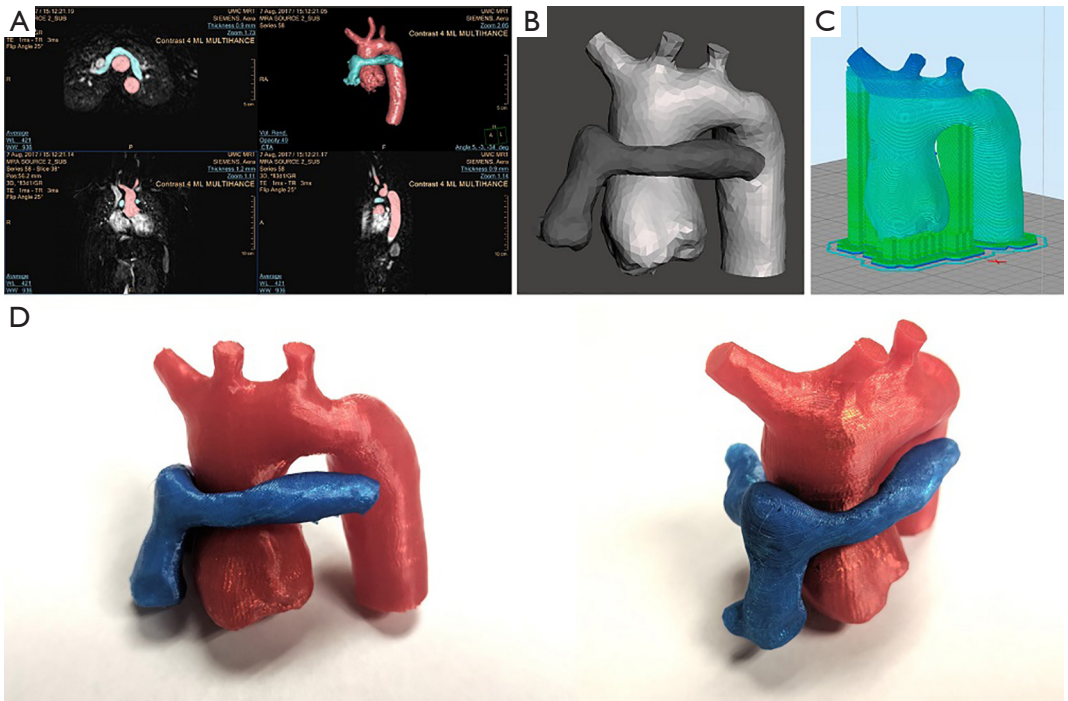


Figure 7 Creation of a 3D model (images courtesy of Dr. Michael Seckeler, Banner University Medical Center). (A) Segmenting of the axial imaging (MR or CT) involves highlighting the areas of interest to generate a virtual 3D model. This is then exported in stereolithography file format. This model was created in a 3-year-old with transposition of the great arteries and coarctation of the aorta, s/p arterial switch procedure, with Lecompte procedure of the pulmonary arteries, now presenting with recurrent coarctation; (B) the 3D model of the aorta and branch pulmonary arteries is further cleaned and smoothed as needed; (C) the model is then sliced to convert the stereolithography format into instructions for the 3D printer to execute. Note the support structures that are generated to allow for printing complex structures; (D) the completed model is printed, in this case with polylactic acid (PLA) to create a hard model. Multiple colors can be used to highlight different structures (aorta shown here in red and pulmonary arteries in blue).

has decreased significantly over the recent years, these are still very real limitations to wide-spread use of the technology (101). In terms of clinical use for direct patient care decisions, more stringent validation of these models across imaging modality and printing materials is necessary before it can be widely used to make crucial, real-time patient decisions (99,100). Cardiac structures are dynamic, and 3D models provide only one look at this changing structure. A more thorough understanding of the phase of the cardiac structure used for a model, and the properties of the materials used for printing will be necessary (99,101).

3D printing and modeling—conclusions

Despite its current limitations, 3D printing is an evolving technology within cardiology which will continue to expand as the technology and materials for printing evolve. The future of 3D printing is the potential for creation of custom implants or prosthesis, including heart valves and devices. At our center, Morrison *et al.*, have already created such a device, an airway splint, for patients with tracheobronchomalacia (117). While a cardiac application is still in development, the ability to print a cardiac device, created to accommodate an individual patient's anatomy is an exciting prospect and the epitome of personalized cardiac medicine.

Conclusions

Innovative techniques in cardiac catheterizations for patients with congenital heart disease are rooted in tremendous advances in both technology and imaging. These advances will continue to broaden our ability to treat patients using less-invasive techniques hopefully leading to

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both excellent immediate procedural success and also long-term improvement in patient outcomes compared to the state-of-the-art approaches of the recent past.

Acknowledgements

The authors would like to acknowledge Dr. Martin Bocks for providing his expertise on biodegradable technologies, Drs. Kanishka Ratnayaka and Elena Grant for providing their expertise and images of MRI-guided cardiac catheterization, and Dr. Michael Seckeler, for providing images of 3D printing.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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Cite this article as: Zampi JD, Whiteside W. Innovative interventional catheterization techniques for congenital heart disease. Transl Pediatr 2018;7(2):104-119. doi: 10.21037/tp.2017.12.02

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SS Rec Summary

ISSUE: Cardiac Catheterization for Congenital Defects
TAB: 10

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93451	000	Right heart catheterization including measurement of	26	0.0339			2.47			98	30	3	5			30			30					
2nd REF	93454	000	Catheter placement in coronary artery(s) for	6	0.1029			4.54			98	30	3	5			30			30					
CURRENT	93530	000	Right heart catheterization, for		0.0206			3.97			185	38					95			52					
SVY	93593	000	Right heart catheterization for congenital heart defect(s),	46	0.0362	2.47	2.83	3.99	5.00	10.55	160	40	15	15	12	30	45	60	120	45	0	10	35	60	250
ACC	93593	000	Right heart catheterization for congenital heart defect(s),	4	0.0482	2.50	3.06	3.25	3.31	3.59	106	27	11	9	25	34	39	45	60	20	0	4	5	8	15
AAP	93593	000	Right heart catheterization for congenital heart defect(s),	5	0.0940	3.00	5.00	6.50	6.70	7.55	140	35	10	15	30	40	50	60	60	30	0	5	30	100	250
SCAI	93593	000	Right heart catheterization for congenital heart defect(s),	37	0.0344	2.47	2.70	4.00	5.00	10.55	164	44	15	15	12	30	45	60	120	45	2	20	40	60	160
REC	93593	000	Right heart catheterization for congenital heart defect(s) including imaging guidance by		0.0422			3.99			148	40	3	15			45			45					
MPC	36475	000	Endovenous ablation therapy of incompetent vein, extremity		0.0966			5.30			94	20	4	10			45			15					
MPC	31628	000	Bronchoscopy, rigid or flexible, including fluoroscopic		0.0693			3.55			78	10	3	5			40			20					
MPC	49405	000	Image-guided fluid collection drainage by catheter (eg		0.0710			4.00			95	25	5	5			40			20					
COMP	49422	000	Removal of tunneled intraperitoneal catheter		0.0592			4.00			111	33	3	10			45			20					

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93459	000	Catheter placement in coronary artery(s) for	6	0.0957			6.35			123	35	3	5			50			30					
2nd REF	93451	000	Right heart catheterization including measurement of	6	0.0339			2.47			98	30	3	5			30			30					
CURRENT	93530	000	Right heart catheterization, for		0.0206			3.97			185	38					95			52					
SVY	93594	000	Right heart catheterization for congenital heart defect(s),	45	0.0589	3.00	5.00	6.10	7.25	14.24	184	46	15	15	20	45	60	70	180	48	2	20	30	50	250
ACC	93594	000	Right heart catheterization for congenital heart defect(s),	3	0.0447	3.00	3.38	3.75	4.00	4.25	124	35	10	10	40	40	50	55	60	19	2	4	5	13	20
AAP	93594	000	Right heart catheterization for congenital heart defect(s),	5	0.0818	5.00	7.00	7.00	8.20	8.70	163	40	10	15	30	60	60	60	70	38	2	5	40	75	250
SCAI	93594	000	Right heart catheterization for congenital heart defect(s),	37	0.0556	3.50	5.00	6.10	7.25	14.24	193	55	15	15	20	45	60	75	180	48	2	20	30	50	142
REC	93594	000	Right heart catheterization for congenital heart defect(s),		0.0634			6.10			172	46	3	15			60			46					
MPC	52351	000	Cystourethroscopy, with ureteroscopy and/or		0.0962			5.75			118	33	5	15			45			20					
MPC	37212	000	Transcatheter therapy, venous occlusion for thrombolysis, any		0.0893			6.81			128	30	3	5			60			30					
COMP	37248	000	Transluminal balloon angioplasty, open or percutaneous,		0.0950			6.00			109	23	3	5			50			28					
COMP	93457	000	Catheter placement in coronary artery(s) for		0.1015			6.64			123	35	3	5			50			30					
COMP	36217	000	Selective catheter placement, arterial system; initial third		0.0870			6.29			111	23	3	5			60			20					

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93458	000	Catheter placement in coronary artery(s) for	11	0.0922			5.60			113	30	3	5			45			30					
2nd REF	93464	000	Catheter placement in coronary artery(s) for	9	0.1029			4.54			98	30	3	5			30			30					
CURRENT	93799	XXX	Unlisted cardiovascular		#DIV/0!						0														
SVY	93595	000	Left heart catheterization for	46	0.0725	2.50	5.25	6.00	7.00	11.55	170	46	15	15	15	32	45	60	180	46	0	10	24	50	250
ACC	93595	000	Left heart catheterization for congenital heart defect(s),	4	0.0676	3.50	4.81	5.38	5.76	6.55	131	34	11	9	25	46	57	64	75	20	0	2	4	9	20
AAP	93595	000	Left heart catheterization for congenital heart defect(s),	5	0.0781	6.70	7.00	7.00	8.50	9.45	173	40	10	15	45	60	60	60	60	48	4	5	20	75	250
SCAI	93595	000	Left heart catheterization for congenital heart defect(s),	37	0.0665	2.50	5.20	5.90	6.80	11.55	180	55	15	15	15	30	45	60	180	50	0	15	25	50	200
REC	93595	000	Left heart catheterization for congenital heart defect(s),		0.0781			6.00			158	46	3	15			45			46					
MPC	52351	000	Cystourethroscopy, with ureteroscopy and/or		0.0962			5.75			118	33	5	15			45			20					
MPC	37212	000	Transcatheter therapy, venous occlusion for thrombolysis, any		0.0893			6.81			128	30	3	5			60			30					
COMP	37248	000	Transluminal balloon angioplasty, open or percutaneous,		0.0950			6.00			109	23	3	5			50			28					
COMP	93453	000	Combined right and left heart catheterization, including		0.1009			5.99			113	30	3	5			45			30					

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93460	000	Catheter placement in coronary artery(s) for	13	0.1130			7.10			118	30	3	5			50			30					
2nd REF	93461	000	Catheter placement in coronary artery(s) for	8	0.0950			7.55			143	35	3	5			65			35					
CURRENT	93533	000	Combined right heart catheterization and transseptal		0.0334			6.69			240	60					120			60					
SVY	93596	000	Right and left heart catheterization for congenital	46	0.0858	3.00	6.45	7.91	8.89	13.55	193	50	15	15	5	45	60	89	240	53	0	20	50	79	250
ACC	93596	000	Right and left heart catheterization for congenital	4	0.0826	4.10	5.53	6.38	7.06	8.00	132	33	11	9	5	35	59	79	90	20	0	2	4	8	17
AAP	93596	000	Right and left heart catheterization for congenital	5	0.0858	8.50	9.00	9.90	10.00	12.55	211	43	10	15	60	60	85	85	90	58	10	20	20	50	250
SCAI	93596	000	Right and left heart catheterization for congenital	37	0.0768	3.00	6.35	7.82	8.34	13.55	204	55	15	15	19	45	60	90	240	59	10	30	50	80	175
REC	93596	000	Right and left heart catheterization for congenital		0.0902			7.91			181	50	3	15			60			53					
MPC	52353	000	Cystourethroscopy, with ureteroscopy and/or		0.1013			7.50			133	33	5	15			60			20					
MPC	52356	000	Cystourethroscopy, with ureteroscopy and/or		0.1097			8.00			133	33	5	15			60			20					
COMP	33952	000	Extracorporeal membrane oxygenation		0.1103			8.15			138	30	3	15			60			30					
COMP	93461	000	Catheter placement in coronary artery(s) for		0.0950			7.55			143	35	3	5			65			35					

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93461	000	Catheter placement in coronary artery(s) for	16	0.0950			7.55			143	35	3	5			65			35					
2nd REF	93460	000	Catheter placement in coronary artery(s) for	9	0.1130			7.10			118	30	3	5			50			30					
CURRENT	93532	000	Combined right heart catheterization and transseptal		0.0417			9.99			298	60					175			60					
SVY	93597	000	Right and left heart catheterization for congenital	46	0.0704	3.50	7.81	8.88	10.00	15.70	228	55	15	15	30	60	83	99	300	60	2	23	50	79	250
ACC	93597	000	Right and left heart catheterization for congenital	3	0.0750	4.50	5.70	6.90	7.20	7.55	150	40	10	10	50	64	70	80	90	20	2	4	5	8	11
AAP	93597	000	Right and left heart catheterization for congenital	5	0.0771	9.00	10.00	10.00	13.50	15.70	224	44	10	15	60	90	95	100	120	60	10	15	50	70	250
SCAI	93597	000	Right and left heart catheterization for congenital	35	0.0694	3.50	7.85	8.65	10.00	15.55	232	60	19	15	30	60	75	113	300	60	15	30	50	80	250
REC	93597	000	Right and left heart catheterization for congenital		0.0871			9.99			216	55	3	15			83			60					
XWALK	92924	000	Percutaneous transluminal coronary atherectomy, with		0.1249			11.74			143	23	1	5			84			30					
MPC	52356	000	Cystourethroscopy, with ureteroscopy and/or		0.1097			8.00			133	33	5	15			60			20					
MPC	36905	000	Percutaneous transluminal mechanical thrombectomy and		0.1057			9.00			126	22	4	5			75			20					
COMP	92920	000	Percutaneous transluminal coronary angioplasty; single		0.1265			9.85			127	23	1	5			68			30					
COMP	37241	000	Vascular embolization or occlusion, inclusive of all		0.0851			8.75			142	14	3	5			90			30					
COMP	92920	000	Percutaneous transluminal coronary angioplasty; single		0.1265			9.85			127	23	1	5			68			30					

Source	CPT	Global	DESC	Resp	INPUT	RVW MIN	RVW 25th	RVW MID	RVW 75th	RVW MAX	Total Time	PRE-TIME EXIL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MID	INTRA-TIME 75th	INTRA-TIME MAX	IWMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93567	ZZZ	Injection procedure during	15	0.0647			0.97			15						15								
2nd REF	36227	ZZZ	Selective catheter placement,	12	0.1393			2.09			15						15								
CURRENT	93561	ZZZ	Indicator dilution studies such		0.0633			0.95			15						15								
CURRENT	93562	ZZZ	Indicator dilution studies such		0.0642			0.77			12						12								
SVY	93598	ZZZ	Cardiac output measurement,	46	0.1000	0.20	1.00	2.00	3.00	13.00	20				5	12	20	45	300	0	0	5	10	30	300
ACC	93598	ZZZ	Cardiac output measurement,	4	0.1569	1.00	1.75	2.04	2.18	2.55	13				7	10	13	23	40	0	0	4	5	79	300
AAP	93598	ZZZ	Cardiac output measurement,	5	0.0333	0.97	1.00	1.50	5.00	13.00	45				5	30	45	60	60	0	0	5	20	25	60
SCAI	93598	ZZZ	Cardiac output measurement,	37	0.1000	0.20	1.00	2.00	3.00	8.50	20				5	12	20	45	300	0	0	5	10	30	200
REC	93598	ZZZ	Cardiac output measurement,		0.0875			1.75			20						20								
Xwalk Code	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity		0.0875			1.75			20						20								
MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during		0.0709			1.44			21						20			1					
MPC	36227	ZZZ	Selective catheter placement, external carotid artery,		0.1393			2.09			15						15								
COMP	99292	ZZZ	Critical care, evaluation and management of the critically ill		0.0750			2.25			30						30								
COMP	20931	ZZZ	Allograft, structural, for spine surgery, when used to supplement		0.0905			1.81			20						20								

August 25, 2020

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 10 Practice Expense

Dear Dr. Manaker:

Tab 10 on the October 2020 RUC agenda addresses five physician work codes and one add-on code for cardiac catheterization for congenital defects. These services are provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 10.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,

Richard Wright, MD
ACC RUC Advisor

Edward Toggart, MD
SCAI RUC Advisor

Steve Krug, MD
AAP RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2020

3D Imaging of Cardiac Structures – Tab 11

In May 2020, the CPT Editorial Panel created one new add-on code to describe the 3D echocardiographic imaging and postprocessing during transesophageal or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s).

93319 ***3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)***

The RUC reviewed the survey results from 108 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 0.50 for CPT code 93319. The RUC recommends 20 minutes of intra-service time. The specialties note that this service is distinct from existing 3D rendering imaging codes as it is all active physician work where the physician themselves are performing the work of image acquisition – this service does not involve post processing on a separate workstation.

The RUC compared the survey code to top key reference code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU= 0.38, intra-service time of 15 minutes) and noted that the survey code has 5 more minutes of intra-service time and 88 percent of the survey respondents that selected this key reference code indicate the survey code was more intense and complex to perform. For additional support, the RUC referenced 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU= 0.61, intra-service time of 20 minutes) and second key reference code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU=0.85, intra-service time of 15 minutes). **The RUC recommends a work RVU of 0.50 for CPT code 93319.**

Practice Expense

The Practice Expense Subcommittee adjusted the clinical activity times for CA030 and CA032 to reflect only 3 total minutes of clinical staff time to QC images and scan exam documents into the PACS as the physician is performing the procedure. Also, EF018 *stretcher* was removed from the equipment inputs as it is not typically required. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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New Technology/New Service
The RUC recommends that 93319 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Other Procedures**				
76376		*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation* *(Use 76376 in conjunction with code[s] for base imaging procedure[s])* (Do not report 76376 in conjunction with 31627, 34839, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75635, 76377, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012-78999, 93355, 93319, 0523T, 0559T, 0560T, 0561T, 0562T, *0623T, 0624T, 0625T, 0626T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T)*)		
76377		*requiring image postprocessing on an independent workstation* (Do not report 76377 in conjunction with 34839, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75635, 76376, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012-78999, 93355, 93319, 0523T, 0559T, 0560T, 0561T, 0562T, *0623T, 0624T, 0625T, 0626T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T)*		

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Medicine **Cardiovascular** **Echocardiography**				
+●93319	G1	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging) (Use 93319 in conjunction with 93303, 93304, 93312, 93314, 93315, 93317) (Do not report 93319 in conjunction with 76376, 76377, 93325, 93355)	ZZZ	0.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93319 Tracking Number Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **0.50**

CPT Descriptor: 3D echocardiographic imaging and postprocessing during transesophageal echocardiography or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, intraterial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with a history of mitral valve prolapse and mitral regurgitation present with dyspnea on exertion. A complete transthoracic echocardiogram shows moderate to severe mitral regurgitation. A transesophageal echo with 3D imaging is requested to better assess the mechanism and severity of mitral regurgitation.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The 2D images are prepped for 3-D imaging by optimizing the image quality and gain for each of the views. Real-time 3D images (narrow sector with display of pyramidal volume, focused wide sector (a zoomed image)) to give a focused, wide sector view of cardiac structures, and full volume electrocardiographic gated multiple-beat 3D images are acquired by the physician. For the zoomed image, the biplane mode is utilized and adjusted to ensure that the structure of interest is centered on the orthogonal view. The images are reviewed as acquired, including real time 3-D images with en-face views of the valvular structure. The focused wide sector views are reviewed, rotated, and cropped as needed for the best en-face views of the cardiac structures. The images are rotated for proper orientation and en-face views concurrent with image acquisition from the physician. The 3D images are repeated with color flow Doppler with multi-beat acquisition to obtain the 3D color flow Doppler sets to evaluate cardiac valvular function. The 3D images are analyzed utilizing specialized software. The full volume data set acquired can be cropped or multiplane transected to remove tissue planes to better visualize the structures or visualize cross-sectional views and orthogonal planes. The color 3D data sets are manipulated on the 3D software system to orientate perpendicularly and parallel to the regurgitant or antegrade flow orifice to assess valvular function such as the severity of mitral valve regurgitation. The images are acquired and saved to the patient's study.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	ACC:Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD ASE: Michael Main, MD; Geoff Rose, MD					
Specialty Society(ies):	American College of Cardiology, American Society of Echocardiography					
CPT Code:	93XX0					
Sample Size:	1700	**Resp N:**	108			
Description of Sample:	ACC and ASE surveyed a random sample of membership; ACC sample size - 500; ASE sample size - 1200					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	120.00	**180.00**	400.00	2500.00
Survey RVW:	0.20	0.50	**0.80**	1.10	3.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	12.00	**20.00**	27.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93XX0	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93220	ZZZ	0.38	**RUC Time**

CPT Descriptor Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76979	ZZZ	0.85	**RUC Time**

CPT Descriptor Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51797	ZZZ	0.80	**RUC Time**	117,137

CPT Descriptor 1 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	62,951

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36218	ZZZ	1.01	**RUC Time**

CPT Descriptor Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 41 **% of respondents:** 37.9 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93XX0	Top Key Reference CPT Code: 93220	2nd Key Reference CPT Code: 76979
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	10%	62%	28%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	29%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	33%	65%

Physical effort required	1%	19%	80%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	32%	68%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	29%	64%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	62%	33%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	55%	42%
Physical effort required	7%	42%	51%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	44%	54%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The ACC and ASE conducted a survey of new add on CPT code +93319 (3D echocardiographic imaging and postprocessing during transesophageal echocardiography or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, intraterial septum, interventricular septum) and function, when performed (List separately in

addition to code for echocardiographic imaging)) for the October 2020 RUC meeting. ACC and ASE conducted a random membership survey and received 108 responses.

Our multi-specialty consensus panel reviewed the survey data for code +93319, comparing the data and work RVUs (wRVUs) to the current data for similar add on codes that were recently approved by the RUC. The consensus panel agreed with the overall survey data. +93319 provides a service that allows single or multi-beat acquisition of datasets during breath hold without the need for off-line reconstruction. The 3D technology allows the visualization of cardiac valves and congenital abnormalities and provides improved accuracy and reproducibility by eliminating the need for geometric modeling offline.

The primary reference service, chosen by 38% of respondents, was CPT +93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (RUC 2014), with a WRVU of 0.38, a total time of 15minutes. The second reference service, chosen by 18% of respondents, was CPT 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection* (RUC 2018), has 0.85 WRVU, 15 minutes total time. Seventy percent of respondents ranked the surveyed code somewhat more or much more intense and complex than the primary and secondary reference services on the overall intensity/complexity measure. Respondents ranked the surveyed code as more or similar in intensity to the two reference codes on the submeasures.

The total time for +93319 is 20 minutes and we recommend a **wRVU of 0.50.** This value is equal to the 25th percentile of survey data.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Base congential TTE and TEE services

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Intra Time	Post Time	Total Time
93303	TTE Congenital complete	XXX	1.3	0	0	0	39
93304	TTE follow-up	XXX	0.75	0	0	0	34
93312	TEE probe placement, image acquisition, interpretation and report	XXX	2.3	10	30	15	55
93314	TEE image acquisition, interpretation and report only	XXX	1.85	5	30	15	50
93315	TEE congenital including probe placement, image acquisition, interpretation and report	XXX	2.69	10	40	15	65
93317	TEE congenital; image acquisition, interpretation and report only	XXX	1.84	5	20	15	40

3.
4.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatricians How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 85000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3D imaging is performed more commonly in the non-Medicare population. We estimate that it is performed 75% in the commercial patient population and 25% in the Medicare population

Specialty Cardiology Frequency 65000 Percentage 76.47 %

Specialty Interventional Cardiology Frequency 15000 Percentage 17.64 %

Specialty Pediatricians Frequency 5000 Percentage 5.88 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,250 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 25% of 85,000 = ~21,250 Medicare

Specialty Cardiology Frequency 17000 Percentage 80.00 %

Specialty Interventional Cardiology Frequency 3750 Percentage 17.64 %

Specialty Pediatricians Frequency 500 Percentage 2.35 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
NA

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93312

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	AP	AQ	AR	AS	AT
13	**ISSUE:**	**3D Imaging of Cardiac Structures**																								
14	**TAB:**	**11**																								
15																										
16							**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**SURVEY EXPERIENCE**				
17	**Source**	**CPT**	**Global**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**MIN**	**25th**	**MED**	**75th**	**MAX**
18	**1st REF**	**93320**	**ZZZ**	**Doppler echocardiography, puls**	**60**	**0.025**			**0.38**			**15**						**15**								
19	**2nd REF**	**76979**	**ZZZ**	**Ultrasound, targeted dynamic m**	**31**	**0.057**			**0.85**			**15**						**15**								
20	**CURRENT**											**0**														
21	**SVY**	**93319**	**ZZZ**	**3D echocardiographic imaging a**	**108**	**0.040**	**0.20**	**0.50**	**0.80**	**1.10**	**3.50**	**20**				**3**	**12**	**20**	**27**	**90**	**0**	**2**	**120**	**180**	**400**	**2500**
22	**REC**	**93319**	**ZZZ**	**3D echocardiographic imaging and postprocessing during transesophageal echocardiography or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, intraterial septum, interventricular septum) and function, when performed**		**0.025**			**0.50**			**20**						**20**								

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): +93319**

SPECIALTY SOCIETY(IES):
American College of Cardiology and American Society of Echocardiography
PRESENTER(S): Dr. Richard Wright /Dr. Geoffrey Rose

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, intraterial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
93319	A 70-year-old male with a history of mitral valve prolapse and mitral regurgitation present with dyspnea on exertion. A complete transthoracic echocardiogram shows moderate to severe mitral regurgitation. A transesophageal echo with 3D imaging is requested to better assess the mechanism and severity of mitral regurgitation.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Cardiology and the American Society of Echocardiography queried physicians who have the appropriate expertise for this code to provide PE details in order to determine clinical time and applicable standard which were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference code +93320 - Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No, this code is not typically reported with an E/M service on the same date of service

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   N/A new code

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:
   N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
   N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:
   b. Service period (includes pre, intra and post):
      Line 68 – CA030 – Technologist QC images in PACS, checking all images, reformats, etc.– 2 Minutes
      Line 70 – CA032 - Scan exam documents into PACS, Complete exam to RIS system – 1 Minute
   c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*
    During the exam the sonographer time is primarily captured during the base TEE service, however, he/she remains in the room to assist with the image QC, formatting, labeling and scanning into PACS system.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Line 115 – Specific 3D probe required to perform service in addition to the base echocardiography machine. Invoice included. This probe is not included in the current ultrasound room, general.

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formula was used for all equipment.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Lines 112-115 – the time requested reflects the physician time who is the person manipulating the probe and obtaining and marking images. Sonographer is labeling images in computer, assisting with ultrasound machine and entering images into PACS.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

- Line 52 – CA021 – perform service not directly related to Physician work time – 5 minutes - DELETE
- Line 68 – CA030 – Technologist QC images in PACS, checking all images, reformats, etc.– 2 Minutes
- Line 70 – CA032 - Scan exam documents into PACS, Complete exam to RIS system – 1 Minutes
- Line 113 – EF018 – stretcher 20 minutes – DELETE

	A	B	D	E	F	G	H	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 93320**		**CPT Code 93319**	
3		***RUC Collaboration Website***							
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 11 3D Imaging of Cardiac Structures Specialty:ACC, ASE**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Doppler echocardiography, pulsed wave and/or continuous wave with		3D echocardiographic imaging and postprocessing during transesophageal	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**ZZZ**		**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 34.69**	**$ -**	**$ 39.26**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**19.0**	**0.0**	**3.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**19.0**	**0.0**	**3.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 9.50**	**$ -**	**$ 1.11**	**$ -**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37				
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37				
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37				
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37				
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37				
23			L037D	RN/LPN/MTA	0.37				
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]	L037D	RN/LPN/MTA	0.37				
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37				
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37				
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37				
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37				
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37				
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37				
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37				
42			L037D	RN/LPN/MTA	0.37				
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
48		**Intra-service (of service period)**							
49	CA018	Assist physician of other qualified healthcare professional---directly related	L050A	Cardiac Sonogr	0.5	19			
50	CA019	Assist physician of other qualified healthcare professional---directly related	L037D	RN/LPN/MTA	0.37				
51	CA020	Assist physician of other qualified healthcare professional---directly related	L037D	RN/LPN/MTA	0.37				
52	CA021	Perform procedure/service---NOT directly related to physician work time	L050A	Cardiac Sonogr	0.5				
55			L037D	RN/LPN/MTA	0.37				
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37				
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37				
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37				
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37				
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37				
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37				
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and [illegible]	L037D	RN/LPN/MTA	0.37			2	
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to [illegible]	L037D	RN/LPN/MTA	0.37			1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37				
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L037D	RN/LPN/MTA	0.37				
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37				
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37				
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37				
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37				
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16						
88		99212 27 minutes	27						
89		99213 36 minutes	36						
90		99214 53 minutes	53						
91		99215 63 minutes	63						
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37				
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
99		**End: with last office visit before end of global period**							

	A	B	D	E	F	G	H	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 93320**		**CPT Code 93319**	
3		***RUC Collaboration Website***							
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 11 3D Imaging of Cardiac Structures Specialty:ACC, ASE**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Doppler echocardiography, pulsed wave and/or continuous wave with		3D echocardiographic imaging and postprocessing during transesophageal	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**ZZZ**		**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 34.69**	**$ -**	**$ 39.26**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**19.0**	**0.0**	**3.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**19.0**	**0.0**	**3.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**
102									
103									
104									
105									
106									
107									
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 25.19**	**$ -**	**$ 38.15**	**$ -**
112	ED034	video SVHS VCR (medical grade)	1250		0.004952745	5			
113	EF018	stretcher	5005.0105	Other Formula	0.013281929	14		0	
114	EL016	room, ultrasound, vascular	470912.44	Other Formula	1.784296253	14		20	
115	New	3D Probe	31754.3	Other Formula	0.123051951			20	
116									
117									
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request – Codes 99358 and 99359

October 2020

Prolonged Services – Tab 12

In September 2019, the CPT Editorial Panel added a new table to the CPT introductory language for Prolonged Services that illustrates the elements of all existing and new prolonged care services and how they are to be reported. This clarification was in response to a request of CMS in the July 2019 Proposed Rule for the 2020 Medicare Physician Payment Schedule. CMS also stated that the valuation of CPT codes 99358 and 99359 be reviewed.

In the Final Rule for 2020, CMS indicated:

> *Since Medicare began separately paying for CPT codes 99358-99359 in 2017 under the PFS, their PFS utilization has increased more than ten-fold from approximately 10,000 claim lines in 2016 to approximately 126,000 claim lines in 2018. While this remains a small percentage of E/M visit claims, utilization may further increase once all office/outpatient E/M visits can be reported based on time alone and new activities such as documenting clinical information are explicitly counted as qualifying time. We continue to believe that the new CPT prefatory language on these codes is difficult to follow and interpret. For example, it states, "for prolonged time without direct patient contact on the date of office or other outpatient services, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to-face encounter." But for CPT code 99417 it states not to report 99417 in conjunction with 99358, 99359 which could mean not to report 99358-99359 if 99417 is reported, even on a separate day. Additionally, CPT would allow reporting at the midpoint of time for CPT codes 99358-99359 but not 99417, and these codes have discrepant time increments (one hour for CPT codes 99358-9 reportable after the midpoint, and 15 minutes for CPT code 99417 not reportable after the midpoint). Under the new CPT framework allowing the use of time to select visit level and the new list of qualifying activities, there is a new Medicare program vulnerability and potential increased beneficiary cost sharing associated with the inability to assess what visit(s) prolonged service codes reported on a date other than the visit are associated with and, accordingly, to assess whether the prolonged time was reasonable and necessary. If more than one visit was furnished (for example, if a beneficiary has an inpatient visit or another outpatient visit by the same practitioner within a wide time range of a given office/outpatient visit), it would not be clear which visit the prolonged time reported under CPT codes 99358-99359 is associated with for evaluating medical necessity and increments of time in relation to the base/companion code.*
>
> *We continue to believe it would be administratively simpler and improve payment accuracy and program integrity to have only a single add-on code specific to prolonged office/outpatient E/M visits that is clearly linked to the companion E/M office/outpatient visit code.* ***We believe that under the new coding framework, CPT codes 99358-99359 are potentially misvalued, need to be revised for clarity and present new program integrity challenges****. Therefore, we are finalizing our proposal that CPT codes 99358-99359 will not be payable in association with office/outpatient E/M visits beginning in CY 2021. We will consider future changes made to these codes by the CPT Editorial Panel or the RUC for possible future rulemaking. We note that a number of other codes such as CCM, TCM, and other care management codes may be used to report time spent outside the direct patient contact on dates other than the office/outpatient visit, if the reporting requirements for those services*

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are met. While these care management codes are not identical to the prolonged visit codes, they can be used to report a number of similar activities.

In January 2020, no specialty societies indicated an interest to survey these services. The American Academy of Family Physicians indicated that they interpreted the CPT changes as editorial only. In the Final Rule, CMS had ongoing concern and confusion with 99358 and 99359 and their guidelines, even in the wake of the CPT Editorial Panel's action in September 2019. Further, the specialty societies would like to address questions and concerns that CMS has in this regard, so these prolonged services codes may be appropriately used in conjunction with the Evaluation and Management (E/M) office visit codes in CY 2021 and beyond, after needed CPT clarification. The specialty societies recommended that these services be referred to CPT prior to a resurvey. The RUC discussed this issue and recommended that CPT codes 99358 and 99359 be referred to the May 2020 CPT Editorial Panel to clarify how these services may be reported with other E/M services.

In May 2020, the CPT Editorial Panel revised the existing Prolonged Services section to remove references to typical times to reflect the new total time definition for office visits.

At the October 2020 RUC meeting, the specialty societies indicated that the recent changes at CPT were editorial, clarifying when the codes should be reported rather than the work inherent in the codes themselves, and the descriptors were unchanged. The RUC was concerned that CPT codes were identified as potentially misvalued by CMS and 99358 and 99359 have not been surveyed since 1993. The specialty societies requested additional time for physicians to gain experience reporting the prolonged services codes with the revised office visit codes prior to surveying 99358 and 99359.

The RUC noted that the joint CPT/RUC Workgroup on E/M is continuing its work of revising the E/M code set and prolonged services 99358 and 99359 may be part of and/or affected by these revisions. The CPT/RUC Workgroup on E/M intends to examine coding guideline changes and code revisions for the remaining E/M services at the February 2021 CPT meeting and the RUC will review these recommendations at its April 2021 meeting. **The RUC recommends that CPT codes 99358 and 99359 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 cycle and the 2023 Medicare Physician Payment Schedule.**

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Prolonged Services** **Prolonged Service with Direct Patient Contact <u>(Except with Office or Other Outpatient Services)</u>** Codes 99354-99357 are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient<u>, observation</u> or outpatient setting<u>, except with office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)</u>. Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure. ~~(ie, the designated evaluation and management services at any level, code 90837, Psychotherapy, 60 minutes with patient, 90847, Family psychotherapy [conjoint psychotherapy] [with patient present], 50 minutes), and any other services provided at the same session.~~ Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period. Codes 99354-99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the ~~office or other~~ outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes 99356-99357 are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous. *Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.* *Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.* Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported ~~because the work involved is included in the total work of the evaluation and management or psychotherapy codes~~. *Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.*				

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The use of the time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99417.

For prolonged total time in addition to ~~the~~ ~~O~~office or ~~O~~other ~~O~~outpatient ~~S~~services (ie, 99205, 99215), use 99417.

The following table illustrates the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the inpatient or observation ~~office~~ setting beyond the usual service time.

Total Duration of Prolonged Services	**Code(s)**
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	~~99354~~ 99356 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	~~99354~~ 99356 X 1 AND ~~99355~~ 99357 X 1
105 or more (1 hr. 45 min. or more)	~~99354~~ 99356 X 1 AND ~~99355~~ 99357 X 2 or more for each additional 30 minutes.

~~***Coding Tip***~~
~~**Reporting Service of Less than 30 Minutes**~~
~~Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes. *CPT Coding Guidelines, Evaluation and Management, Prolonged Physician*~~

★✚▲99354 Prolonged ~~evaluation and management or psychotherapy~~ service(s) ~~(beyond the typical service time of the primary procedure)~~ in the ~~office or other~~ outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for ~~office or other~~ outpatient **Evaluation and Management** or psychotherapy service, except with office or other outpatient services [99202-99215])
(Use 99354 in conjunction with 90837, 90847, ~~99201-99215~~, 99241-99245, 99324-99337, 99341-99350, 99483)

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(Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)

★✚▲99355 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99355 in conjunction with 99354)

(Do not report 99355 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)

✚▲99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation **Evaluation and Management** service)

(Use 99356 in conjunction with 90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)

+ 99357 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99357 in conjunction with 99356)

Prolonged Service Without Direct Patient Contact

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the ~~office or~~ outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215) ~~and is beyond the usual physician or other qualified health care professional service time~~. For prolonged total time in addition to ~~without direct patient contact on the date of~~ office or other outpatient services (ie, 99205, 99215) on the same date of service without direct patient contact, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to face encounter.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date ~~and commences upon receipt of past records~~. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management. ~~A typical time for the primary service need not be established within the CPT code set.~~

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported ~~because the work involved is included in the total work of the evaluation and management or psychotherapy codes~~.

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Code 99359 is used to report each additional 30 minutes beyond the first hour ~~regardless of the place of service~~. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time ~~spent~~ without direct patient contact reported in other services such as care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other qualified health care professional (99491), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/internet/electronic health record consultations (99446-99452), or on-line digital evaluation and management services (99421, 99422, 99423).

99358	U1	*Prolonged evaluation and management service before and/or after direct patient care; first hour*	XXX	Refer to CPT February 2021
+99359	U2	*each additional 30 minutes (List separately in addition to code for prolonged service)* *(Use 99359 in conjunction with 99358)* (Do not report 99358, 99359 on the same date of service as 99417) *(Do not report 99358, 99359 during the same month with 99484, 99487-99489, 99490, 99491, 99492, 99493, 99494)* (Do not report 99358, 99359 when performed during the service time of codes 99495 or 99496, if reporting 99495 or 99496)	ZZZ	Refer to CPT February 2021

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	***Code(s)***
less than 30 minutes	*Not reported separately*
30-74 minutes *(30 minutes - 1 hr. 14 min.)*	*99358 X 1*
75-104 minutes *(1 hr. 15 min. - 1 hr. 44 min.)*	*99358 X 1 AND 99359 X 1*

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105 or more *(1 hr. 45 min. or more)*	*99358 X 1 AND 99359 X 2* *or more for each additional* *30 minutes.*

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes 99415, 99416 are used when a prolonged evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the ~~typical face-to-face~~ highest total time of the E/M service, as stated in the ranges of time in the code descriptions. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.

Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than ~~45~~ 30 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes. The highest total time in the time ranges of the code descriptions ~~typical face-to-face time of the primary service~~ is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after ~~25~~ 39 minutes, and 99415 is not reported until at least ~~70~~ 69 minutes total face-to-face clinical staff time has been performed. When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.
Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Codes 99415, 99416 may be reported for no more than two simultaneous patients. The use of the time-based add-on codes requires that the primary E/M service has a ~~typical or specified~~ time published in the CPT code set.

For prolonged services by the physician or other qualified health care professional, ~~use~~ see 99354, 99355, 99417. Do not report 99415, ~~or~~ 99416 with 99354, ~~or~~ 99355, 99417.
Facilities may not report 99415, 99416.

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#✚▲99415 Prolonged clinical staff service (the service beyond the highest time in the range of total time of the ~~typical~~ service ~~time~~) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient **Evaluation and Management** service)

(Use 99415 in conjunction with ~~99201,~~ 99202, 99203, 99204, 99205, ~~99211,~~ 99212, 99213, 99214, 99215)

(Do not report 99415 in conjunction with 99354, 99355, 99417)

#✚▲99416 each additional 30 minutes (List separately in addition to code for prolonged service)
(Use 99416 in conjunction with 99415)
(Do not report 99416 in conjunction with 99354, 99355, 99417)

The Total Duration of Prolonged Services Table illustrates the correct reporting of prolonged services provided by clinical staff with physician supervision in the office setting beyond the initial ~~45~~30 minutes of clinical staff time:

Total Duration of Prolonged Services		***Code(s)***
less than ~~45~~30 minutes		*Not reported separately*
~~45~~30-74 minutes (~~45~~ 30 minutes – 1 hr. 14 min.)		*99415 X 1*
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)		*99415 X 1 AND 99416 X 1*
105 or more (1 hr. 45 min. or more)		*99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.*

Prolonged Service with or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service

Code 99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services (ie, 99205, 99215). Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the ~~total~~ minimum time required to report ~~of~~ the highest-level service (ie, 99205 or 99215) has been exceeded by 15 minutes. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes.

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The listed time ranges for 99205 (ie, 60-74 minutes) and 99215 (ie, 40-54 minutes) represent the complete range of time for which each code may be reported. Therefore, when reporting 99417, the initial time unit of 15 minutes should be added once the minimum time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (ie, 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (ie, 55 minutes) on the date of the encounter.

Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.

For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215), see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, see 99415, 99416. Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416.
Prolonged services of less than 15 minutes total time is not reported on the date of ~~the~~ office or other outpatient service when the highest level is reached (ie, 99205, 99215) ~~is not reported~~.

★✚●99417 Prolonged office or other outpatient evaluation and management service(s) ~~(~~beyond the minimum required ~~total~~ time of the primary procedure which has been selected using total time~~)~~, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service~~;~~, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

(Use 99417 in conjunction with 99205, 99215)

(Do not report 99417 ~~in conjunction with~~ on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)

(Do not report 99417 for any time unit less than 15 minutes)

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	**Code(s)**
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes.

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Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes.

Proposed Revision to CPT code Descriptors

★▲**99205** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

(For services 75 minutes or longer, see ~~P~~prolonged ~~S~~services code 99417)

★▲**99215** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes or longer, see ~~P~~prolonged ~~S~~services code 99417)

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▶Table XX: Comparison of Prolonged Services Codes 99354, 99355, 99356, 99357, 99358, 99359, 99417◀

▶Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use In Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service
+99354	Face-to-Face Only	30 minutes (Beyond listed typical time)	90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483	99202-99215, 99415, 99416, 99417	99358, 99359
+99355	Face-to-Face Only	Each additional ~~30~~15 minutes (Beyond 99354)	99354	99202-99215, 99415, 99416, 99417	99358, 99359
+99356	Face-to-Face and Unit/ Floor Time	30 minutes (Beyond listed typical time)	90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310		99358, 99359
+99357	Face-to-Face and Unit/ Floor Time	Each additional ~~30~~15 minutes (Beyond 99356)	99356		99358, 99359
99358	Non-Face-to-Face Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99215, 99417 On same date of service	99354, 99356
+99359	Non-Face-to-Face Only	Each additional ~~30~~15 minutes (Beyond 99358)	99358	99202-99215, 99417 On same date of service	99354, 99356
+99417	Both	Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more ***(Total time on the date of encounter)***	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A

*Do not count the time of any separately reported service as Prolonged Services time
99355 is for prolonged services time beyond 99354 and may be reported in multiple units
99357 is for prolonged services time beyond 99356 and may be reported in multiple units
99359 is for prolonged services time beyond 99358 and may be reported in multiple units
99417 is for prolonged services time beyond 99205/99215 and may be reported in multiple units of at least 15 minutes◀

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AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2020

Anesthesia for Cardiac Electrophysiologic Procedures – Tab 13

In October 2016, the RUC identified 00537 *Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation* via the high volume growth screen for services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014**.** In October 2019, the RUC reviewed this service and recommended survey for the October 2020 meeting.

Compelling Evidence
The specialty society indicated, and the RUC agreed with the compelling evidence that there has been a change in patient population and change in technique since the previous survey in 2000.

Change in patient population
When this code was last surveyed in 2000, the vignette described a 32-year-old man undergoing an electrophysiology procedure for identification of Wolff-Parkinson-White (WPW) syndrome pathway and ablation. The underlying procedure for which 00537 is currently typically provided is CPT code 93656 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation*. The vignette used in the current survey reflects the change in the typical patient and the underlying procedure being performed: a 62-year-old man with recurrent atrial fibrillation having electrophysiologic studies with induction or attempted induction of arterial fibrillation and then intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation (PVI). For the previous survey and vignette, the patient was described as otherwise healthy and without other medical co-morbidities. In contrast, the patient in the current survey requires more time for pre-anesthesia evaluation, as well as preparation of equipment and medications and the need for vasoactive infusions. In addition, the current patient often has cardiac and other co-morbidities. This change in patient population is well described in a 2014 article published in the Journal of Cardiothoracic and Vascular Anesthesia wherein the authors provide a clear picture of the complexity of the patients, challenges of the environment of care, the risk of significant complications, and the ongoing intensity of effort required to coordinate with the proceduralist throughout a lengthy intervention.[1]

[1] Nicoara, A., Holmquist, F. et al. (2014). Anesthesia for Catheter Ablation Procedures. *Journal of Cardiothoracic and Vascular Anesthesia*; 28(6), 1589-1603. http://dx.doi.org/10.1053/j.jvca.2014.05.030

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The RUC noted that it anticipates this patient population will become even more complex in the future.

Change in technique

The anesthetic care required is different for the current vignette patient than in previous vignette patients. For the young patient with WPW, moderate to deep sedation was the primary anesthetic plan and no invasive monitoring was required. For the PVI technique, the typical anesthesia approach requires general anesthesia with endotracheal intubation. General anesthesia is chosen to provide better patient comfort, immobility throughout the catheterization of the pulmonary vein and during the ablation, control and modification of ventilation patterns (which can affect the ablation), and better outcomes for the ablation. Ongoing communication and close coordination between the anesthesiologist and cardiologist are required throughout the duration of the procedure in order to provide optimal conditions for the ablation technique and to avoid or permit the early detection of major complications.

A 2018 article in the Journal of Cardiothoracic and Vascular Anesthesia describes the increasing demands on anesthesiologists performing this procedure and that anesthesiologists are becoming integral members of the electrophysiologic teams. The authors find that as the complexity and duration of cardiac ablation procedures increase, there is a growing demand for anesthesiologist involvement in the electrophysiology suites for sedation and anesthesia provision, hemodynamic and neuromonitoring, and procedural guidance through transesophageal echocardiography. The authors conclude that, "As the population ages and EP technologies improve, the scope of practice will grow to include more elderly, more moribund, and more complex patients, including those with CHD and VADs." [2]

00537 ***Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation***

The RUC reviewed the survey results from 100 anesthesiologists and recommends the median base unit of 12 for CPT code 00537. The RUC recommends 16 minutes pre-anesthesia patient evaluation time, 15 minutes pre-anesthesia equipment/drug/supply preparation time, 15 minutes intra-operative anesthesia induction time, 180 minutes intra-operative anesthesia post-induction time and 12 minutes post-anesthesia evaluation time. The majority of survey respondents indicated that the intensity and complexity measures for 00537 are identical to slightly more to somewhat more intense than top key reference service 00560 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator* (base unit = 15) and identical to slightly more intense than the second top key reference service 00350 *Anesthesia for procedures on major vessels of neck; not otherwise specified* (base unit = 10), which bracket the base unit recommendation. The RUC noted that the surveyed code requires 180 minutes post-induction intra-operative anesthesia time, where 00560 requires 152 minutes and 00350 requires 120 minutes.

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[2] Fujii, S., Zhou, J. R., & Dhir, A. (2018). Anesthesia for Cardiac Ablation. *Journal of Cardiothoracic and Vascular Anesthesia,* 32(4), 1892-1910. https://doi.org/10.1053/j.jvca.2017.12.039

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For further support, the RUC also referenced other cardiac related anesthesia services such as CPT code 00534 *Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator* (base unit = 7) and 00541 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation* (base unit = 15).

The RUC-approved anesthesia building block methodology and regression analysis are important tools to compare relativity among anesthesia services and are used to validate the recommendation. The regression line graph in the summary of recommendation form supports the recommended base unit of 12 as it is the closest base unit value to the regression line. The closer a point is to the regression line, the better the agreement between the proxy RVU value derived from the building block methodology and the actual base unit.

Post-Induction Period Procedure Anesthesia (PIPPA) is the relative intensity methodology used to validate base unit values. Survey respondents were asked to allocate the post induction period to five different intensity levels. PIPPA only looks at the post-induction period and it is conceptually equivalent to the time during which the surgeon performs the procedure. CPT code 00537 has a greater overall amount of time spent in the higher PIPPA levels in comparison to the top key references but falls in line with the overall weighted PIPPA intensity for 00537 (0.0503), compared to 00350 (0.0513) and 00560 (0.0583).

The RUC agreed that the survey median base unit of 12 appropriately places 00537 in the proper rank order with other anesthesia services when examining the anesthesiologists' time, PIPPA levels of intensity, the proxy anesthesia value and regression line. **The RUC recommends a base unit of 12 for CPT code 00537.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

CPT Code	CPT Descriptor	Global Period	Base Unit Recommendation
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX	12

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:00537 Tracking Number: Original Specialty Recommended Base Unit Value: **12**
Presented Recommended Base Unit Value: **12**
Global Period:XXX Current Base Unit Value: **7** RUC Recommended Base Unit Value: **12**

CPT Descriptor: Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old man with a history of hypertension has recurrent atrial fibrillation. Despite rate or rhythm control with antiarrhythmic drugs, he remains symptomatic. He undergoes cardiac electrophysiologic studies with induction or attempted induction of arrythmia and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation.

Percentage of Survey Respondents who found Vignette to be Typical: 84.00%

Description of Pre-Service Work: Obtain a thorough medical history including patient's medical co-morbidities, current medications, medication allergies, cardiac and pulmonary status, previous operations and anesthestics, and family history of problems with anesthestics. Perform a physical examination including an airway examination and auscultation of the heart and lungs. Review patients' medical record and laboratory studies including electrocardiogram (ECG), transesophageal echocardiogram (TEE), other cardiac workup, cardiologist's history and physical, and other tests that may be significant in this patient population. Discuss anesthesia care including anxiolysis, analgesia, general anesthesia, and intubation, the possible risks from anesthesia care, and obtain informed consent with patient and/or family. Prepare anesthesia equipment and medications required for general anesthesia as well as vasoactive infusions required in this patient population for this procedure.

Description of Intra-Service Work: In holding area of the cardiac catherization suite, administer IV anxiolytic, and transport patient to the cardiac catherization/EP room. In the room, transfer the patient from the stretcher to the procedure bed. Place standard monitors (ECG, pulse oximetry, noninvasive blood pressure [NIBP], end-tidal CO2 [carbon dioxide]). Participate in presurgical review, confirming correct patient will have correct procedure. Induce general anesthesia and intubate the patient. Monitor patient, including blood pressure, by cuff and intra-arterial catheter; multi-lead ECG; pulse oximetry; and end-tidal carbon dioxide analysis. During general anesthesia, titrate anesthestic medications and vasoactive infusions as needed. Administrator antibiotics, heparin, and other medications that the cardiologist requires to perform the procedure. Draw blood samples for ACT monitoring. Coordinate monitoring and physiological interventions with cardiologist to optimize procedural conditions and allow early detection of complications. At the end of the procedure, emerge the patient and extubate the patient. Transfer patient to stretcher and transfer patient to the recovery area, review the first set of vital signs and evaluate repiratory status. If stable, provide report to the recovery nurse.

Description of Post-Service Work: Write post-anesthesia orders that include, but not limited to, analgesic and/or anti-emetic medications. Dispose of anesthesia equipment and drugs consistent with The Joint Commission (TJC) standards. Make a postoperative evaluation in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and determine whether any anesthetic-related complications have occurred. Discharge patient from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD
Specialty Society(ies):	American Society of Anesthesiologists

CPT Code:	00537				
Sample Size:	4938	**Resp n:** 100			
Description of Sample:	Random Sample				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**15.00**	30.00	700.00
Survey Base Unit Values:	3.00	10.00	**12.00**	14.00	66.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**5.00**	**12.00**	**16.00**	**25.00**	**52.00**
Equipment/Drug/Supply Preparation	**0.00**	**10.00**	**15.00**	**20.00**	**45.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	4.00	10.00	**15.00**	20.00	180.00
Post-Induction Period Anesthesia	4.00	30.00	**180.00**	240.00	624.00
Post-Anesthesia Evaluation Time:			**12.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 00537	
	Specialty Recommended
Base Unit Value:	**12.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**16.00**
Equipment/Drug/Supply Preparation	**15.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**15.00**
Pos-Induction Period Anesthesia	**180.00**
Post-Anesthesia Evaluation Time:	**12.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00560	XXX	15	Other

CPT Descriptor Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00350	XXX	10	**Other**

CPT Descriptor Anesthesia for procedures on major vessels of neck; not otherwise specified

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Base Unit Value	Time Source
00670	XXX	13	Other

CPT Descriptor Anesthesia for extensive spine and spinal cord procedures (eg spinal instrumentation or vascular procedures)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 38 **% of respondents:** 38.0 **%**

Number of respondents who choose 2nd Key Reference Code: 31 **% of respondents:** 31.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 00537	Top Key CPT Code: 00560	2nd Key CPT Code: 00350
Median Pre-Service Time - Evaluation	16.00	20.00	15.00
Median Pre-Service Time - Equipment/Supply Preparation	15.00	25.00	15.00
Median Intra-Service Time – Induction Period	15.00	20.00	15.00
Median Intra-Service Time – Post-Induction Period	180.00	152.00	120.00
Median Post-service Time	12.00	20.00	14.50
Median Total Time	**238.00**	**237.00**	**179.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	29%	47%	16%	5%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	61%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	34%	58%	8%
Physical effort required	27%	63%	10%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	21%	50%	29%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	10%	45%	45%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	35%	55%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	64%	23%
Physical effort required	16%	55%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	45%	45%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	30.79	21.37	28.19
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	24.57	16.23	22.36
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	21.96	19.09	23.88
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	14.93	24.83	17.19
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	7.75	18.49	8.38
Total (must total 100%)	101.00%	99.00%	99.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit an anesthesia base unit recommendation for code 00537 (*Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation*).

Compelling Evidence

The specialty is submitting compelling evidence because they are requesting an increase from the current value of the code. Their compelling evidence arguments are based on: change in patient population and change in technique since the previous survey.

Change in patient population.
When this code was surveyed previously, the vignette described a 32-year-old man undergoing an electrophysiology procedure for identification of WPW pathway and ablation. The vignette used in the current survey reflects the change in the typical patient and the underlying procedure being performed: a 62-year-old man with recurrent atrial fibrillation having electrophysiologic studies with induction or attempted induction of arterial fibrillation and then intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation (PVI). For the previous survey and vignette, the patient is described as otherwise healthy and has no other medical co-morbidities. In contrast, the patient in the current survey requires more time for pre-anesthesia evaluation as well as preparation of equipment and medications, in particular, the need for vasoactive infusions. In addition, the current patient often has cardiac and other co-morbidities. (Note. Consistent with RUC approved methodologies, the vignette was chosen based on the most common procedure that the anesthesia care code was provided.) This change in patient population is well described in a 2014 article published in the *Journal of Cardiothoracic and Vascular Anesthesia* the authors provide a clear picture of the complexity of the patients, challenges of the environment of care, the risk of significant complications, and the ongoing intensity of effort required to coordinate with the proceduralist throughout a lengthy intervention.[1]

Change in technique.
The anesthetic care required is different for the current vignette patient than in previous vignette patients. For the young patient with WPW, moderate to deep sedation was the primary anesthetic plan and no invasive monitoring was required. For the PVI technique, the typical anesthesia approach requires general anesthesia with endotracheal intubation. General anesthesia is chosen to provide better patient comfort, immobility throughout the catheterization of the pulmonary vein and during the ablation, control and modification of ventilation patterns (which can affect the ablation), and better outcomes for the ablation. Ongoing communication and close coordination between the anesthesiologist and cardiologist are required throughout the duration of the procedure in order to provide optimal conditions for the ablation technique and to avoid or permit the early detection of major complications.

A 2018 article in the *Journal of Cardiothoracic and Vascular Anesthesia* describes the increasing demands on anesthesiologists performing this procedure and that anesthesiologists are becoming integral members of the electrophysiologic teams. The authors find that as the complexity and duration of cardiac ablation procedures increase, there is a growing demand for anesthesiologist involvement in the electrophysiology suites for sedation and anesthesia provision, hemodynamic and neuromonitoring, and procedural guidance through transesophageal echocardiography. The authors conclude that, "As the population ages and EP technologies improve, the scope of practice will grow to include more elderly, more moribund, and more complex patients, including those with CHD and VADs." [2]

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[1] Nicoara, A., Holmquist, F. et al. (2014). Anesthesia for Catheter Ablation Procedures. *Journal of Cardiothoracic and Vascular Anesthesia*; 28(6), 1589-1603. http://dx.doi.org/10.1053/j.jvca.2014.05.030

[2] Fujii, S., Zhou, J. R., & Dhir, A. (2018). Anesthesia for Cardiac Ablation. *Journal of Cardiothoracic and Vascular Anesthesia,* 32(4), 1892-1910. https://doi.org/10.1053/j.jvca.2017.12.039

Background

CPT code 00537 is used for the reporting anesthesia for more complex electrophysiologic procedures. CPT code 00537 was originally surveyed in 2000. CPT code 00537 was identified by the Relativity Assessment Workgroup (RAW) for increased utilization

by at least 100% from 2009-2014. The code was originally surveyed for the April 2020 meeting but the society requested a delay to the October 2020 meeting.

The approved methodology to identify the vignette for an anesthesia service, is to base the typical patient off the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with code 00537, after add-on codes and ancillary codes were removed, is:

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by 93656.

Expert Panel Recommendation

ASA is recommending the survey median of 12 anesthesia base units.

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 4,938 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the comparisons to other anesthesia services, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The expert panel is recommending the survey median of 12 anesthesia base units.
The survey was viewed as robust with 100 responses, 84% of respondents agreed with the typical patient vignette and the median experience in the past 12 months was 15.

The expert panel acknowledged that this was an increase from the current value. The service has not been surveyed in 20 years. The expert panel agreed that this increase was appropriate and reflected the how the service and the role of the anesthesiologist had evolved over time. As discussed in the compelling evidence discussion, since 2000 the typical patient for this procedure has grown more complex, requiring more intensive anesthetic services. This growing complexity is reflected in the growing complexity of cardiac ablation procedures in the past twenty years. This has created a more demanding and rigorous procedure for the anesthesiologist.

Key Reference Codes

38% of survey respondents selected 00560 (*Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator*) valued at 15 anesthesia base units. 68% of these respondents rated the surveyed code to be identical, somewhat more, and much more in overall intensity and complexity.

31% of survey respondents selected 00350 (Anesthesia for procedures on major vessels of neck; not otherwise specified) valued at 10 anesthesia base units. 90% of these respondents rated the surveyed code to be identical, somewhat more, and much more in overall intensity and complexity.

The expert panel concluded that the intensity/complexity measures supported their recommendation.

Comparisons to Other Anesthesia Services

RUC-surveyed cardiac-related anesthesia services: The expert panel compared 00537 to other RUC-surveyed cardiac-related anesthesia services. The expert panel agreed the recommended value maintained appropriate rank order. The recommended value of 12 anesthesia base units placed it between less intensive procedures such as code 00534 (*Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator*) valued at 7 base units and more intensive procedures such as 00541 (*Anesthesia*

for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation) valued at 15 base units.

CPT Code	Long Desc	Global	Work RVU
00561	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age	XXX	25
00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest	XXX	25
00566	Anesthesia for direct coronary artery bypass grafting; without pump oxygenator	XXX	25
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	XXX	20
00539	Anesthesia for tracheobronchial reconstruction	XXX	18
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	XXX	18
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation	XXX	15
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX	12
01926	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; intracranial, intracardiac, or aortic	XXX	8
00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	XXX	7
01925	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; carotid or coronary	XXX	7
01924	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; not otherwise specified	XXX	5
01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified	XXX	5

Other RUC surveyed anesthesia services valued between 10-15 base units: Reviewing these codes, the expert panel agreed that the recommendation maintained appropriate rank order with other anesthesia services in a similar value range.

CPT Code	Long Descriptor	Global	Base Unit
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation	XXX	15
00626	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; utilizing 1 lung ventilation	XXX	15
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	XXX	15
00625	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing 1 lung ventilation	XXX	13
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	XXX	13

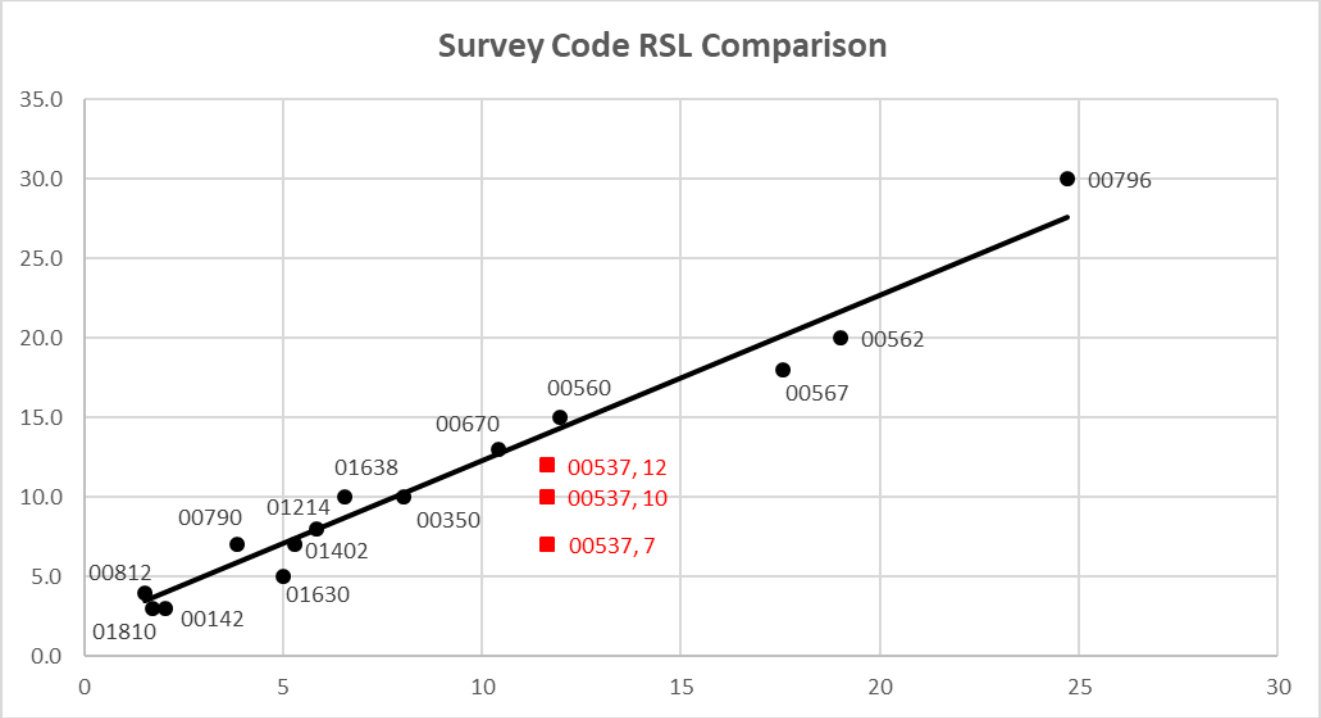
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX	12
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified	XXX	12
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	XXX	12
00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing 1 lung ventilation	XXX	11
00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	XXX	11
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	XXX	10
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	XXX	10
00211	Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma	XXX	10
00550	Anesthesia for sternal debridement	XXX	10
01215	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	XXX	10

Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values ("proxy RVUs"). The proxy RVU for 00537 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align.

Using the BBM methodology, a proxy value of 11.6506 was calculated. This proxy value is very close to the recommended value of 12 anesthesia base units. The calculation of this value can be found in the Data Analysis document submitted with this recommendation.

The recommended value was also supported when it was plotted on the RSL Regression Analysis. The proxy RVU value for 00537 plotted very close to the regression line, an indication that this recommendation maintains appropriate rank order when compared to other codes on the Anesthesia RSL.



Survey Code Key:

- 00537, 12 base units; *Survey 50th – Recommendation*
- 00537, 10 base units; *Survey 25th*
- 00537, 7 base units, *Current Value*

Anesthesia Reference Service List

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841

01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	12.0	11.650
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

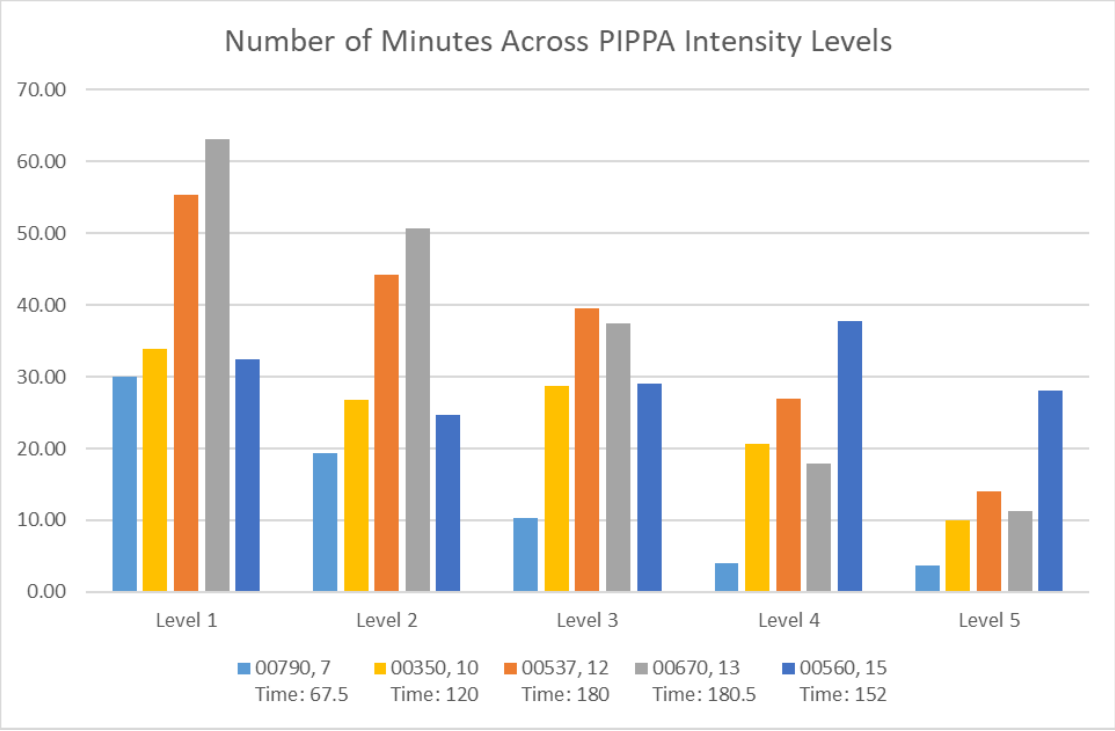
Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 00537 is 0.0503. This value validates the recommendation of 12 base units in comparison with other codes on the Anesthesia RSL. It is important to recognize that while there are codes with higher weighted PIPPA values and lower base unit values, PIPPA is used to validate recommendations and not establish recommended base unit values.
As an example of how PIPPA is used, code 00670 has a base unit value of 13 and a weighted PIPPA intensity of 0.0472. This value is lower than the weighted PIPPA value for 00350, 0.0513, which has a base unit value of 10. However, there are other clinically complex components that are not captured in PIPPA that support a higher base unit value for 00670 compared to 00350. The expert panel believes the same is true for the recommendation for 00537.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7	0.0440	44.48%	28.78%	15.28%	5.94%	5.52%
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10	0.0513	28.19%	22.36%	23.88%	17.19%	8.38%
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	12	0.0503	30.79%	24.57%	21.96%	14.93%	7.75%
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13	0.0472	34.95%	28.07%	20.79%	9.93%	6.26%
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15	0.0583	21.37%	16.23%	19.09%	24.83%	18.49%

The expert panel also evaluated how the percent distribution across PIPPA levels compared to the number of intra-service minutes. The below table visually depicts how the surveyed PIPPA intensities vary across services. As previously stated, the weighted PIPPA intensity for 00537 is lower than that for 00350, however, when evaluating how these percentages are distributed over the median intra-service time, 00537 has much greater overall time in total and spent in higher PIPPA intensity levels. Based on the evaluation of the weighted PIPPA intensities and the below distribution of the number of minutes across PIPPA intensity levels, the expert panel believes that the PIPPA analysis supports the recommendation of 12 base units for 00537. The weighted average and number of minutes of 00537 is very similar to that of code 00670 (13 base units).



In conclusion, ASA is recommending the survey median of 12 anesthesia base units. For time the specialty is recommending:

- Pre-anesthesia
  - *Evaluation*: 16 minutes
  - *Equipment/Drug/Supply preparation*: 15 minutes
- Intra-op
  - *Induction*: 15 minutes
  - *Post induction*: 180 minutes
- Post anesthesia: 12 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 00537

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Pain Management How often? Rarely

Specialty Interventional Pain Management How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 269,907
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 267,719 Percentage 99.56%

Specialty Pain Management Frequency 243 Percentage 0.09%

Specialty Interventional Pain Management Frequency 108 Percentage 0.04%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 89,969 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare Utilization Data

Specialty Anesthesiology Frequency 89,573 Percentage 99.56%

Specialty Pain Management Frequency 81 Percentage 0.09%

CPT Code: 00537

Specialty	Frequency	Percentage
Interventional Pain Management	36	0.04%

Do many physicians perform this service across the United States? Yes

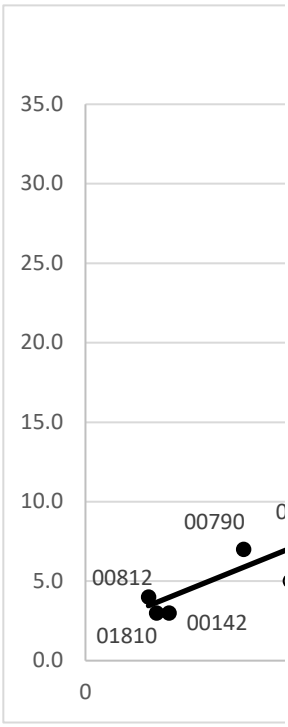
Build Block Methodology Calculations and Anesthesia Reference Service Comparison

ISSUE: Anesthesia for Cardiac Electrophysiologic Procedures

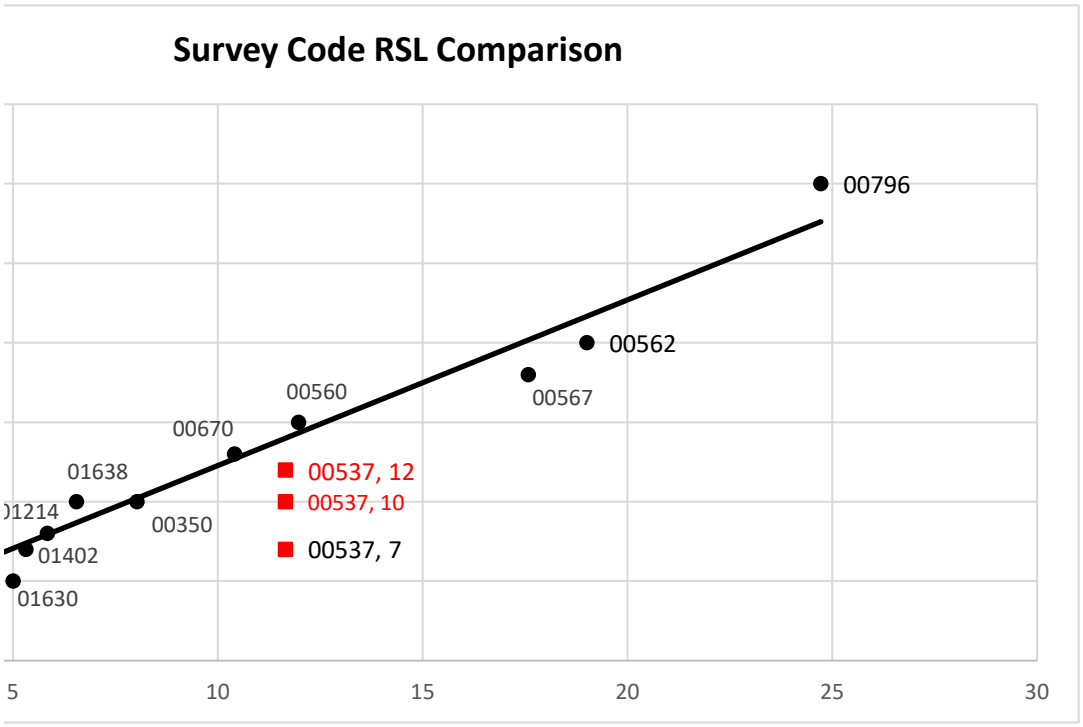
TAB: 13

	BB Value Estimates		Regression Comparison	
Code	X	Y	X	Y
00812	1.735	3	1.735	3.6608857
01810	2.038	3	2.038	3.9773211
00142	1.538	4	1.538	3.4553905
01630	5.004	5	5.004	7.0674518
00790	3.858	7	3.858	5.8732014
01402	5.309	7	5.309	7.385386
01214	5.833	8	5.833	7.9312083
00350	8.021	10	8.021	10.211531
01638	6.550	10	6.550	8.6787625
00670	10.406	13	10.406	12.697136
00560	11.965	15	11.965	14.321422
00567	17.577	18	17.577	20.169281
00562	19.006	20	19.006	21.658925
00796	24.719	30	24.719	27.612646

Survey C	
Code	BB Value
00537	11.65056
00537	11.65056
00537	11.65056



Code	
Base Unit Value	
12	*Survey Median, Recommendation*
10	*Survey 25th*
7	*Current Value*



Build Block Methodology Calculations and Anesthesia Reference Service Comparison

ISSUE: Anesthesia for Cardiac Electrophysiologic Procedures

TAB: 13

						Pre-Anesthesia Period				
						1A. Evaluation of the patient prior to the beginning of reportable anesthesia time				
			NOTE: The **Anesthesia Base Unit Value** comes from the 2019 Medicare Physician Fee Schedule; the **Building Block (BB) Value** is calculated using the methodology approved by the Anesthesia Workgroup and the RUC. At the request of the Anesthesia Workgroup this value was calculated with PIPPA (methdology approved by the RUC) and without PIPPA.							
Survey Date	**Source**	**CPT**	**Descriptor**	**Anesthesia Base Unit**	**BB Value w/ PIPPA***	**Min**	**25th**	**Median**	**75th**	**Max**
Apr-19	RUC	00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	**1.735**	1	6	8	10	30
Apr-19	CMS/Other	01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	**1.857**	1	7	10	14	30
Apr-19	RUC	00142	Anesthesia for procedures on eye; lens surgery	4	**1.538**	1	5	10	11.75	32
Apr-19	CMS/Other	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	**4.772**	1	9.25	12	16	43
Apr-19	CMS/Other	00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7	**3.858**	1	9	10	15	35
Apr-19	CMS/Other	01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7	**5.309**	1	10	15	19.5	43
Apr-19	RUC	01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8	**5.833**	1	10	15	20	39
Apr-19	CMS/Other	00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10	**8.841**	1	11.75	15	20	60

Apr-19	CMS/Other	01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10	**6.550**	1	10	15	19	43
Oct-20	RUC	00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	12	**11.651**	5	12	16	25	52
Apr-19	CMS/Other	00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13	**10.406**	1	10	15	20	45
Apr-19	CMS/Other	00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15	**11.965**	1	15	20	28	60
Oct-19	RUC	00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18	**17.577**	5	19	25	32	90
Apr-19	RUC	00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20	**19.006**	1	16	20	30	60
Apr-19	CMS/Other	00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30	**24.719**	1	15	23	45	90
	* Building Block (BB) Value is calculated using the methodology approved by the Anesthesia Workgroup and the RUC.									

FOR REFERENCE ONLY

Equipment, Drug, Supply Prep	
Internal Medicine	7
Complex Patient/Straightforward Anesthetic	15
Straightforward Patient/Complex Anesthetic	12
Complex Patient/Complex Anesthetic	25

Induction Period	
Straightforward Patient/Straightforward Anesthetic	2

Complex Patient/Straightforward Anesthetic	8
Straightforward Patient/Complex Anesthetic	5
Complex Patient/Complex Anesthetic	15

PIPPA Intensity Factors				
Level 1	Level 2	Level 3	Level 4	Level 5
0.031	0.044	0.055	0.070	0.096

						Intra-op Anesthesia Period									
1B. Equipment and Supply preparation						**1C. Induction period**						**1D. Post-induction period**			
Straightforward Patient/Straightforward Anesthetic= 7 minutes Complex Patient/Straightforward Anesthetic= 15 minutes Straightforward Patient/Complex Anesthetic= 12 minutes Complex Patient/Complex Anesthetic= 25 minutes						Straightforward Patient/Straightforward Anesthetic= 2 minutes Complex Patient/Straightforward Anesthetic= 8 minutes Straightforward Patient/Complex Anesthetic= 5 minutes Complex Patient/Complex Anesthetic= 15 minutes									
Min	**25th**	**Median**	**75th**	**Max**	**Time Package Selected (select from drop-down)**	**Min**	**25th**	**Median**	**75th**	**Max**	**Time Package Selected**	**Min**	**25th**	**Median**	**75th**
1	5	7	10	20	Straightforward Patient/Stra	0	5	6	10	36	rward Patient/Straightforward	1	20	29.5	41.25
1	6	10	14	25	Straightforward Patient/Stra	1	5	9.5	12	33	rward Patient/Straightforward	1	20	30	49.75
0	4	5	10	20	Straightforward Patient/Stra	0	4	5	8	30	Straightforward Patient/Straig	0	15	25	37
1	9	12	15	54	Straightforward Patient/Stra	1	10	15	20	59	rward Patient/Straightforward	1	60	90	131
1	7	10	15	36	Straightforward Patient/Stra	1	7.25	10	15	31	tforward Patient/Complex Ane	1	41.5	67.5	120
1	9.25	14	19	54	Straightforward Patient/Con	1	10	15	18	59	tforward Patient/Complex Ane	1	60	96	122.25
1	10	13.5	16.5	43	Straightforward Patient/Con	1	10	15	18.5	46	tforward Patient/Complex Ane	1	60	106	135
1	10	15	20	30	Complex Patient/Straightfor	1	9	15	22.25	40	mplex Patient/Complex Anesth	1	75	120	150

1	10	15	19	54	Straightforward Patient/Con	1	10	15	21	59	tforward Patient/Complex Ane	1	67.5	120	151
0	10	15	20	45	Complex Patient/Straightfor	4	10	15	20	180	mplex Patient/Complex Anesth	4	30	180	240
1	10	15	22	1215	Complex Patient/Straightfor	1	10	15	25.25	50	ex Patient/Straightforward Ane	1	120	180.5	241.5
1	15	25	30.5	60	Complex Patient/Complex A	1	13	20	31.5	60	mplex Patient/Complex Anesth	1	109.5	152	240
0	20	30	40	75	plex Patient/Complex Anest	0	18	30	45	60	mplex Patient/Complex Anesth	0	200	240	320
1	18	27	39.3	60	Complex Patient/Complex A	1	17.5	30	45.5	66	mplex Patient/Complex Anesth	1	200	258.5	347.75
1	16	30	45	65	Complex Patient/Complex A	1	20	36	50	93	mplex Patient/Complex Anesth	1	280	360	480

	1E. Post-anesthesia time					Post-Induction Anesthesia Time-Intensity Allocation (%)						BBM Value Calculation			1C: Induction Period	
												1A: Pre-Anesthesia Evaluation	1B: Equipment and Supply Preparation			
															Pre-Induction Assessment	
Max	Min	25th	Median	75th	Max	Level 1	Level 2	Level 3	Level 4	Level 5	Total	BBM value based on median	Minutes based on selected package	BBM value	Minutes	
240	1	5	5.5	10.25	180	58.02%	24.69%	7.89%	5.38%	4.02%	100.00%	0.1792	7	0.0567	2	
180	1	5	8	12	90	58.35%	24.03%	8.59%	4.66%	4.37%	100.00%	0.224	7	0.0567	2	
240	1	3	5	11.5	60	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%	0.224	7	0.0567	2	
254	1	7	11	18	426	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%	0.2688	7	0.0567	2	
1205	1	6	10	18	435	44.48%	28.78%	15.28%	5.94%	5.52%	100.00%	0.224	7	0.0567	2	
240	1	7.25	10	23.5	435	42.20%	30.57%	15.24%	6.67%	5.32%	100.00%	0.336	12	0.0972	2	
250	1	8	10.5	19.5	427	40.20%	30.62%	15.96%	8.04%	5.18%	100.00%	0.336	12	0.0972	2	
240	1	10	14.5	22.5	120	28.19%	22.36%	23.88%	17.19%	8.38%	100.00%	0.336	15	0.1215	4	

296	1	8	12	21	476	38.28%	30.56%	18.33%	7.63%	5.19%	100.00%	0.336	12	0.0972	2
624	1	8	12	17.25	120	30.79%	24.57%	21.96%	14.93%	7.75%	100.00%	0.3584	15	0.1215	4
700	1	10	15	20.5	720	34.95%	28.07%	20.79%	9.93%	6.26%	100.00%	0.336	15	0.1215	4
420	1	14	20	32	120	21.37%	16.23%	19.09%	24.83%	18.49%	100.00%	0.448	25	0.2025	4
3158	0	15	20	30	480	17.80%	19.62%	20.65%	20.01%	21.92%	100.00%	0.56	25	0.2025	4
420	1	14.75	22	30	60	19.68%	15.15%	18.50%	22.00%	24.68%	100.00%	0.448	25	0.2025	4
660	1	20	28	45	120	19.48%	17.24%	23.24%	19.19%	20.86%	100.00%	0.5152	25	0.2025	4
												0			

				1D: Post-Induction Period	**1E: Post-Anesthesia Time**
	Induction				
BBM value	**Minutes based on selected package**	**Intensity Factor**	**BBM value**	**BBM value based on median**	**BBM value based on median**
0.0448	2	0.0636	0.1272	1.203609305	0.1232
0.0448	2	0.0636	0.1272	1.224873456	0.1792
0.0448	2	0.0636	0.1272	0.9728	0.1120
0.0448	2	0.0636	0.1272	4.028533275	0.2464
0.0448	5	0.0636	0.318	2.990201431	0.224
0.0448	5	0.0636	0.318	4.288830692	0.224
0.0448	5	0.0636	0.318	4.801415117	0.2352
0.0896	15	0.1172	1.758	6.2114	0.3248

0.0448	5	0.0636	0.318	5.485186391	0.2688
0.0896	15	0.1172	1.758	9.054261	0.2688
0.0896	8	0.1172	0.9376	8.585416	0.336
0.0896	15	0.1172	1.758	9.0187	0.4480
0.0896	15	0.1172	1.758	14.51846867	0.448
0.0896	15	0.1172	1.758	16.01516716	0.4928
0.0896	15	0.1172	1.758	21.52690286	0.6272

SS Rec Summary

ISSUE: Anesthesia for Cardiac Electrophysiologic Procedures
TAB: 13

Source	CPT	DESC	Resp	Anesthesia Base Unit Value MIN	25th	MED	75th	MAX	Total Time	Pre-Anesthesia Time: Patient Evaluation MIN	25th	MED	75th	MAX	Pre-Anesthesia Time: Equipment/Drug/Supply Preparation MIN	25th	MED	75th	MAX	Intra-op Anesthesia Time: Induction Period MIN	25th	MED	75th	MAX	Intra-op Anesthesia Time: Post-Induction Period MIN	25th	MED	75th	MAX	Post-Anesthesia Evaluation POST	Post-Induction Anesthesia Time-Intensity Allocation Level 1	Level 2	Level 3	Level 4	Level 5	Total
1st REF	00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator				15.00			237			20					25					20					152			20	21.37%	16.23%	19.09%	24.83%	18.49%	100.00%
2nd REF	00350	Anesthesia for procedures on major vessels of neck; not otherwise specified				10.00			180			15					15					15					120			15	28.19%	22.36%	23.88%	17.19%	8.38%	100.00%
CURRENT	00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation				7.00			150			15														120			15						
SVY	00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	100	3.00	10.00	12.00	14.00	66.00	238	5	12	16	25	52	0	10	15	20	45	4	10	15	20	180	4	30	180	240	624	12	30.79%	24.57%	21.96%	14.93%	7.75%	100%
REC	00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation				12.00			238			16					15					15					180			12						0%

NONFACILITY DIRECT PE INPUTS **CODE(S):__00537_____**

SPECIALTY SOCIETY(IES):__ASA_____

PRESENTER(S): Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
00537	A 62-year-old man with a history of hypertension has recurrent atrial fibrillation. Despite rate or rhythm control with antiarrhythmic drugs, he remains symptomatic. He undergoes cardiac electrophysiologic studies with induction or attempted induction of arrythmia and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We are requesting the standard anesthesia PE package. *CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiologists of 11 minutes and agreed that this was a direct practice expense; however, 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.*

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   00537

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   N/A

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

3 minutes – anesthesia scheduling
5 minutes – case assignment, scheduling coordination, and completion of forms

   b. Service period (includes pre, intra and post):

   c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?
    N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    N/A

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):__00537_____**

SPECIALTY SOCIETY(IES):__ASA_____

PRESENTER(S): Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
00537	A 62-year-old man with a history of hypertension has recurrent atrial fibrillation. Despite rate or rhythm control with antiarrhythmic drugs, he remains symptomatic. He undergoes cardiac electrophysiologic studies with induction or attempted induction of arrythmia and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We are requesting the standard anesthesia PE package. *CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiologists of 11 minutes and agreed that this was a direct practice expense; however, 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.*

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   00537

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

3 minutes – anesthesia scheduling ***5 minutes – case assignment, scheduling coordination, and completion of forms***

   b. Service period (includes pre, intra and post):

   c. Post-service period:

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitude D600), ED038?

a. If yes, please explain how the computer is used for this service(s).
b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**	
2						**00537**		**00537**	
3		***RUC Collaboration Website***				Anesthesia for cardiac electrophysiologic procedures including radiofrequency		Anesthesia for cardiac electrophysiologic procedures including radiofrequency	
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 13 Specialty: American Society of Anesthesiologists**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37				
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37				
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37				
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37				
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37				
23	CA041	Schedule (3 min), assign case and complete forms (5 min) for anesthesia	L037D	RN/LPN/MTA	0.37	8	8	8	8
26			L037D	RN/LPN/MTA	0.37				
27			L037D	RN/LPN/MTA	0.37				
28		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37				
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37				
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37				
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37				
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37				
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37				
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37				
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37				
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37				
42			L037D	RN/LPN/MTA	0.37				
45		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37				
48		**Intra-service (of service period)**							
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37				
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37				
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37				
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37				
55			L037D	RN/LPN/MTA	0.37				
56		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37				
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37				
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37				
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37				
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37				
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37				
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37				
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37				
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37				
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37				
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs,	L037D	RN/LPN/MTA	0.37				
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37				
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37				
78		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37				
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37				
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37				
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16						
88		99212 27 minutes	27						
89		99213 36 minutes	36						
90		99214 53 minutes	53						
91		99215 63 minutes	63						
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37				
96		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37				
99		**End: with last office visit before end of global period**							

	A	B	D	E	F	I	J	K	L
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3		***RUC Collaboration Website***				Anesthesia for cardiac electrophysiologic procedures including radiofrequency		Anesthesia for cardiac electrophysiologic procedures including radiofrequency	
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 13** **Specialty: American Society of Anesthesiologists**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**
102									
103									
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**
112									
113									
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

Cut and paste to spreadsheet from column A only.
Please note that bold activities in column B are not included on the default PE spreadsheet.

	Activity	Type of Activity	Standards/Guidelines
CA001	Complete pre-service diagnostic and referral forms	General Activity	*See Instructions for 000 and 010 day
CA002	Coordinate pre-surgery services (including test results)	General Activity	*See Instructions for 000 and 010 day
CA003	Schedule space and equipment in facility	General Activity	*See Instructions for 000 and 010 day
CA004	Provide pre-service education/obtain consent	General Activity	*See Instructions for 000 and 010 day
CA005	Complete pre-procedure phone calls and prescription	General Activity	*See Instructions for 000 and 010 day
CA006	Confirm availability of prior images/studies	General Activity	For use in imaging services.
CA007	Review patient clinical extant information and questionnaire	General Activity	For use in imaging services.
CA008	Perform regulatory mandated quality assurance activity (pre-service)	General Activity	
CA009	Greet patient, provide gowning, ensure appropriate medical records are available	General Activity	Standard time for this activity is 3 minutes.
CA010	Obtain vital signs	General Activity	Level 0 (no vital signs taken) = 0 minutes
CA011	Provide education/obtain consent	General Activity	Include only the additional education/consent activities not included in the pre-service period.
CA012	Review requisition, assess for special needs	General Activity	
CA013	Prepare room, equipment and supplies	General Activity	2 minute standard
CA014	Confirm order, protocol exam	General Activity	For use in imaging services.
CA015	Setup scope (nonfacility setting only)	General Activity	5 minutes standard for scope set up in the non facility setting only.
CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	General Activity	2 minute standard
CA017	Sedate/apply anesthesia	General Activity	2 minute standard RN/LPN/MA
CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	General Activity	100% of physician or other qualified healthcare professional intra-service time.
CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	General Activity	67% of physician or other qualified healthcare professional intra-service time.
CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	General Activity	other% of physician or other qualified healthcare professional intra-service time. Percentage must be included in PE SOR.
CA021	Perform procedure/service---NOT directly related to physician work time	General Activity	
CA022	Monitor patient following procedure/service, multitasking 1:4	General Activity	For monitoring following procedure, the standard is 15 minutes of RN/LPN/MTA time per 1 hour of monitoring.
CA023	Monitor patient following procedure/service, no multitasking	General Activity	
CA024	Clean room/equipment by clinical staff	General Activity	3 minute standard
CA025	Clean scope	General Activity	--5 minutes for a disposable scope,
CA026	Clean surgical instrument package	General Activity	*Must have instrument package included in
CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	General Activity	
CA028	Review/read post-procedure x-ray, lab and pathology reports	General Activity	
CA029	Check dressings, catheters, wounds	General Activity	Standard time for this activity is 1 minute.
CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	General Activity	Baseline time for this activity is 2 minute. For use in imaging services.
CA031	Review examination with interpreting MD/DO	General Activity	Standard time for this activity is 2 minute. For use in imaging services.
CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	General Activity	Standard time for this activity is 1 minute. For use in imaging services.
CA033	Perform regulatory mandated quality assurance activity (service period)	General Activity	
CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	General Activity	
CA035	Review home care instructions, coordinate visits/prescriptions	General Activity	For non-facility (office) setting use this activity
CA036	Discharge day management	General Activity	min)
CA037	Conduct patient communications	General Activity	increments
CA038	Coordinate post-procedure services	General Activity	
CA039	Post-operative visits (total time)	General Activity	
CA040	**Perform additional positioning of patient**	**General Activity**	
CA041	**Schedule (3 min), assign case and complete forms (5 min) for anesthesia**	**General Activity**	**Standard package for all anesthesia codes.**
CA042	**Perform procedure/service in post-service period---NOT directly related to physician work time**	**General Activity**	
CA043	**Remove splint or cast**	**General Activity**	**Generally in post-service period.**
CA044	**Clean probe**	**General Activity**	**Generally in post-service (of service period).**
CA045	**Setup scope at global postoperative office visit**	**General Activity**	**Generally in post-service period.**
CA046	**Clean scope at global postoperative office visit**	**General Activity**	**Generally in post-service period.**
PA001	Accession and enter information	Pathology Activity	
PA002	Acquire image(s) and print	Pathology Activity	
PA003	Assist pathologist	Pathology Activity	
PA004	Cleaning	Pathology Activity	
PA005	Disengage instrument(s)	Pathology Activity	
PA006	Engage instrument(s)	Pathology Activity	
PA007	Examine and screen	Pathology Activity	
PA008	File specimen, supplies, and other materials	Pathology Activity	
PA009	Manage pre-evaluation activities	Pathology Activity	
PA010	Prepare and analyze specimen	Pathology Activity	
PA011	Prepare slides	Pathology Activity	
PA012	Prepare supplies	Pathology Activity	
PA013	Record results	Pathology Activity	

2020 CMS Direct PE Inputs Clinical Staff Types

cut and paste to spreadsheet from column A only

CMS Code	STAFF Type	Rate Per Minute
L041A	Angio Technician	0.41
L052A	Audiologist	0.52
L057B	Behavioral Health Care Manager	0.57
L050A	Cardiac Sonographer	0.5
L038B	Cardiovascular Technician	0.38
L039A	Certified Retinal Angio	0.39
L037E	Child Life Specialist	0.37
L038A	COMT/COT/RN/CST	0.38
L045C	CORF socialworker/psychologist	0.45
L046A	CT Technologist	0.46
L045A	Cytotechnologist	0.45
L050B	Diagnostic Medical Sonographer	0.5
L032B	EEG Technician	0.32
L037A	Electrodiagnostic Technologist	0.37
L045B	Electron Microscopy Technologist	0.45
L057A	Genetics Counselor	0.567
L037B	Histotechnologist	0.37
L035A	Lab Tech/Histotechnologist	0.35
L030A	Lab Tech/MTA	0.3
L033A	Lab Technician	0.33
L043A	Mammography Technologist	0.43
L063A	Medical Dosimetrist	0.63
L107A	Medical Dosimetrist/Medical Physicist	1.075
L038C	Medical Photographer	0.383
L152A	Medical Physicist	1.523
L026A	Medical/Technical Assistant	0.26
L047A	MRI Technologist	0.47
L049A	Nuclear Medicine Technologist	0.615
L033B	Optician/COMT	0.33
L037C	Orthoptist	0.37
L023A	Physical Therapy Aide	0.23
L039B	Physical Therapy Assistant	0.39
L039C	Psychometrist	0.394
L050C	Radiation Therapist	0.5
L041B	Radiologic Technologist	0.41
L047B	REEGT	0.47
L042B	Respiratory Therapist	0.42
L051A	RN	0.51
L051C	RN/CORF	0.51

L051B	RN/Diagnostic Medical Sonographer	0.51
L042A	RN/LPN	0.42
L037D	RN/LPN/MTA	0.37
L056A	RN/OCN	0.79
L047D	RN/Registered Dietician	0.47
L047C	RN/Respiratory Therapist	0.47
L053A	RN/Speech Pathologist	0.53
L050D	Second Radiation Therapist for IMRT	0.5
L041C	Second Radiologic Technologist for Vertebroplasty	0.41
L055A	Speech Pathologist	0.55
L054A	Vascular Technologist	0.54

2020 CMS Direct PE Inputs Medical Supplies Listing

CMS Code	*cut and paste to spreadsheet from column A only* Supply Description
SD003	anoscope
SD005	biopsy sponge (Histo-Prep)
SD006	bite block
SD008	brush, ureteral
SD009	canister, suction
SD010	canister, vacuum
SD011	cannula (radiofrequency denervation) (SMK-C10)
SD012	catheter adapter
SD014	catheter stylet
SD015	catheter tip adapter
SD016	catheter, balloon, esophageal (pressure monitoring)
SD017	catheter, balloon, rectal pressure
SD018	catheter, balloon, thermal ablation (Thermachoice)
SD019	catheter, balloon, ureteral-GI (strictures)
SD020	catheter, CVA, tunneled, dual (Tesio)
SD021	catheter, CVA, non-tunneled
SD023	catheter, enteroclysis
SD024	catheter, Foley
SD025	catheter, intrauterine insemination
SD026	catheter, Pezzar (mushroom)
SD027	catheter, pressure, urodynamic
SD028	catheter, Racz (Tun-L-Kath)
SD029	catheter, red rubber
SD030	catheter, straight
SD031	catheter, suction
SD033	catheter, ureteral, open-ended
SD034	catheter, ureteral, Stamey open-tip
SD037	clip, tissue marker
SD039	curette, suction, endometrial (Pipelle)
SD040	cytology, brush
SD042	dilator, ductal, galactography
SD043	dilator, vessel, angiographic
SD044	ear tip, earphone
SD045	ear tip, immittance
SD046	ear tip, tympanometry probe
SD047	eartip insert with sound tube
SD048	electrode alligator clip, pair
SD049	electrode needle, concentric EMG w-lead
SD050	electrode needle, injectable (Myoject)
SD051	electrode needle, monopolar EMG w-lead
SD052	electrode, bar-style (single)
SD053	electrode, ECG (single)
SD054	electrode, EEG, tin cup (12 pack uou)
SD055	electrode, electrical stimulation
SD056	electrode, EMG sponge

SD057	electrode, external pelvic muscle
SD058	electrode, grid
SD059	electrode, ground
SD060	electrode, internal for pH
SD061	electrode, sphenoidal
SD062	electrode, surface
SD063	electrode, TENS-EMS, 2in x 2in (4 pack uou)
SD066	endoscopic biopsy forceps
SD067	endoscopic cytology brush
SD068	endoscopic polypectomy snare
SD070	endosheath
SD071	epistaxis balloon
SD072	eyelid weight implant, gold
SD074	filiform
SD075	filter, pulmonary function filter
SD077	gas, air
SD079	gas, helium
SD080	gas, intraocular C3F8 (ISPAN) (per dose)
SD082	gas, liquid nitrogen
SD083	gas, nitrous oxide
SD084	gas, oxygen
SD085	gas, test mixture
SD086	grids
SD087	guide, needle, for localization
SD088	guidewire
SD089	guidewire, hydrophilic
SD090	guidewire, STIFF
SD093	HEPA filter
SD094	Mammotome probe
SD096	markers, radiographic, multi-modality
SD097	monofilament, sensory testing
SD099	mouthpiece, respiratory
SD100	nasal cannula
SD101	nebulizer mouthpiece with tubing
SD102	noseclips
SD103	occluder, clip-on
SD104	oximetry sensor wrap
SD105	oxygen mask (1) and tubing (7ft)
SD106	pad, cardioversion R2 (2 pack)
SD107	peg, for prosthetic ocular implant
SD109	probe, radiofrequency, 3 array (StarBurstSDE)
SD110	reservoir, drain (Jackson-Pratt)
SD111	respiratory monitoring belt
SD112	sensor, airflow cannula (adult)
SD113	sensor, EMG, vaginal-rectal
SD114	sensor, glucose monitoring (interstitial)
SD115	sensor, microvolt (Micro-V)
SD116	sensors, bioimpendance (4 pack uou)
SD117	sigmoidoscope
SD118	specula, vaginal

SD121	suction specimen trap, sterile
SD122	suction tip, Yankauer
SD123	tourniquet, ankle, sterile
SD124	tourniquet, non-latex 1in x 18in
SD125	transducer dome (pressure)
SD127	tube, suction NG (Salem sump)
SD128	tubing, for pump head
SD129	tubing, irrigation (cysto)
SD130	tubing, latex
SD131	tubing, pressure
SD132	tubing, suction, non-latex (6ft uou)
SD133	tubing, suction, non-latex (6ft) with Poole tip (1)
SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)
SD135	tubing, vacuum (for Mammotome device)
SD136	vascular sheath
SD140	bag system, 1000ml (for angiography waste fluids)
SD141	brush, protected airway specimen
SD142	bur, surgical, sterile (drill)
SD144	canister, vacuum, pleural (w-drainage line)
SD145	cannula, anterior chamber, 18-27g
SD146	catheter percutaneous fastener (Percu-Stay)
SD147	catheter, (Glide)
SD148	catheter, (SIM2F1)
SD149	catheter, balloon inflation device
SD150	catheter, balloon ureteral (Dowd)
SD151	catheter, balloon, low profile PTA
SD152	catheter, balloon, PTA
SD153	catheter, curved
SD154	catheter, microcatheter (selective 3rd order)
SD155	catheter, RF endovenous occlusion
SD156	catheter, Swan Ganz
SD157	catheter, ureteral, acorn tip
SD158	conformer, sterile, acrylic
SD161	drainage catheter, all purpose
SD163	drainage pouch, nephrostomy-biliary
SD164	electrode, Bugbee
SD165	electrode, EEG (single)
SD166	electrode, EGG (single)
SD167	endoscopic deflecting brush
SD169	forceps, Kelly
SD170	gas, 5% CO2 - balance air
SD171	guidewire bowl w-lid, sterile
SD172	guidewire, cerebral (Bentson)
SD173	guidewire, low profile (SpartaCore)
SD174	guidewire, steerable (Hi-Torque)
SD175	guidewire, steerable (Transcend)
SD176	guidewire, torque
SD177	hysteroscope, ablation device
SD178	kit, bcr/abl DNA Probe
SD179	lacrimal duct stent-tube set

SD180	manifold (for angiography)
SD182	mask, CPR (RespAide)
SD183	nasal tip, olive
SD184	nebulizer medication cup
SD186	plasma LDL adsorption column (Liposorber)
SD188	plasma separator (Liposorber)
SD189	plate, surgical, mini-compression, 4 hole
SD190	plate, surgical, mini-i, 16mm
SD191	plate, surgical, reconstruction, left, 5 x 16 hole
SD192	plate, surgical, reconstruction, template, 5 x 16 hole
SD193	plate, surgical, rigid comminuted fracture
SD194	plate, surgical, rigid comminuted fracture, template
SD195	prosthesis, voice button (Blom-Singer)
SD196	screw, surgical, auto-drive, 2.0mm x 4mm
SD197	screw, surgical, Carroll-Girard, 9cm x 3.75in
SD198	screw, surgical, lag, 2.4mm x 26mm
SD199	screw, surgical, locking, 2.4mm x 16mm
SD200	screw, surgical, self-tapping, 1.5-2.0mm
SD201	screw, surgical, standard, 2.4mm x 14mm
SD202	screw, surgical, standard, 2.7mm x 12mm
SD203	sensor, manometry
SD204	sensor, pH capsule (Bravo)
SD206	sheath, peel away
SD207	suture device for vessel closure (Perclose A-T)
SD208	towel clamp, plastic
SD209	tracheostomy tube
SD210	transducer, pressure monitoring (for angiography)
SD211	tubing, pressure injection line (angiography)
SD212	tubing, sterile, connecting (fluid administration)
SD213	tubing, sterile, non-vented (fluid administration)
SD214	tubing, suction, non-latex (2ft) with Frazier tip (1)
SD215	probe, endometrial cryoablation (Her Option)
SD216	catheter, balloon, esophageal or rectal (graded distention test)
SD218	stent, ureteral, without guidewire
SD220	catheter, balloon, lacrimal
SD221	catheter, CVA, system, tunneled w-port, dual (LifeSite)
SD222	catheter, intradiscal (spineCATH)
SD223	electrode, array, nerve, preconfigured,
SD224	Filter, Foam Plug (10/Pk)
SD225	Flutter Valve for Tee-Connector
SD226	forceps, sterile, blunt tip, polystyrene
SD227	gas, argon
SD228	gas, CO_2, use w-automated insufflation, CT colonography
SD230	impedance catheter, infusion
SD231	needle, introducer (spineCATH)
SD232	probe, cryoablation (Visica ICE 30 or 40)
SD233	probe, cryoablation, renal
SD234	QuinGas-3, 150 H_2, 75 CH_4, 6% CO_2, BreathTracker SC Calibration Gas
SD235	sensor, patch, bronchosopy (for kit, locatable guide) (patient)
SD236	Single Patient Discard Bag, 400 ml

SD237	Sivrite-4
SD238	stent, GORE VIATORR TIPS Endoprosthesis
SD239	stent, ureteral, w-guidewire, 3cm flexible tip
SD240	strut, replacement, dynamic external fixation
SD241	Substrate, D-Xylose, 25 gm Packet
SD242	Tee-Connector, Plastic
SD243	tube, jejunostomy
SD244	Water Barriers/Dust Traps (5/Pk)
SD245	Renessa probe
SD246	urgent PC lead
SD247	human amniotic membrane allograft
SD248	human amniotic membrane allograft mounted on a non-absorbable self-retaining ring
SD249	Sterile Radio-opaque ruler (le Maitre, documentation available)
SD250	introducer sheath, Ansel [45 cm 6 Fr Ansel]
SD251	Sheath Shuttle (Cook)
SD252	guidewire, Amplatz wire 260 cm
SD253	atherectomy device (Spectronetics laser or Fox Hollow)
SD254	covered stent (VIABAHN, Gore)
SD255	Reentry device (Frontier, Outback, Pioneer)
SD256	Embolic Protection Device Spider FX (EV3, documentation available)
SD257	Tunneler
SD259	Peritoneal Dialysis Sterile Solution (1500 ml)
SD260	Y-set connection tubing
SD261	B5-2C Double Lumen Balloon 10 mm dia
SD262	Insuffalator - Boston Scientific
SD263	WatchPAT pneumo-opt slp probes
SD266	stent, self expanding 2-5 mm XPERT (Abbott)
SD267	IVC filter
SD268	IVC retrieval set
SD269	Grounding pad
SD271	Rectal probe
SD272	SmartPill capsule
SD273	Pediatric cannula
SD274	Self-adherent velcro wraps
SD275	Disposable electrode pack
SD276	Indicator powder
SD277	polypropelene funnel
SD278	Disposable oximeter cable
SD279	Fibrillar, surgical
SD280	Trial lead kit
SD281	Trial lead array
SD282	endoscopic clip
SD284	cautery, bipolar, probe, endoscopy
SD285	catheter, optical endomicroscopy
SD286	endoscopic guidewire
SD287	endoscopic balloon, dilation
SD289	PROXY endoscopic grasping forceps
SD290	electrode, BIS (bioimpedance spectroscopy)
SD291	Urolift Implant and implantation device
SD292	10g IVAS drill

SD293	10g cannulae
SD294	Balloon for Bronchoscopy Fiberscope
SD298	Shannon cyto funnel, cytospin
SD299	stent, balloon, implantable
SD304	IVUS catheter
SD305	IVUS Catheter Sterile Cover
SD306	Nephroureteral Catheter
SD307	patient/laser interface (single-use, disposable)
SD308	earwash bottle disposable tips
SD309	Immunofluorescent mounting media
SD312	Internal/external biliary catheter
SD313	Viabil covered biliary stent
SD314	Radial Jaw
SD315	Stone basket
SD316	Catheter securement device
SD318	Disposable biopsy forceps
SD321	Thermoplastic tissue bolus 30X30X0.3cm
SD323	Venaseal (glue)
SD324	Varithena (foam)
SD325	Endocavity Balloon
SD326	patient/clinician goggles
SD328	single-channel radio-frequency handpiece
SD329	Uterine Sound
SD330	Tenaculum
SD331	Turbo-Ject PICC Line
SD332	bubble contrast
SD333	tumescent tubing
SF001	arch bar
SF003	blade, dermatome
SF004	blade, microtome
SF005	blade, single edge
SF006	blade, surgical, super
SF007	blade, surgical (Bard-Parker)
SF008	blade, surgical 64,65,67 (Beaver)
SF009	blade, surgical chisel 81-86 (Beaver)
SF010	blade, surgical hair clipper
SF011	blade, surgical, sterile, power saw
SF012	cautery, bipolar cord
SF013	cautery, bipolar, pencil-handpiece
SF014	cautery, electrode extender
SF015	cautery, monopolar, blade, extended shaft
SF016	cautery, monopolar, electrode tip
SF017	cautery, monopolar, electrode, loop
SF018	cautery, monopolar, electrode, needle
SF019	cautery, monopolar, electrode, spatula
SF020	cautery, monopolar, pencil-handpiece
SF021	cautery, patient ground pad w-cord
SF022	comedone extractor
SF023	curette for ear cerumen
SF024	curette, dermal

SF025	dental elastics
SF026	endoscopic blade, surgical
SF028	laser tip (single use)
SF029	laser tip, bare (single use)
SF030	laser tip, diffuser fiber
SF031	loop, surgical (Surg-I-Loop)
SF032	rubber bands, sterile for ligation
SF033	scalpel with blade, surgical (#10-20)
SF034	stapler, surgical
SF035	suture, chromic, 2-0 to 5-0
SF036	suture, nylon, 3-0 to 6-0, c
SF037	suture, nylon, 4-0 to 6-0, p, ps
SF038	suture, prolene, 3-0 to 7-0, p, ps, pc
SF039	suture, silk, 2-0 to 5-0, x, fs, c
SF040	suture, vicryl, 3-0 to 6-0, p, ps
SF042	wire, Kirschner 7.5in
SF043	wire, surgical steel
SF044	blade, surgical, super-sharp
SF045	blade, urethrotome
SF047	scalpel, safety, surgical, with blade (#10-20)
SF048	suture, monocryl, 3-0 to 6-0, p, ps
SF049	suture, nylon, 8-0 to 9-0
SF050	suture, plain, gut, 2-0 to 6-0
SF051	suture, polyester, 0 to 3-0 (Mersilene)
SF052	suture, vicryl, 7-0
SF053	blade, sharp pointed surgical
SF054	wire, orthodontic
SF055	Bone biopsy device
SF056	Detachable coil
SF057	Non-detachable embolization coil
SF058	LC Beads (2mL vial)
SF059	Hysteroscopic tissue removal device
SB001	cap, surgical
SB003	cover, probe (cryosurgery)
SB004	cover, thermometer probe
SB005	cover-condom, transducer or ultrasound probe
SB006	drape, non-sterile, sheet 40in x 60in
SB007	drape, sterile barrier 16in x 29in
SB008	drape, sterile, c-arm, fluoro
SB009	drape, sterile, femoral
SB010	drape, sterile, fenestrated 16in x 16in (eye)
SB011	drape, sterile, fenestrated 16in x 29in
SB012	drape, sterile, for Mayo stand
SB013	drape, sterile, hand-upper extremity
SB014	drape, sterile, three-quarter sheet
SB015	drape, sterile, u-shape
SB016	drape-cover, sterile, OR light handle
SB017	drape-sleeve, sterile (4in x 8ft)
SB018	drape-sleeve, sterile, for handpiece
SB019	drape-towel, sterile 18in x 26in

SB020	drape-towel, sterile OR blue (2 pk uou)
SB021	gloves, cotton
SB022	gloves, non-sterile
SB023	gloves, non-sterile, nitrile
SB024	gloves, sterile
SB026	gown, patient
SB027	gown, staff, impervious
SB028	gown, surgical, sterile
SB029	cap-headcover, patient
SB030	lab coat, staff
SB031	lap sponge, sterile, 18inx18in (5 pack uou)
SB032	liner, baby scale
SB033	mask, surgical
SB034	mask, surgical, with face shield
SB035	paper, chinrest
SB036	paper, exam table
SB037	pillow case
SB038	safety glasses
SB039	shoe covers, surgical
SB040	slippers, paper
SB042	towel, non-sterile
SB043	towel, professional 13in x 18in
SB044	underpad 2ft x 3ft (Chux)
SB045	drape, sterile, incise, ophthalmic
SB046	drape, sterile, split-sheet
SB048	sheath-cover, sterile, 96in x 6in (transducer)
SB049	condom, Diapulse, Asepticap
SB050	bolster covers, disposable
SB051	Disposable underwear
SB053	Gold Fiducial Marker
SB054	Sauna suit
SC001	angiocatheter 14g-24g
SC002	angiocatheter set
SC003	arm board
SC004	blood collection bag
SC006	blood collection tube (Vacutainer)
SC008	catheter, angiographic, pig-tail
SC010	closed flush system, angiography
SC012	heparin lock
SC013	infusion pump cassette-reservoir
SC014	Interlink adaptor
SC015	Interlink vial access
SC018	iv infusion set
SC019	iv tubing (extension)
SC021	lancet
SC022	Mammotome probe guide
SC025	needle, 14-20g, biopsy
SC026	needle, 15-16g
SC027	needle, 18-19g, filter
SC028	needle, 18-26g 1.5-3.5in, spinal

SC029	needle, 18-27g
SC030	needle, 19-25g, butterfly
SC031	needle, 30g
SC032	needle, biopsy for breast-prostate core sample
SC033	needle, biopsy, spring-loaded
SC034	needle, blunt tip
SC035	needle, Chiba
SC037	needle, dental
SC038	needle, epidural (RK)
SC039	needle, Huber point
SC041	needle, arterial (Seldinger)
SC042	needle, spine, Sprotte
SC043	needle, transbronchial, cytology (Wang)
SC044	needle, variceal injection
SC045	needle-wire for localization
SC046	punch, biopsy
SC047	sialography infusion unit
SC048	spinal manometer
SC049	stop cock, 3-way
SC050	stop cock, 4-way
SC051	syringe 10-12ml
SC052	syringe 1ml
SC053	syringe 20ml
SC054	syringe 30 ml
SC055	syringe 3ml
SC056	syringe 50-60ml
SC057	syringe 5-6ml
SC058	syringe w-needle, OSHA compliant (SafetyGlide)
SC059	syringe, 25ml (MRI power injector)
SC060	syringe, pressure (radiology)
SC062	syringe, Toomey
SC063	syringe-needle 10ml 26g
SC064	syringe-needle 3ml 22-26g
SC065	adapter, luer lock
SC067	blood collection tube holder
SC068	blood collection tube needle
SC070	catheter, hyperthermia, closed-end
SC071	catheter, hyperthermia, open-end
SC073	implant catheter, button-end, single leader
SC074	iv pressure infusor bag
SC075	needle, acupuncture
SC076	needle, arterial, percutaneous
SC077	needle, bone biopsy
SC078	needle, flexi, hyperthermia
SC079	needle, micropigmentation (tattoo)
SC080	needle, OSHA compliant (SafetyGlide)
SC081	needle, retrobulbar (Atkinson)
SC082	syringe 12ml, coronary control
SC083	tubing set (Liposorber)
SC084	tubing set, blood warmer

SC085	tubing set, plasma exchange
SC087	tubing set, Y-type blood recipient
SC088	fistula needle, dialysis, 17g
SC089	needle, Vacutainer
SC090	tube, gastrostomy
SC091	Vacutainer
SC092	catheter, needle (for CPT 31626)
SC093	IV infusion set, Sof-set (Minimed)
SC094	Syringe, 35 ml, Monoject, Plastic
SC095	syringe filter
SC096	Quick Cross Catheter (Sprectranetics, documentation available)
SC097	Peritoneal Dialysis Catheter
SC098	catheter, angiographic, Berman
SC099	needle, cystoscope
SC100	bifurcated needle or stylet
SC101	ultrasound needle
SC102	EBUS, single use aspiration needle, 21g
SC103	catheter, RF ablation, endoscopic
SC104	suture, nylon, 10-0
SC107	needle, dry needling
SM001	atomizer tip shield (RhinoGuard)
SM002	autoclave bag
SM003	autoclave tape
SM008	biohazard specimen transport bag
SM010	cleaning brush, endoscope
SM011	cleaning brush, instruments
SM012	disinfectant spray (Transeptic)
SM013	disinfectant, surface (Envirocide, Sanizide)
SM014	endoscope anti-fog solution
SM015	enzymatic detergent
SM016	eye shield, splash protection
SM017	formaldehyde spill control
SM018	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)
SM019	glutaraldehyde test strips (Cidex, Metrex)
SM020	lotion, antibacterial
SM021	sanitizing cloth-wipe (patient)
SM022	sanitizing cloth-wipe (surface, instruments, equipment)
SM023	scrub brush (impregnated)
SM024	soap, liquid, antibacterial
SM025	specula tips, otoscope
SM026	whirlpool antiseptic (80gm pack) (Chlorazene)
SM027	wipes, lens cleaning (per wipe) (Kimwipe)
SM028	filter, mouthpiece (NIOX)
SM029	skin prep barrier wipes
SA001	kit, activity-crafts
SA002	kit, ambulatory Holter
SA003	kit, arterial blood gas (ABG)
SA004	kit, barium with insufflator
SA005	kit, capsule endoscopy w-application supplies (M2A)
SA006	kit, catheter, suprapubic

SA007	kit, cooking activity ingredients (mac-cheese)
SA009	kit, CVA catheter, non-tunneled
SA010	kit, CVA catheter, tunneled, without port-pump
SA011	kit, CVA catheter, tunneled, with subcut port
SA012	kit, CVA device repair
SA014	kit, electrode, iontophoresis
SA015	kit, for percutaneous thrombolytic device (Trerotola)
SA016	kit, guidewire introducer (Micro-Stick)
SA019	kit, iv starter
SA020	kit, loop snare (Microvena)
SA022	kit, percutaneous neuro test stimulation
SA023	kit, phenol applicator
SA024	kit, photopheresis procedure
SA025	kit, PICC with subcut port
SA026	kit, radiofrequency introducer
SA027	kit, scissors and clamp
SA028	kit, sensory integration
SA029	kit, sharp debridement
SA030	kit, staple removal
SA031	kit, suture removal
SA032	kit, tangible reinforcement-reward for children
SA033	kit, therapeutic toys-games
SA035	kit, tracheostomy care
SA036	kit, transurethral microwave thermotherapy
SA037	kit, transurethral needle ablation (TUNA)
SA039	kit, vertebroplasty (LP2, CDO)
SA040	kit, woodworking
SA041	pack, basic injection
SA042	pack, cleaning and disinfecting, endoscope
SA043	pack, cleaning, surgical instruments
SA044	pack, moderate sedation
SA045	pack, drapes, cystoscopy
SA046	pack, drapes, laparotomy (chest-abdomen)
SA047	pack, EM visit
SA048	pack, minimum multi-specialty visit
SA049	pack, ocular photodynamic therapy
SA050	pack, ophthalmology visit (no dilation)
SA051	pack, pelvic exam
SA052	pack, post-op incision care (staple)
SA053	pack, post-op incision care (suture & staple)
SA054	pack, post-op incision care (suture)
SA055	pack, post-op incision care, craniotomy
SA056	pack, post-op incision care, neurosurgical
SA058	pack, urology cystoscopy visit
SA059	tray, amniocentesis
SA060	tray, arthrogram
SA061	tray, biopsy procedure
SA062	tray, bone marrow biopsy-aspiration
SA063	tray, catheter insertion (w-o catheter)
SA064	tray, epidural

SA065	tray, lumbar puncture
SA066	tray, myelogram
SA067	tray, shave prep
SA068	tray, spinal anesthesia
SA069	tray, suturing
SA070	tray, thoracentesis
SA071	kit, AccuStick II Introducer System with RO Marker
SA073	kit, barium enema
SA074	kit, endovascular laser treatment
SA075	kit, hysteroscopic tubal implant for sterilization
SA076	kit, refill for implantable medication pump
SA077	kit, pleural catheter insertion
SA078	kit, slit catheter (for compartment pressure monitor)
SA080	pack, drapes, ortho, large
SA081	pack, drapes, ortho, small
SA082	pack, ophthalmology visit (w-dilation)
SA083	pack, protective, ortho, large
SA084	pack, protective, ortho, small
SA086	tray, circumcision
SA087	tray, RTS applicator (MammoSite)
SA088	tray, surgical skin prep, sterile
SA089	kit, boston original system
SA090	kit, moulage (implantech)
SA091	tray, scoop, fast track system
SA094	kit, capsule, ESO, endoscopy w-application supplies (ESO)
SA096	kit, introducer, radiofrequency, XIi-enhanced RF probe
SA097	kit, locatable guide, ext. working channel, w-b-scope adapter
SA098	kit, nebulizer, w-tubing and aerosole mask (Hope)
SA099	Kit, probe, cryoablation, prostate (Galil-Endocare)
SA100	kit, probe, radiofrequency, XIi-enhanced RF probe
SA101	kit, stent, urethral, prostatic, insertion tool and surveyor
SA102	kit, tubing, use w-automated insufflation, CT colonography
SA103	stent, vascular, deployment system, Cordis SMART
SA104	ThinPrep UroCyte Urine Collection Kit
SA105	UroVysion test kit
SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)
SA108	kit, tissue expansion
SA110	Congo Red kits
SA111	Kyphoplasty kit, first fracture
SA112	Kyphoplasty kit, additional fracture
SA113	Kit, thoracentesis
SA114	Kit, Contrast Imaging
SA115	hemorrhoidal banding system
SA116	continuous peripheral nerve block tray
SA117	Universal Detection Kit
SA119	kit, low frequency ultrasound wound therapy (MIST)
SA120	intrastromal corneal ring
SA121	Imaging Tray
SA122	Claravein Kit
SA123	Hysteroscopic fluid management tubing kit

SA124	scleral shell tubing kit
SA125	Varithena admin pack
SA126	Biodegradable Material Kit - PeriProstatic
SA127	subcutaneous cardiac rhythm monitor system
SA128	kit, Rezum delivery device
SA129	pudendal block tray, sterile
SA130	IV line kit for Rb Generator
SA131	kit, negative pressure wound therapy, disposable
SL001	acetone
SL004	alcohol reagent solvent
SL005	alcohol, acid
SL006	alcohol, ethyl, denatured
SL012	antibody IgA FITC
SL013	antibody IgG FITC
SL018	beaker, 250 ml
SL020	bleach
SL021	calibration beads (each test)
SL024	centrifuge tube
SL025	chloroform
SL026	clearing agent (Histo-clear)
SL027	color coded cap and vial (for antigen)
SL030	cover slip, glass
SL031	cover slip, liquid (M-1)
SL032	culture media
SL033	culture swab system (Culturette)
SL034	cup, biopsy-specimen 86oz
SL035	cup, biopsy-specimen non-sterile 4oz
SL036	cup, biopsy-specimen sterile 4oz
SL037	cup, medicine (1oz size)
SL038	cup-container, sterile, graduated 1000ml
SL039	cytology, lysing soln (CytoLyt)
SL040	cytology, preservative and vial (Preserv-cyt)
SL041	cytology, specimen filter (Transcyt)
SL042	cytology, transport prefilled container
SL043	cytology, vacuum grease
SL044	DDSA
SL045	decalcifier solution
SL046	dental impression tray
SL047	dental stone powder
SL048	desiccant-absorber
SL050	DMP 30
SL051	DNA 0.05N HCl rinse reagent
SL052	DNA 0.1N HCl staining soln
SL053	DNA 5N HCl
SL054	DNA calibration slides
SL055	DNA stain kit (per test)
SL057	embedding capsules
SL058	embedding cassette
SL059	embedding epoxy (NMA)
SL060	embedding mold

SL061	embedding paraffin
SL064	filter paper, qualitative, <15.0cm
SL065	filter paper, qualitative, 18.5cm
SL066	filter, nylon mesh (55mm)
SL068	fixative (for tissue specimen)
SL070	fixative processing (buffered formalin)
SL071	fixative spray
SL072	formalin
SL074	glass strip (each)
SL075	glutaraldehyde 25%
SL077	hematoxylin reagent
SL078	histology freezing spray (Freeze-It)
SL079	hydrochloric acid 0.1%, std soln
SL080	immersion oil
SL081	impression material, alginate (dental)
SL083	indocyanine green (25ml uou)
SL084	Isoton II diluent
SL085	label for microscope slides
SL087	lens paper
SL088	lint-free cloth
SL089	lysing reagent (FACS)
SL090	methanol, absolute, 99.8% min.
SL091	methylbutane (Isopentane)
SL093	mold release agent, liquid
SL095	mounting media (Histomount)
SL097	OCT Tissue-Tek
SL098	osmium tetroxide
SL099	paraformaldehyde
SL103	petri dish
SL104	phosphate buffer, dibasic
SL105	phosphate buffer, monobasic
SL107	phosphate buffered saline solution
SL108	pipette
SL109	pipette, transfer 23ml
SL110	pipette tip (blue-yellow)
SL111	Poly Bed 812
SL112	positive control slide
SL115	propidium iodide
SL116	propylene oxide
SL120	slide container (for 20 microscope slides)
SL121	slide specimen mailer (1-5 microscope slides)
SL122	slide, microscope
SL125	sodium cacodylate
SL126	sodium chloride, 99.0% min.
SL127	sodium citrate
SL128	sodium hydroxide
SL130	spatula (pathology)
SL134	stain, frozen section, H&E (1ml per slide)
SL135	stain, hematoxylin
SL136	stain, Lugol's

SL137	stain, PAP EA-50
SL138	stain, PAP toluidine blue O
SL139	stain, quick differential (5ml per slide)
SL140	stain, Wright's Pack (per slide)
SL141	stain, Wright's soln
SL143	test tube
SL144	thrombin reagent (Thromboquik)
SL146	tubed culture media
SL147	uranyl acetate
SL149	waterbath reagent
SL150	wax, bite registration wafer
SL151	xylenes solvent
SL152	acrylic tray-base material
SL154	alcohol ethyl 100%
SL155	applicator, wood, 6.5in
SL156	cup, sterile, 12-16 oz
SL157	cup, sterile, 8 oz
SL158	diamond knife cleaning rod
SL159	gas, nitrogen
SL160	glass knife boat
SL161	grid storage box (holds 50 grids)
SL162	lead citrate
SL164	osmometer sample tip and cleaner
SL165	osmometer std, 50 mOsm-kg, 2ml amp
SL166	osmometer std, 850 mOsm-kg, 2ml amp
SL167	paper, weighing (glassine)
SL168	pipette bulb
SL169	pipette, 9inch
SL171	sodium barbital
SL172	specimen block storage box
SL173	sucrose, reagent
SL174	Toluidine Blue O (for microscopy)
SL175	underpad 2ft x 2ft (lab bench)
SL176	vial, specimen-sample, 4ml
SL177	wax sheet
SL178	0.2N HCL
SL179	1.0N NaOH
SL180	phosphate buffered saline (PBS)
SL181	pipette tips, sterile
SL182	mounting media (DAPI II counterstain)
SL183	slide, organosilane coated
SL184	slide, negative control, Her-2
SL185	slide, positive control, Her-2
SL186	antibody, flow cytometry (each test)
SL187	balance salt solution (BSS), sterile, 15cc
SL188	EM fixative, karnovsky's
SL189	ethanol, 100%
SL190	ethanol, 70%
SL191	ethanol, 85%
SL192	formamide

SL193	glycolic acid, 20-50%
SL194	Hemo-De
SL195	kit, FISH paraffin pretreatment
SL196	kit, HER-2/neu DNA Probe
SL197	label for blood tube
SL198	label, vial
SL199	lithium carbonate, saturated
SL200	sodium bicarbonate spray, 8 oz
SL201	stain, eosin
SL202	tissue conditioner, coesoft (0.5 oz, each, liquid and powder)
SL203	vial, 10 ml, plastic (-70 degree storage)
SL204	vial, kimble sample, non sterile, glass, 20 ml
SL205	acylic, dental
SL208	alloy framework, laboratory processing
SL211	caffeine
SL212	CHCT buffer (NaCl, NaHCO3, KCl, KH2PO4, MgSO4,CaCl12-2H20)
SL222	gas, halothane
SL223	gas, mixture, tank G, 5% CO2 and 95% O2
SL224	gas, mixture, tank H
SL228	Greenstick compound
SL229	HCl, 1% hydrochloric acid
SL230	impression material, final
SL231	kit, stain, H&E
SL232	KOH
SL236	reline material, Trusoft
SL237	silicone
SL238	slide, glass, (plain blank slide)
SL240	tube, centrifuge, micro, 1.5 ml, DNase free snap lock
SL244	water, de-ionized
SL245	weighing dishes, pour boats
SL246	buffer, lysis
SL247	caps, Capsure Macro LCM
SL248	ethanol, 95%
SL250	methylene blue stain
SL251	Rnase-free water
SL253	Non-Gyn Filter unit
SL254	0.45 µm pore filtration unit
SL255	12-well slides
SL256	ThinPrep UroCyte filter
SL257	Humidity cards
SL258	Control slides
SL259	Bleach cleaning wipe
SL260	Fresh Fixative (3:1, methanol: acetic acid)
SL261	FISH pre-treatment kit
SL262	Anerobic culture tube
SL263	Plastic storage container, 11oz
SL264	uranyl nitrate
SL265	hydroquinone
SL266	gum mastic
SL267	silver nitrate

SL268	ammonium hydroxide
SL269	NADH
SL270	Nitro blue tetrazolium
SL271	10% Gum Tragacanth/OCT
SL272	cork disc (5 mm thick 15 mm diameter)
SL273	weighing boat
SL274	Oil Red O
SL463	Aluminum Chloride 70%
SL464	Atomizer tips (disposable)
SL468	Paraffin repel
SL469	Clarifier
SL470	Marking Dyes
SL471	Q-tip
SL472	Specimen containter
SL473	Slide, charged
SL474	Confirm anti-CD15 Mouse Monoclonal Antibody (Ventana 760-2504)
SL475	E-bar labels (Ventana 1358501)
SL476	E-Bar Printer Ribbon (Ventana 1632900) (prints 8100 labels)
SL477	Permanent marking pen
SL478	Reaction buffer 10X (Ventana 950-300)
SL479	Liquid coverslip (Ventana 650-010)
SL480	SSC (10X) (Ventana 950-110)
SL481	EZ Prep (10X) (Ventana 950-102)
SL482	Cell Conditioning 1 (Ventana 950-124)
SL483	Hematoxylin II (Ventana 790-2208)
SL484	Bluing reagent (Ventana 760-2037)
SL485	Cover slip glue/Mounting media
SL486	250 Test Prep Kit # 78 (Ventana 786-3034)
SL487	monoclonal rabbit anti-AMACR, clone 13 H4 (Cell Marque)
SL488	UltraView Universal DAB Detection Kit
SL489	UtraView Universal Alkaline Phosphatase Red Detection Kit
SL490	microscopic slide, cytology liquid based preparation
SL491	stain, PAP OG-6
SL493	Antibody Estrogen Receptor monoclonal
SL494	Surface Decontaminant (DNA Away)
SL495	Anti CD45 Monoclonal Antibody
SL496	34 Beta E12
SL497	(EBER) DNA Probe Cocktail
SL498	Kappa Probe Cocktail
SL499	Lambda Probe Cocktail
SL500	CMV DNA Probe Cocktail
SL502	Millipore filter
SL503	fixative spray for cytospin
SL504	slide, microscope coated cytospin (single circle)
SL506	Protease
SL507	EBER positive control slide
SL508	positive control slide (proxy for Kappa Positive Control Slide)
SL509	positive control slide (proxy for Kappa Negative Control Slide)
SL510	positive control slide (proxy for Lambda Positive Control Slide)
SL511	positive control slide (proxy for Lambda Negative Control Slide)

SL512	positive control slide (proxy for CMV Positive Control Slide)
SL513	positive control slide (proxy for CMV Negative Control Slide)
SL514	positive control slide (proxy for IGH@BCL2 Positive Control Slide)
SL515	positive control slide (proxy for IGH@BCL2 Negative Control Slide)
SL516	positive control slide (proxy for EBER Negative Control Slide)
SL518	Zeus medium
SL519	Urethane Foaming Agent
SX007	NO SUPPLIES
SK001	ages & stages questionnaire
SK002	anatomical drawings (for treatment recording)
SK003	aphasia assessment forms, average
SK004	apple sauce
SK005	assessment monitoring instruments
SK008	audiology scoring forms
SK009	bath soap (one bar uou)
SK010	battery, 9 volt
SK011	battery, AAA
SK012	CDC information sheet
SK017	cookie (each)
SK018	cup, drinking
SK019	diluent, olive oil
SK020	drinking straw
SK021	emery board
SK024	film, dental
SK030	film, Tri-x 35mm BW (per exposure)
SK032	film, type 667 Polaroid (per exposure)
SK039	foam 3in, therapy positioning (per 1 sq in)
SK040	graham crackers (one packet)
SK041	ice (per cup)
SK042	juice, apple
SK043	label for files-folders
SK044	lamination sheet (letter size)
SK045	lip screen
SK046	lotion, massage, unscented
SK047	map, Moh's surgery (per sheet)
SK048	measuring tape, paper
SK050	neurobehavioral status forms, average
SK051	pad, feminine maxi
SK052	pad, feminine mini
SK054	pad, urinary incontinence (Depends)
SK055	paper, card stock (8.5 x 11)
SK056	paper, graph-plotter
SK057	paper, laser printing (each sheet)
SK058	paper, photo printing (8.5 x 11)
SK059	paper, recording (per sheet)
SK060	paper, recording, roll (per foot)
SK061	paraffin for therapy bath
SK062	patient education booklet
SK065	photographic stop bath
SK066	plastic wrap

SK068	razor
SK070	Rep-band, light (6yd uou)
SK071	rubber bands, non-sterile
SK072	sandpaper (per sheet)
SK073	skin marking ink (tattoo)
SK074	skin marking pen, fluorescent (Spotlighter)
SK075	skin marking pen, sterile (Skin Skribe)
SK076	slide sleeve (photo slides)
SK077	spoon, plastic
SK078	sunscreen lotion (spf15)
SK079	tape, toupee
SK082	towel, paper (Bounty) (per sheet)
SK084	Velcro, standard
SK085	Velcro, strong (Poly-Lock)
SK087	water, distilled
SK088	Woodcock Johnson test record
SK095	battery, AA
SK097	canned air (Dust-Off)
SK100	preventive assessment forms
SK103	cork sheet, 1cm x 1 cm
SK104	foil, aluminum, 10 cm x 10 cm
SK109	paper, articulating
SK114	tissue (Kleenex)
SK115	Reproduced patient worksheet
SK116	fluency assessment form, average
SK117	speech assessment form, average
SK118	language assessment form, average
SK119	Beck Youth Inventory, Second Edition (BYI-II); Combination Inventory Booklet
SK120	Hydrophobic PAP Pen
SK121	Bread
SK122	Egg Whites
SK123	Jelly
SK124	Paper plate
SK125	Adhesive ruler
SK127	antigen vial transport envelopt
SK130	WAIS-IV Record Form
SK131	WAIS-IV Response Booklet #1
SK132	WMS-IV Response Booklet #2
SK133	Sleep mask
SJ001	alcohol isopropyl 70%
SJ002	allergen patch test card, T.R.U.E. (24 test card)
SJ003	allergen patch test cell, Finn Chambers (10 cell card)
SJ004	allergen patch test cell, Finn Chambers (5 cell card)
SJ006	anthralin ointment
SJ007	bacitracin oint (0.9gm uou)
SJ008	bacitracin oint (15gm uou)
SJ009	basin, irrigation
SJ010	basin, emesis
SJ011	bulb syringe (Asepto)
SJ012	Cetacaine spray (56gm size bottle)

SJ013	coal tar soln
SJ014	collodion (2oz uou)
SJ015	contact lens soln (12oz uou)
SJ016	denture cup
SJ017	DuraPrep surgical soln (26ml uou)
SJ018	earplugs
SJ019	electrode adhesive disk
SJ020	electrode conductive gel
SJ021	electrode conductive paste
SJ022	electrode skin prep gel (NuPrep)
SJ023	electrode skin prep tape (One-Step)
SJ024	electrolyte coupling gel
SJ025	ethyl chloride spray
SJ026	Eucerin cream
SJ027	goggles, uv-blocking
SJ028	hydrogen peroxide
SJ029	ice pack, instant
SJ030	ipecac syrup (1oz uou)
SJ031	leg or urinary drainage bag
SJ032	lubricating jelly (K-Y) (5gm uou)
SJ033	lubricating jelly (Surgilube)
SJ034	methoxsalen 10mg (Oxsoralen)
SJ035	mineral oil
SJ036	Monsel's soln
SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)
SJ038	petroleum jelly
SJ039	pH buffer solution
SJ040	phenylephrine 1% nasal spray (NeoSynephrine)
SJ041	povidone soln (Betadine)
SJ042	povidone surgical scrub (Betadine)
SJ043	povidone swabsticks (3 pack uou)
SJ044	pre-thickened juice (4oz uou)
SJ045	sensor strip, skin temperature
SJ046	silver nitrate applicator
SJ047	splint straps 1in
SJ048	splint straps 2in
SJ049	stoma adhesive
SJ050	stoma pouch and wafer
SJ051	swab, lemon-glycerine (3 pak uou)
SJ052	swab, procto 16in
SJ053	swab-pad, alcohol
SJ054	test strip, glucose-protein (Chemstrip GP, Uristix)
SJ055	test strip, INR
SJ056	Thera-bands (6in width)
SJ057	thermometer (single use)
SJ058	thick-it pack
SJ059	tincture of benzoin, liquid
SJ060	tincture of benzoin, swab
SJ061	tongue depressor
SJ062	ultrasound transmission gel

SJ063	urinal
SJ064	zinc oxide ointment
SJ065	contact lens (hard) care kit
SJ066	contact lens (hard) extra strength cleaning solution
SJ067	contact lens (RGP) polishing soln (Silo2 Care)
SJ068	saline, viscous (swallow challenge medium)
SJ069	test strip, glucose (blood test)
SJ070	rubber cement
SJ071	ACD-A anticoagulant
SJ072	brush, disposable applicator
SJ073	DMV remover
SJ074	lens cleaner
SJ075	methoxsalen, 10ml vial
SJ076	nose pads
SJ077	screws, spectacles
SJ078	temple tips
SJ079	basin, sterile 500cc
SJ080	lens cleaner, daily (Allergan)
SJ081	swab, patient prep, 1.5 ml (chloraprep)
SJ082	paste, registration
SJ083	polyurethane sheets (quantity as rolls)
SJ084	teeth set
SJ085	triad tray material
SJ086	wax, baseplate
SJ087	wax, boxing
SJ088	swab, patient prep, 3.0 ml (chloraprep)
SJ089	ultrasound transmission gel, sterile (single use)
SJ090	Voice Augmentation Gel
SJ092	allergen, diagnostic, multi (eg, pollen, mold, environmental)
SJ093	allergy single-test device
SH001	acetic acid 5%
SH002	acetylcholine (for patient use)
SH004	albumin saline
SH006	antigen, mite
SH007	antigen, multi (pollen, mite, mold, cat)
SH008	antigen, single
SH009	antigen, venom
SH010	antigen, venom, tri-vespid
SH011	atropine 1% ophth
SH013	barium high density susp (11-12oz uou)
SH015	barium sulfate, sterile (Biotrace) (6gm uou)
SH016	barium suspension (Polibar)
SH017	barium, honey (Varibar)
SH018	barium, nectar (Varibar)
SH019	barium, pudding (Varibar)
SH020	bone cement (full dose pack uou) (Osteobond, Simplex)
SH021	bupivacaine 0.25% inj (Marcaine)
SH022	bupivacaine 0.5% inj (Marcaine)
SH023	chlorhexidine 0.12% (Peridex)
SH024	Cipro HC otic soln

SH025	cocaine 4% solution, topical
SH026	Conray Inj (iothalamate 43%)
SH027	dexamethasone 0.5% oph oint (4gm uou)
SH029	effervescent granules (Sparkles, EZ Gas) (4gm uou)
SH030	Emla cream
SH032	erythromycin ophth oint (3.5gm uou)
SH033	fluorescein inj (5ml uou)
SH034	fluorescein strips
SH035	fluori-methane (cold spray)
SH037	Goniosol 2.5% ophth
SH038	hemostatic solution (Lumicain)
SH039	heparin 1,000 units-ml inj
SH040	heparin lock flush soln
SH041	Indigo Carmine soln 0.8% inj (5cc vial uou)
SH042	inhalant
SH044	Iopidine 1% ophth soln (0.1ml uou)
SH045	Laminaria tent
SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)
SH047	lidocaine 1%-2% inj (Xylocaine)
SH048	lidocaine 2% jelly, topical (Xylocaine)
SH049	lidocaine 2% w-epi inj (Xylocaine w-epi)
SH050	lidocaine 4% soln, topical (Xylocaine)
SH053	neomycin-polymyxin-hc otic soln (Cortisporin)
SH055	phenol 1000ppm
SH056	phenylephrine 2.5% ophth (Mydfrin)
SH057	prednisolone acet 1% oph soln (5ml uou)
SH058	proparacaine 0.5% ophth (Ophthaine, Alcaine)
SH059	purified protein derivative (0.1ml per test) (PPD-Tubersol)
SH060	renographin-60
SH062	sclerosing solution inj
SH064	silver sulfadiazene cream (Silvadene)
SH065	sodium chloride 0.9% flush syringe
SH066	sodium chloride 0.9% inj (10ml uou)
SH067	sodium chloride 0.9% inj (250-1000ml uou)
SH068	sodium chloride 0.9% inj bacteriostatic (30ml uou)
SH069	sodium chloride 0.9% irrigation (500-1000ml uou)
SH070	talc, sterile (Sclerosol) (4gm uou)
SH071	Telepaque capsule
SH072	triamcinolone acetonide 0.1% cream
SH073	tropicamide 1% ophth (Mydriacyl)
SH074	water, sterile for irrigation (250-1000ml uou)
SH075	water, sterile inj
SH076	adhesive, cyanoacrylate (2ml uou).doc
SH077	albuterol inhal soln (3ml vial)
SH078	balanced salt soln (BSS) (15ml uou)
SH081	Floxin 0.3% otic soln
SH082	hyaluronic acid viscoelastic inj (Amvisc, 0.5ml uou)
SH083	Jessner's soln
SH084	Kenalog 40 inj
SH088	phenol, liquified, USP

SH089	skin refrigerant-anesthetic spray (Frigiderm)
SH090	sodium bicarbonate 8.4% inj w-needle (1ml uou)
SH091	trichloroacetic acid 90% (sat soln)
SH092	LMX 4% anesthetic cream
SH093	heparin 5,000 units-ml inj
SH095	protamine sulfate 10 mg/ml (5ml uou vial)
SH096	nitroglycerin injection USP 5 mg/mL (10ml uou vial)
SH097	Pilocarpine 2%
SH098	chlorhexidine 4.0% (Hibiclens)
SH099	.9% sodium chloride
SH100	Bone cement with mixer
SH101	negative control, allergy test
SH102	positive control, allergy test
SH103	benzylpenicilloyl polylysine (eg, PrePen) 0.25ml uou
SH104	kit, antigen, venom (5 insects)
SH105	negative control, allergy intradermal test
SH106	CavityShield 5% Varnish .25mL
SH107	Spherusol
SH108	Sotradecol Sclerosing Agent
SG001	adherent, pre-tape spray
SG002	adhesive bonder, orthotic
SG003	adhesive foam
SG004	adhesive liquid (Mastisol) (0.67ml uou)
SG005	adhesive remover, liquid (Detachol) (0.67ml uou)
SG006	adhesive remover, pad (acetone)
SG007	adhesive, skin (Dermabond)
SG008	applicator, cotton-tipped, non-sterile 6in
SG009	applicator, sponge-tipped
SG010	bandage, elastic wrap 2in (Ace)
SG011	bandage, elastic wrap 3in (Ace)
SG012	bandage, elastic wrap 4in (Ace)
SG013	bandage, elastic wrap 6in (Ace)
SG014	bandage, elastic, self-adherent wrap 1in (Coban)
SG015	bandage, Esmarch-Martin, sterile 3in x 9ft
SG016	bandage, Kerlix, sterile 4.5in
SG017	bandage, Kling, non-sterile 2in
SG018	bandage, Kling, non-sterile 3in
SG020	bandage, Kling, sterile 4in
SG021	bandage, strip 0.75in x 3in (Bandaid)
SG025	cast, padding 4in x 4yd (Webril)
SG027	cast, stockinette 4in
SG028	cast, stockinette 6in
SG029	casting tape, fiberglass 4in x 4yd
SG030	cotton balls, non-sterile
SG031	cottonoid
SG032	dental rolls
SG033	dressing, 12-7mm (Gelfoam)
SG034	dressing, 3in x 3in (Adaptic)
SG035	dressing, 3in x 4in (Telfa, Release)
SG036	dressing, 4in x 4.75in (Polyskin)

SG037	dressing, 4in x 4.75in (Tegaderm)
SG038	dressing, 4in x 4in (Vigilon)
SG039	dressing, 5in x 9in (ABD-Combine)
SG040	dressing, 5in x 9in (Adaptic)
SG041	dressing, 5in x 9in (Xeroform)
SG042	dressing, ear (Glasscock)
SG043	dressing, eye pad (Opticlude)
SG044	dressing, Merocel nasal standard 4.5cm
SG046	eye pad, sterile, strabismus
SG047	eye shield (fox) and garter
SG048	eye shield, fox
SG049	eye shield, non-fog
SG050	gauze, non-sterile 2in x 2in
SG051	gauze, non-sterile 4in x 4in
SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)
SG053	gauze, sterile 2in x 2in
SG054	gauze, sterile 3in x 3in
SG055	gauze, sterile 4in x 4in
SG056	gauze, sterile 4in x 4in (10 pack uou)
SG057	gauze, x-ray detectable, sterile 4in x 4in (10 pack uou)
SG058	moleskin 9in width
SG059	oto-wick
SG060	outrigger line
SG061	outrigger post
SG062	packing, gauze plain 0.25-0.50in (5 yd uou)
SG063	packing, gauze plain 1in (5 yd uou)
SG064	packing, gauze w-iodoform 0.25-0.5in (5 yd uou)
SG065	packing, gauze w-iodoform 1in (5 yd uou)
SG066	packing, gauze w-petrolatum, 0.5in (6yd uou)
SG067	penrose drain (0.25in x 4in)
SG068	plaster bandage (4in x 5yd uou)
SG070	punctum plug
SG071	scrotal support
SG072	septal button prosthesis, silicone
SG073	splint, adhesive nasal (Denver)
SG074	steri-strip (6 strip uou)
SG075	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)
SG076	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)
SG077	tape, porous-hypoallergenic 2in (Scanpore)
SG078	tape, surgical occlusive 1in (Blenderm)
SG079	tape, surgical paper 1in (Micropore)
SG080	unna boot
SG081	applicator, cotton-tipped, sterile, 6in
SG082	cotton balls, sterile
SG085	microsponge, cellulose (10 pack uou)
SG086	splint, finger (metal-foam)
SG087	stockings, knee length, 20-30mm compression
SG088	tape, foam, elastic, 2in (Microfoam)
SG089	tape, phix strips (for nasal catheter)

SG090	tracheostomy collar-neckband
SG091	tracheostomy dressing
SG092	packing, gauze, plain, 1 in (5 yd uou)
SG094	Tisseel Fibrin Glue, 1 ml
SG095	Hemostatic patch
SG096	Multi-layer compression system bandages
SG097	foam underwrap
SG098	rigid strapping tape

Unit	Purchase Price
item	1.2115
item	0.121
item	2.05
item	42.645
item	4.109
item	7.278
item	24.615
item	1.445
item	22.479
item	1.014
item	38.71
item	28.2575
tray	744.795
item	185.955
item	338.225
item	118.585
item	185.215
item	9.335
item	7.1
item	12.985
item	16.5415
item	64.5725
item	0.9215
item	2.23
item	0.47
item	12.655
item	34.2
item	84.655
item	4.9355
item	0.75
item	9.14
item	6.92
item	0.525
item	0.2025
item	1.1815
item	0.3765
pair	10.195
item	10.0565
item	22.545
item	2.99
item	0.305
item	0.075
item	16.875
item	0.861
item	11.5185

item	1.75
item	475
item	0.8625
item	45.195
item	68.9365
item	1.2315
item	4.0985
item	59.315
item	14.775
item	24.025
item	16.265
item	43.7615
item	247.465
item	37.375
item	1.625
cu ft	0.025
cu ft	0.795
item	4.3715
ml	0.0315
liter	0.0235
liter	0.0065
liter	0.056
item	0.165
item	16.02
item	12.924
item	39.435
item	34.595
item	4.981
item	167.5
item	4.635
item	0.325
item	0.2285
item	1.196
item	1.417
item	0.594
item	1.551
item	0.45
item	0.9315
item	30.155
item	58.333
item	2261
item	14.495
item	153.335
item	3.085
item	48.925
item	56.195
item	8.4
item	12.8
item	2.459
item	0.95

item	2.505
item	0.763
item	29.86
item	0.163
item	5.615
item	3.174
item	4.725
item	4.3085
foot	0.5665
item	3.16
item	1.2125
item	2.8695
item	2.8155
item	16.045
item	36.65
item	19.55
item	16.5
item	4.961
item	23.08
item	2.949
item	10.7475
item	55.475
item	15.11
item	49.13
item	107.08
item	381.805
item	216.68
item	18.0125
item	334.995
item	637.5
item	83.225
item	10.61
item	41.5
item	88.505
item	11.67
item	93.28
item	2.089
item	2.4935
item	76.61
item	1.9225
liter	0.075
item	3.495
item	31.385
item	88.125
item	65.235
item	205.795
item	50.11
item	1545.565
kit	44.495
item	71.155

item	13.561
item	31.635
item	1.075
item	0.475
item	1026.2
item	94.66
item	218.415
item	138.14
item	782.725
item	119.31
item	329.225
item	62.745
item	48
item	37.88
item	92
item	43.59
item	107
item	27
item	45.895
item	60.33
item	41.22
item	238.21
item	55.855
item	207
item	0.658
item	20.932
item	7.02
item	2.715
item	1.54
item	1.2845
item	19.4033
item	1272.5
item	296.485
item	135.57
item	424.195
item	1750
item	1380
item	33.47
item	0.37
item	1.36
item	1.0975
cu ft	0.425
liter	1.808
item	101.205
item	69
item	1480.56
item	1172.61
cc	1.218
item	2.57
item	1.12

g	0.098
item	3986.5
item	174.89
item	1168.39
item	13.075
item	1.65
item	93.825
item	6.365
item	1650.91
item	65
item	720.665
item	1023.455
item	109.81
item	81.32
item	109.69
item	40.955
kit	4014
item	3448.5
item	2343.12
item	1253.945
item	
item	7.17
item	152.385
item	126.75
item	85
item	73.37
item	2901.345
item	1395.125
kit	312.31
item	2.425
item	50.815
item	929.195
item	114.255
item	6.62
each	2.085
item	
item	0.415
item	10.96
item	
item	504.47
item	570.435
item	46.485
item	160.075
item	
item	191.24
item	176.215
item	19.215
	30.975
	875
	111.75

	58.03
	26.0875
item	3.393
item	1156.215
item	941.665
pack (10	118.78
item	111.035
item	172.5
item	1.72
ml	39.115
Item	110.3
Item	2743.38
Item	94.2
Item	347.51
Item	0
item	24.96
item	36.865
item	1495
item	3195
item	39.9
item	6
item	353.64
item	3.17
item	3.77
item	170
5 ml vial	126.59
item	11
inch	0.73
item	22.87
item	2.1665
item	0.4455
item	2.7315
item	0.6075
item	2.6585
item	3.4505
item	6.663
item	10.925
item	4.7965
item	33.7
item	8.9315
item	4.2165
item	0.3945
item	18.9015
item	2.466
item	42.7
item	5.154
item	5.045
item	2.445
item	0.8395
item	2.0765

item	0.039
item	45.81
item	329.995
item	169.775
item	709.583
item	2.0375
item	0.4775
item	0.867
item	10.2545
item	7.7455
item	2.8055
item	7.217
item	14.275
item	3.348
item	8.186
item	5.7685
foot	0.149
item	4.3783
item	88.695
item	3.5565
item	12.6485
item	16.31
item	5.1557
item	4.8476
item	28.8665
item	0.965
item	
item	158.425
item	1067.15
item	215.265
item	2220.965
item	675.015
item	0.6745
item	0.77
item	0.129
item	2.405
item	0.176
item	0.502
item	4.942
item	12.5495
item	3.7275
item	0.5935
item	1.379
item	13.228
item	3.645
item	8.8935
item	1.0795
item	0.1795
item	0.1145
item	0.376

item	1.2435
pair	2.4175
pair	0.192
pair	0.95
pair	0.875
item	0.5615
item	1.186
item	4.9005
item	0.0555
item	6.896
item	3.811
item	0.074
item	0.153
item	1.2395
item	0.008
foot	0.014
item	0.3885
item	2.411
pair	0.219
pair	0.201
item	0.4205
item	0.04
item	0.275
item	5.895
item	7.3812
item	9.583
item	0.725
item	0.07
item	
item	136.835
item	9.99
item	1.9775
item	12.616
item	0.779
item	7.265
item	0.1905
item	15.245
item	92.3665
item	0.6885
item	10.8565
item	1.3775
item	2.255
item	1.191
foot	0.685
item	0.124
item	6.875
item	9.7525
item	0.206
item	0.29
item	6.637

item	0.0645
item	0.669
item	0.442
item	30.81
item	22.265
item	0.5
item	9.2885
item	0.098
item	10.65
item	3.649
item	4.8125
item	9.24
item	66.075
item	48
item	15
item	2.289
item	30.855
item	15.3075
item	1.1075
item	1.1405
item	0.197
item	0.2
item	0.694
item	0.79
item	0.173
item	1.0055
item	0.14
item	0.4625
item	9.3225
item	9.8445
item	3.038
item	0.3065
item	0.105
item	23.3693
item	0.1625
item	0.366
item	22.5
item	21.875
item	19.035
item	17.105
item	0.097
item	10.62
item	68.5
item	30.52
item	22.77
item	0.617
item	1.4875
item	7.895
item	48.84
item	7.7029

item	229.89
item	5.135
item	1.425
item	0.32
item	94.365
item	6.395
item	29.115
item	9.49
item	2.59
item	1.955
item	168.415
item	353
item	
item	32.885
item	0.77
	13.175
	283.37
	1640
item	11.51
item	0.2495
item	0.79
item	0.07
yd	0.071
item	0.0575
item	4.071
item	3.775
ml	0.039
oz	0.1715
ml	0.9135
oz	0.2245
item	2.3255
ml	0.0125
oz	1.8025
item	0.926
oz	0.28
item	0.0535
item	0.058
item	3.4445
oz	0.1865
item	0.24
item	1.7395
item	0.0265
item	4.975
	0.2
kit	7.87
kit	4.5745
kit	1.4675
kit	33.5375
kit	508.29
kit	43.715

kit	1.04
kit	71.785
kit	403.825
kit	502.865
kit	94.23
kit	3.97
kit	591.935
kit	28.36
kit	1.335
kit	327.25
kit	267.26
kit	17.571
kit	1230.78
kit	652.09
kit	37.08
kit	0.72
kit	14.755
kit	5.717
kit	1.203
kit	1.347
kit	1.5
kit	0.2
kit	2.085
kit	1000
kit	900
kit	833.24
kit	12.99
pack	11.06
pack	18.246
pack	8.9745
pack	17.9305
pack	13.597
pack	16.689
pack	4.606
pack	3.0815
pack	18.5125
pack	1.9525
pack	10.666
pack	4.928
pack	5.79
pack	4.7635
pack	7.3
pack	6.203
pack	69.1925
tray	15.4665
tray	24.11
tray	18.115
tray	39.265
tray	2.703
tray	21.2245

tray	16.896
tray	22.2495
tray	1.541
tray	22.496
tray	8.9515
tray	37.156
kit	82.565
kit	7.413
kit	421.165
kit	1211.36
item	26.42
kit	439.88
kit	86.73
pack	38.973
pack	1.689
pack	2.9535
pack	10.021
pack	5.2155
tray	24.3562
item	2688.93
tray	5.1074
kit	4.5
kit	75
tray	750
kit	588.725
kit	188.9
kit	1020.175
kit	28.705
kit	3939.927
kit	2330.835
kit	543.67
kit	15.82
kit	1224.29
kit	7.07
item	153.04
kit	2474.985
kit	8.313
test	5.17
kit	3822.9
kit	2372.205
kit	47.985
kit	7.325
	299.9
	73.405
kit	4
	191.755
pair	1145
item	22.155
	886.665
	320

item	2.35
pack	40
item	2850
item	5032.5
item	1150
item	5.24
kit	16.98
kit	100
ml	0.037
ml	0.011
ml	0.017
ml	0.018
ml	54.761
ml	180.71
item	0.647
ml	0.0055
item	10.54
item	0.067
ml	0.027
ml	0.014
item	0.597
item	0.079
ml	0.0595
ml	0.0165
item	0.9125
item	1.5565
item	0.1385
item	0.4865
item	0.009
item	1.145
ml	0.047
item	1.185
item	4.15
item	0.976
oz	4.48
gm	0.096
ml	0.0135
item	0.463
lb	2.689
item	0.154
gm	0.223
ml	0.004
ml	0.004
ml	0.004
item	1.815
item	147.415
item	0.0575
item	0.16
ml	0.028
item	0.136

kg	5.3315
item	0.1325
item	0.2405
item	0.519
ml	0.013
ml	0.009
ml	0.047
ml	0.009
item	3.4235
ml	0.139
ml	0.17
oz	1.3815
ml	0.017
ml	0.079
lb	8.23
item	76.9075
ml	0.002
item	0.083
item	0.1685
item	0.2215
ml	3.8825
ml	0.0225
ml	0.0305
ml	0.081
ml	0.2675
ml	0.1
gm	36.22
gm	0.0615
item	0.261
gm	0.089
gm	0.084
ml	0.0255
item	0.0465
item	0.249
item	0.089
gm	0.1755
item	21.385
ml	5.885
ml	0.1005
item	5.216
item	0.3
item	0.2075
gm	0.55
gm	0.0345
gm	0.169
gm	0.052
item	0.853
ml	0.6235
ml	0.044
ml	0.6475

ml	0.035
ml	0.0795
ml	0.057
ml	0.161
ml	0.202
item	0.2365
ml	2.8435
item	0.8845
gm	3.13
ml	0.002
item	0.3465
ml	0.012
oz	1.8823
ml	0.028
item	0.0079
item	0.755
item	0.561
item	1.235
cu ft	2.364
item	0.21
item	5.815
gm	0.855
item	0.672
ml	15.115
ml	15.115
item	0.0255
item	0.2604
item	0.1119
gm	0.8376
item	1.3025
gm	0.037
gm	0.58
item	0.4436
item	0.41
item	0.2424
ml	0.0515
ml	0.5695
ml	0.0175
item	0.1264
ml	74.26
item	0.4466
item	28.767
item	27.8
item	8.815
ml	
ml	0.203
ml	0.0033
ml	0.0033
ml	0.0124
ml	0.21

ml	0.248
ml	0.0083
kit	21.233
kit assay	105.588
item	0.0035
item	0.0113
ml	0.015
item	11.375
ml	0.0638
item	7.765
item	1.158
item	0.754
gm	
item	
gm	0.214
liter	1.425
ml	0.382
item	19.74
item	22.295
item	
cc	0.1495
ml	
kit	187.8
gm	0.084
gm	
gm	
item	0.342
item	0.081
ml	0.017
item	0.203
ml	0.52
ml	4.905
ml	0.0033
ml	0.209
ml	2.28
item	4.545
item	8.159
item	0.85
item	8.69
item	0.3003
kit	215.865
item	0.715
item	0.1088
kit	564.105
item	
item	
oz	9.7395
gm	7.69
gm	1.5025
gm	2.675

ml	0.082
mg	0.2055
mg	0.489
oz	1.3725
item	0.625
item	0.204
ml	0.4875
ml	0.225
item	
ml	0.197
ml	0.005
ml	0.4294
each	0.1377
item	1.4365
item	0.297
test	3.715
item	0.68
item	109.555
item	2.175
ml	0.0175
ml	0.0429
ml	0.0101
ml	0.0343
ml	0.6128
ml	0.4013
ml	3.751
ml	0.345
per test	0.275
ml	37.7965
test	10.0925
per test	24.18
item	0.367
ml	0.015
Test	15.2935
ml	0.065
Test	4.045
Test	4.825
Test	9.253
ul	0.5025
ul	0.0675
ul	0.1025
item	1.245
ml	1.383
item	0.3762
mg	0.7684
item	24.78
item	21.8
item	21.8
item	21.8
item	21.8

item	21.8
item	21.8
item	21.8
item	21.8
item	21.8
ml	0.875
	51.48

item	0.3
item	2.625
item	2.415
oz	0.066
item	0.235
item	0.104
item	0.568
item	1.862
item	0.7575
item	0.0175
item	0.085
item	0.025
ml	0.0275
item	0.015
item	0.1065
item	1.3445
item	0.255
item	1.305
item	0.061
item	0.9035
item	0.04
oz	0.0645
item	0.075
item	0.623
item	1.26
oz	0.234
item	0.0225
item	0.0655
item	4
item	0.27
item	0.24
item	0.509
item	0.0575
item	0.7705
item	0.0125
item	0.625
item	0.0635
foot	0.1135
lb	3.149
item	2.175
oz	0.03
foot	0.016

item	0.4495
item	5.68
item	0.025
item	0.604
ml	0.3655
item	1.04
item	1.334
item	0.231
item	0.033
oz	0.6745
inch	0.054
item	0.007
foot	0.671
foot	3.335
oz	0.0165
item	1.76
item	0.64
oz	1.3404
item	1.785
item	0.035
item	0.02
item	0.0445
box	1.695
item	
item	1.095
item	1.24
item	1.855
booklet	1.755
item (10	2.12
per slice	0.175
oz	0.255
Packet (	0.095
item	0.215
item	9.63
item	1.45
item	5.25
item	3.3
item	2
item	9.95
ml	0.016
item	57.405
item	13.255
item	9.075
gm	3.33
item	0.1105
item	1.4385
item	1.771
item	0.233
item	1.415
gm	1.0345

ml	0.024
item	2.6355
item	4.19
item	0.2415
item	7.955
pair	0.2725
item	0.145
ml	0.033
oz	1.441
ml	0.103
inch	0.1285
ml	0.028
oz	5.2855
oz	1.167
item	5.535
ml	0.0215
item	1.23
item	2.2375
item	3.6195
item	0.303
oz	0.5355
item	6.343
ml	0.0155
ml	1.6835
item	1.745
oz	0.3255
ml	0.044
ml	0.333
ml	0.137
ml	0.0145
item	0.4445
item	1.2705
item	1.1475
item	0.13
item	1.9295
item	2.4425
oz	4.38
item	8
item	0.1645
item	0.1935
item	0.0265
item	0.2835
item	5.185
foot	0.602
item	0.143
item	0.5
ml	0.1035
item	0.325
item	0.021
ml	0.0215

item	3.1483
oz	0.975
item	8.605
ml	0.2492
ml	0.1185
ml	0.305
item	1.0705
ml	0.12
item	7.87
item	0.348
item	2.49
ounce	0.69
item	54.965
item	0.79
item	0.14
pair	1
item	3.255
ounce	0.52
item	1.065
gm	
roll	
item	
item	
gm	
gm	
item	1.995
	1.995
ml	583.555
ml	8.44
ml	0.19
ml	0.021
gm	0.465
ml	0.115
ml	4.29
ml	7.83
ml	6.1
ml	25.535
ml	52.145
ml	0.291
item	3.764
item	76.68
ml	0.029
ml	0.1535
ml	0.0355
ml	0.2235
item	80.4575
ml	0.377
ml	0.12
oz	0.554
ml	10.23

ml	4.7565
ml	0.1785
item	6.27
item	2.056
gm	2.1395
item	3.445
item	14.916
item	0.282
ml	0.551
ml	0.61
ml	0.143
ml	0.3315
item	1.455
item	13.52
gm	0.879
item	12.8115
item	3.9065
ml	0.072
ml	0.0475
ml	0.8435
ml	0.1105
ml	0.1665
ml	2.103
ml	0.1095
ml	2.082
item	6.745
ml	1.194
ml	21.7235
ml	0.58
ml	2.5045
gm	0.2105
item	0.7455
item	0.4485
item	2.549
item	0.76
item	2.707
item	126.095
item	0.7625
gm	0.056
ml	0.743
item	2.47
ml	0.0395
item	30.169
item	0.518
item	1.815
ml	2.487
item	64.575
ml	0.2648
ml	4.834
ml	0.3077

oz	5.43
item	2.2
ml	0.8875
gm	2.1835
ml	0.5192
item	243.47
item	178.57
ml	3.3265
oz	
ml	0.016
item	228.14
ml	6.395
ml	24.38
each	87.665
ml	40.605
ml	32.43
	0.91
ml	603.825
Vial	119.145
oz	0.8305
oz	0.375
inch	0.416
item	2.283
item	2.372
item	0.035
item	43.869
item	0.0385
item	0.1445
item	0.682
item	0.859
item	0.8495
item	1.1695
item	1.4485
item	5.8625
item	1.166
item	1.0065
item	0.423
item	0.685
item	0.2265
item	1.6415
yd	0.5295
yd	0.9045
item	12.454
item	0.012
item	0.7865
item	0.025
item	9.597
item	0.498
item	0.097
item	1.3925

item	1.1855
item	2.8205
item	0.2465
item	1.679
item	1.628
item	12.74
item	0.334
item	11.45
item	1.353
item	1.2845
item	0.955
item	0.59
item	0.2865
item	0.0325
inch	0.0415
item	0.057
item	0.1165
item	0.1745
item	0.999
item	2.0565
foot	3.6545
item	2.142
yd	0.0655
item	0.399
item	2.9015
item	4.07
item	3.905
item	5.215
item	2.0885
item	0.7485
item	1.321
pair	43.325
item	6.695
item	82.9535
item	22.435
item	1.328
item	3.8005
item	3.716
inch	0.0235
inch	0.007
inch	0.006
item	5.0005
item	0.0562
item	0.0257
item	3.99
item	1.8325
pair	45.4365
inch	0.0063
item	1.45

item	3.235
item	3.24
item	5.98
ml	262.01
item	38.04
item	17.945
inch	0.0121
inch	0.018

2020 Direct PE Inputs Equipment Listing

CMS Code	Modifier	*cut and paste to spreadsheet from column A only* EQUIPMENT Description	Useful Life
ED003		camera, 35mm system (medical grade)	5
ED004		camera, digital (6 mexapixel)	5
ED004-60	Yes	camera, digital (6 mexapixel)	5
ED005		camera, digital system, 12 megapixel (medical grade)	5
ED006		camera, digital system, for electron microscopy	5
ED008		camera, retinal (TRC 50IX, w-ICG, filters, motor drives)	5
ED009		computer and VDT and software	5
ED011		computer system, record and verify	5
ED012		computer workstation, 3D hyperthermia treatment planning	5
ED014		computer workstation, 3D reconstruction CT-MR	5
ED015		computer workstation, 3D teletherapy treatment planning	5
ED017		computer workstation, brachytherapy treatment planning	5
ED018		computer workstation, cardiac cath monitoring	5
ED019		computer workstation, nuclear medicine analysis-viewing	5
ED020		computer workstation, nuclear pharmacy management (hardware and	5
ED021		computer, desktop, w-monitor	5
ED031		printer, dye sublimation (photo, color)	5
ED032		printer, laser, paper	5
ED033		treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)	5
ED034		video SVHS VCR (medical grade)	5
ED035		video camera	5
ED035-60	Yes	video camera	5
ED036		video printer, color (Sony medical grade)	4
ED036-60	Yes	video printer, color (Sony medical grade)	4
ED037		acquisition system, digidata, molecular	5
ED038		notebook (Dell Latitute D600)	3
ED040		genetic counseling, pedigree, software	5
ED041		MLC shaper	5
ED043		refrigerator, vaccine, temperature monitor w-alarm, security mounting	10
ED044		video camera (machine monitor)	5
ED045		video camera (patient monitor)	5
ED046		low-light video cameras (3) and DVR	5
ED047		Thermal Printer	5
ED048		Digital Printer	5
ED050		Technologist PACS workstation	5
ED051		multimodality software	5
ED052		computer, desktop, w-monitor (for EM scope)	5
ED053		Professional PACS Workstation	5
ED054		PACS Mammography Workstation	5
ED056		CAD Workstation (CPU + Color Monitor)	5

ED058	CAD Software	5
ED060	sheer wave elastography software	5
EF001	bath tub	10
EF002	bed, hospital, electric	12
EF003	bedroom furniture (hospital bed, table, reclining chair)	12
EF004	cart, laboratory	10
EF005	cart-workbench, orthotic, mobile	10
EF006	casting table attachment, Risser	10
EF007	casting table attachment, hip-spica cast	10
EF008	chair with headrest, exam, reclining	15
EF009	chair, medical recliner	10
EF010	chair, thyroid imaging	10
EF011	crash cart (unstocked)	10
EF012	lift, hydraulic, chair	10
EF013	lift, hydraulic, table assist	10
EF014	light, surgical	15
EF015	mayo stand	15
EF016	scale, high capacity (800 lb)	10
EF017	scale, new born, digital	15
EF018	stretcher	10
EF019	stretcher chair	10
EF020	stretcher, endoscopy	10
EF021	table, brachytherapy treatment	15
EF023	table, exam	15
EF024	table, fluoroscopy	15
EF025	table, for seated OT therapy	15
EF027	table, instrument, mobile	15
EF028	table, mat, hi-lo, 6 x 8 platform	15
EF029	table, mobolization-manipulation (Lloyd's)	15
EF030	table, motorized (for instruments-equipment)	15
EF031	table, power	10
EF032	table, tilt (w-trendelenberg)	15
EF033	table, treatment, hi-lo	15
EF034	table, ultrasound	15
EF035	whirlpool (Hubbard tank)	10
EF036	whirlpool, lo-boy tank (whole body)	10
EF038	chair, dental (Cascade 1040 - Adec), with upholstery	15
EF039	light, dental, ceiling mount (Adec)	10
EF040	refrigerator, vaccine, commercial grade, w-alarm lock	10
EF042	One Couch and Two Chairs	10
EF043	Set of 8 chairs	10
EF044	Crib	10
EL001	environmental module - car	15
EL002	environmental module - kitchen	15

EL003		environmental module - the workshop	15
EL004		lane, central pod (oph)	7
EL005		lane, exam (oph)	7
EL006		lane, screening (oph)	7
EL007		room, CT	5
EL007-90	Yes	room, CT	5
EL008		room, MR	5
EL008-90	Yes	room, MR	5
EL011		room, angiography	5
EL012		room, basic radiology	5
EL013		room, mammography	5
EL014		room, radiographic-fluoroscopic	5
EL015		room, ultrasound, general	5
EL016		room, ultrasound, vascular	5
EL018		room, mobile c-ARM	5
EL020		Densitometer (for mammography room)	5
EL021		2D Selenia Dimensions Mammography System (for mammography roor	5
EL022		Mammo Accreditation Phantom (for mammography room)	5
EL023		Cenova 2D Tower System (for mammography room)	5
EL024		Image Checker CAD (9.4) License for One FFDM (for mammography roo	5
EL025		MRS V7 SQL Reporting System (for mammography room)	5
EL026		Worksheet Printing (for mammography room)	5
EL027		Site License (for mammography room)	5
EL028		Additional Concurrent User License (for mammography room)	5
EL050		MR Elastography Package	5
EP001		DNA/Digital Image Analyzer	7
EP004		balance, analytic	10
EP005		balance, scale	7
EP006		camera system, specular microscope	5
EP007		centrifuge (with rotor)	7
EP008		cytology thinlayer processor (ThinPrep)	7
EP010		diamond knife (4.0-4.4mm) (electron microscopy)	7
EP012		differential tally counter, 12-channel	5
EP014		flow cytometer	5
EP015		grossing station w-heavy duty disposal	20
EP016		hood, biohazard	10
EP017		hood, fume	15
EP018		hood, negative flow	15
EP019		hood, ventilator with blower	10
EP021		incubator	10
EP022		incubator, CO2 (dry-wall)	10
EP023		microscope, binocular - dissecting	7
EP024		microscope, compound	7
EP026		microscope, electron, transmission (TEM)	7

EP027	microscope, fluorescence	7
EP029	oven, convection (lab)	10
EP030	pH conductivity meter	10
EP031	paraffin dispenser (five-gallon)	10
EP032	paraffin dispenser (two-gallon)	10
EP033	slide coverslipper, robotic	7
EP034	slide dryer	10
EP035	slide etcher-labeler	7
EP036	slide stainer, automated, high-volume throughput	7
EP037	slide stainer, automated, standard throughput	7
EP038	solvent recycling system	7
EP039	tissue embedding center	8
EP040	tissue processor	7
EP042	vacuum pump	7
EP043	water bath, general purpose (lab)	7
EP044	centrifuge, cytospin	7
EP045	chamber, hybridization	7
EP047	loader, FACS	7
EP048	microfuge, benchtop	7
EP049	oven, isotemp (lab)	10
EP050	scanner, AutoVysion	5
EP051	slide warmer	7
EP052	ultrasonic nebulizer	10
EP053	wash assistant, FACS	7
EP054	water bath, FISH procedures (lab)	7
EP055	amplifiers, transducers, for water bath (EPxxx), 4 at $725 each	10
EP056	articulator (model 96H2 - Hanua)	10
EP057	centrifuge, Eppendorf, model 5415C	7
EP060	dust collecting unit (Handler)	10
EP065	grinding and polishing unit (Handler)	10
EP066	handpiece, laboratory (Ney)	10
EP068	illuminator, fiber optic, for microscope (Grass Telefactor)	5
EP069	light curing unit (Triad 2000)	10
EP070	pH meter, nonglass, solid-state 620 220v (Orion pHuture)	10
EP072	signal conditioner, 8 channel (Cyberamp 380-2)	10
EP074	steamer, portable (Kerr Lab)	10
EP075	stimulator, attenuator, 4 channel (for model SS2) (Grass Telefactor)	10
EP076	stimulator, nerve and muscle, dual output, square pulse, w-power cord	10
EP077	stimulator, splitter, power booster (model SS2) (Grass Telefactor)	10
EP078	transducers, force displacement (for in vitro or in vivo), model FT03	10
EP079	triad unit	10
EP080	trimmer, dental model (Buffalo)	10
EP081	vaporizer, Halothane (Fisher)	8
EP082	washout and curing unit (Nevin)	10

EP083		water bath, pump, w-isotemp circulation	7
EP084		water bath, tissue, 4-unit, high tech organ bath	7
EP085		whip mix combo unit (Vac-U-Spat)	10
EP086		whip mixer	10
EP087		instrument, microdissection (Veritas)	7
EP088		ThermoBrite	7
EP089		Camera (Olympus DP21)	5
EP090		IkoniLan Software	5
EP091		IkoniScope	7
EP092		Olympus BX41 Fluorescent Microscope (without filters or camera)	5
EP093		Filters	5
EP110		Freezer	10
EP111		Automated Casette Labeler	5
EP112		Benchmark ULTRA automated slide preparation system	5
EP114		Thin Prep Vortexer	5
EP115		Electron Microscopy Tissue Processor	7
EP116		VP-2000 Processor	7
EP117		Reentrant well ionization chamber	7
EP118		L-block (needle loading shield)	10
EP119		Central Blood Pressure Monitoring Equipment (XCEL PWA & PWV Syste	5
EP120		water bath, digital control	7
EP121		slide stainer, automated, hematology	7
EQ001		ABR-auditory brainstem response system	7
EQ002		CDP-computerized dynamic posturography system	7
EQ003		CO2 infrared analyzer (COSMO)	7
EQ004		CO2 respiratory profile monitor	7
EQ005		CPAP/BiPAP remote clinical unit	7
EQ006		CSF shunt programmer unit	7
EQ007		ECG R-wave trigger (gating) device	7
EQ008		ECG signal averaging system, w-P-waves and late potentials software	5
EQ009		ECG, 1-channel (Burdick)	7
EQ010		ECG, 3-channel	7
EQ011		ECG, 3-channel (with SpO2, NIBP, temp, resp)	7
EQ012-25	Yes	EECP, external counterpulsation system	5
EQ013		EEG analysis software	5
EQ014		EEG monitor, digital, portable	7
EQ015		EEG recorder, ambulatory	7
EQ016		EEG review station, ambulatory	5
EQ017		EEG, digital, prolonged testing system (computer w-remote camera)	7
EQ018		EEG, digital, standard testing system (computer hardware & software)	7
EQ019		EGG monitoring system	7
EQ020		EMG biofeedback continence training system (Pathway CTS2000)	8
EQ021		EMG botox	7
EQ022		EMG, surface system (OT, PT, clinician) (Therapist System)	8

EQ023	EMG-NCV-EP system, 2-4 channel	10
EQ024	EMG-NCV-EP system, 8 channel	10
EQ025	ENG recording system	5
EQ026	EOG, ERG, VEP electrodiagnostic unit	7
EQ027	Farnsworth-Munsell 100-Hue color vision test w-software	7
EQ029	Humphrey field analyzer	7
EQ030	ICG monitoring system (impedance cardiography)	5
EQ031	INR monitor, home	4
EQ032	IV infusion pump	10
EQ034	OAE-otoacoustic emission system	7
EQ035	QSART acquisition system (Q-Sweat)	5
EQ036	RGP lens modification unit	7
EQ037	TUMT system control unit	7
EQ038	VRA-visual reinforcment audiometry system	5
EQ039	Vmax 229 (PFT equip, computer system)	8
EQ040	Vmax 229 (spirometry testing equip, computer system)	8
EQ042	Vmax 29c (cardio-pulm stress test equip, treadmill, computer system)	8
EQ043	Vmax 29s (spirometry testing equip, computer system)	8
EQ044	Vmax 62j (body plethysmograph autobox)	8
EQ047	air compressor, safety	12
EQ048	anesthesia machine (w-vaporizers)	7
EQ049	anomaloscope, diagnostic (HMC)	10
EQ050	aquatic therapy pool	15
EQ051	arterial tonometry acquisition system (WR Testworks)	7
EQ052	arterial tonometry monitor (Colin Pilot)	7
EQ053	audiometer, clinical-diagnostic	10
EQ054	audiometric soundproof booth (exam and control rooms)	15
EQ055	augmentative communication - AT switches (eg, arm, tongue, pneumati	7
EQ056	augmentative communication - Dragon Naturally-Speaking	7
EQ057	augmentative communication - DynaBeam access w-memory backup	7
EQ058	augmentative communication - DynaVox 3100	7
EQ059	augmentative communication - DynaVox wheelchair mount	7
EQ060	augmentative communication - Hand Held Voice	7
EQ061	augmentative communication - HeadMaster w-adapters	7
EQ062	augmentative communication - IntelliKeys, Overlay, ClickIt	7
EQ063	augmentative communication - Tech Speak	7
EQ064	augmentative communication - Tracker 2000	7
EQ065	augmentative communication - VoicePal Max	7
EQ066	augmentative communication - WhitKit head support	7
EQ067	augmentative communication - auditory trainer	7
EQ068	balance assessment-retraining system (Balance Master)	5
EQ069	balance board	15
EQ070	barostat system, with hardware & software	5
EQ072	blood warmer	7

EQ073	body analysis machine, bioimpedence	10
EQ074	breast biopsy device w-system (Mammotome)	5
EQ075	breast biopsy imaging system, stereotactic (imager, table, software)	5
EQ077	caloric stimulator, air or water	7
EQ078	cardiac monitor w-treadmill (12-lead PC-based ECG)	10
EQ080	cast cart	10
EQ081	cast cutter	10
EQ082	cast vacuum	8
EQ083	catheter, multi-channel, with impedance sensors	3
EQ084	cell separator system	6
EQ085	cochlear implant programming system	7
EQ086	cochlear implant testing system	10
EQ087	cognitive abilities testing software (Woodcock Johnson)	5
EQ088	contrast media warmer	7
EQ089	stimulator, cortical bipolar-biphasic, w-output cable, stim/record switch	7
EQ091	cryo system, w-nerve stimulator, console, digital temp indicator & time	10
EQ092	cryostat	7
EQ093	cryosurgery equipment (for liquid nitrogen)	10
EQ094	cryosurgery system, non-ophthalmic	10
EQ095	cryosurgery system, ophthalmic	7
EQ096	cryosurgical probe, retina	7
EQ097	defibrillator	5
EQ098	dermabrader (Osada)	10
EQ099	dermatome, electric	10
EQ102	diathermy, short wave (AutoTherm 395)	10
EQ103	discogram pressure monitor	7
EQ104	doppler (fetal or vascular)	5
EQ105	dosimeter, aerosol provocation	10
EQ106	drill system, surgical, large (Stryker)	10
EQ107	drill system, surgical, small-micro (Stryker)	3
EQ109	dust extractor	8
EQ110	electrocautery-hyfrecator, up to 45 watts	10
EQ111	electroconvulsive therapy machine	5
EQ112	electromagnetic machine	10
EQ113	electrosurgical generator, gastrocautery	7
EQ114	electrosurgical generator, up to 120 watts	7
EQ115	electrosurgical system (w-smoke evac) (LEEP, Quantum)	7
EQ116	electrotherapy stimulator, high volt, 2 channel	7
EQ117	evaluation system for upper extremity-hand (Greenleaf)	5
EQ118	exercise equipment (treadmill, bike, stepper, UBE, pulleys, balance boa	15
EQ119	external fixation, craniofacial halo (BlueDevice)	4
EQ120	external fixation, mandible (Joe Hall Morris)	4
EQ121	fetal monitor	5
EQ123	food models	4

EQ124		stimulator, constant current, w-stimulating and grounding electrodes ((	20
EQ125		glucose continuous monitoring system	5
EQ126		holter analysys system	7
EQ127		holter monitor	5
EQ128		holter system with one recorder	7
EQ130		hydrocollator, hot	10
EQ131		hyperbaric chamber	15
EQ132		hysteroscopy ablation system	5
EQ133		immittance, middle-ear analyzer	10
EQ134		impedance meter, 32-channel	7
EQ135		impedance recording workstation w-software	5
EQ136		infrared coagulator (with hand applicator, includes lightguide)	10
EQ137		instrument pack, basic ($500-$1499)	4
EQ138		instrument pack, medium ($1500 and up)	4
EQ139		intercom (incl. master, pt substation, power, wiring)	10
EQ139-60	Yes	intercom (incl. master, pt substation, power, wiring)	10
EQ140		intra-compartmental pressure monitor device	7
EQ141		iontophoresis machine	8
EQ143		kit, ADL	10
EQ145		kit, aquatic exercise	10
EQ146		kit, capsule endoscopy recorder	10
EQ147		kit, ergonomic (office)	10
EQ148		kit, hand dexterity, sensory, strength	10
EQ149		kit, hand evaluation	10
EQ150		kit, laryngeal injector	3
EQ151		kit, motor coordination	10
EQ152		kit, sensory	10
EQ153		laser (gs, uro, obg, ge) (Indigo Optima)	5
EQ156		laser, CO2 (Star X)	5
EQ157		laser, YAG	5
EQ158		laser, argon (w-slit lamp adapter)	5
EQ159		laser, argon-kripton	5
EQ160		laser, endovascular ablation (ELVS)	5
EQ161		laser, excimer	5
EQ162		laser, photodynamic therapy	5
EQ163		laser, pulse dye	5
EQ164		lens set, fitting, low vision	10
EQ165		lens set, trial, full diameter, w-frame	10
EQ166		lensometer, auto	7
EQ167		light source, xenon	5
EQ168		light, exam	10
EQ169		light, external PDT, w-probe set (LumaCare)	5
EQ170		light, fiberoptic headlight w-source	5
EQ171		light, infra-red, ceiling mount	10

EQ172	light, infra-red, pole mount	10
EQ173	light, ultra-violet	10
EQ174	liposorber system	7
EQ175	lithotriptor, with C-arm (ESWL)	5
EQ176	loupes, standard, up to 3.5x	7
EQ177	loupes, surgical, prism, up to 8.0x	7
EQ178	magnetic stimulator hand coil (70-90mm)	10
EQ179	magnetic stimulator leg coil (110mm)	10
EQ180	magnetic stimulator system (BiStim)	10
EQ181	manometry system (computer, transducers, catheter)	5
EQ182	micropigmentation (tattoo) system	7
EQ183	microscope, operating	5
EQ184	nerve stimulator (eg, for nerve block)	7
EQ186	nocturnal penile tumescence monitor (Rigiscan Plus)	7
EQ187	nutrition therapy software (Nutritionist Pro)	5
EQ188	optical biometer (IOLMaster)	7
EQ189	otoscope-ophthalmoscope (wall unit)	10
EQ192	oxygen system, portable	8
EQ193	pH ambulatory recorder (Bravo)	5
EQ194	pH ambulatory recorder (Digitrapper)	5
EQ196	pH recording workstation w-software (Bravo)	5
EQ197	pH recording workstation w-software (Digitrapper)	5
EQ198	pacemaker follow-up system (incl software and hardware) (Paceart)	7
EQ200	paraffin bath, hand-foot (institutional)	7
EQ201	parallel bars, platform mounted	15
EQ202	percutaneous neuro test stimulator	7
EQ203	phototherapy UVB measuring device	10
EQ204	phototherapy unit, hand-foot, UVA-UVB	10
EQ205	phototherapy unit, whole body, UVA-UVB	10
EQ206	photopheresor system	6
EQ208	programmer, for implanted medication pump (spine), w-printer	7
EQ209	programmer, neurostimulator (w-printer)	7
EQ211	pulse oximeter w-printer	7
EQ212	pulse oxymetry recording software (prolonged monitoring)	5
EQ213	pump, water perfusion (for manometry)	7
EQ214	radiofrequency generator (NEURO)	5
EQ215	radiofrequency generator (vascular)	5
EQ216	radiofrequency generator, TUNA procedure	5
EQ217	radiusgauge	7
EQ218	range of motion (spinal) device and software (Myo-Logic)	5
EQ219	rehab and testing system (BTE primus)	5
EQ221	review master	5
EQ222	rhinomanometer system (w-transducers and software)	7
EQ223	saw, surgical, electric (Stryker)	10

EQ224	sensory integration equip (eg, ball pit, glider, trampoline, ramp)	15
EQ225	sensory integration equipment, suspension system	10
EQ228	sleep screening system, attended (w-resp plethysmography)	5
EQ230	slit lamp (Haag-Streit), dedicated to laser use	10
EQ231	stairs, ambulation training	15
EQ232	stereo trainer (wheatstone)	7
EQ233	strontium-90 applicator	5
EQ234	suction and pressure cabinet, ENT (SMR)	10
EQ235	suction machine (Gomco)	10
EQ236	telebinocular, ophthalmic	7
EQ237	tomographic device, optical coherence (OCT)	7
EQ239	topography unit, corneal (Magellan)	7
EQ240	tourniquet system (Zimmer1200)	7
EQ241	traction system (hi-low table, digital unit, accessories)	10
EQ243	treadmill	8
EQ244	tympanometer with printer	10
EQ245	ultrasonic biometry, A-scan	5
EQ246	ultrasonic biometry, A-scan, quantitative	5
EQ247	ultrasonic biometry, B-scan	5
EQ248	ultrasonic biometry, pachymeter	5
EQ249	ultrasound color doppler, transducers and vaginal probe	5
EQ250	ultrasound unit, portable	5
EQ251	ultrasound unit, therapeutic	7
EQ255	ultrasound, noninvasive bladder scanner w-cart	5
EQ257	urodynamics system, 4-channel	5
EQ258	urodynamics system, 6-channel, w-video	5
EQ259	uroflowmeter, digital, w-chair	7
EQ260	uterine thermal balloon ablation system (Thermachoice)	7
EQ261	vacuum cart and suction machine	5
EQ263	vasopneumatic compression system	10
EQ264	work samples, clerical comprehension (Valpar 5)	7
EQ265	work samples, fine finger dexterity (Valpar 204)	7
EQ266	work samples, physical capacity (Valpar 201)	7
EQ267	work samples, small tools (Valpar 1)	7
EQ268	cryoablation machine (Her Option)	3
EQ269	blood pressure monitor, ambulatory, w-battery charger	5
EQ271	radiuscope	7
EQ272	sleep diagnostic system, attended (w-acquisition station, review master	5
EQ273	catheter, solid state pressure, 6-channel, reusable (Medtronic)	7
EQ274	CEM, looping	5
EQ275	compressor, air	10
EQ276	delivery unit (Adec)	10
EQ277	ESWT machine	5
EQ278	handpiece, high speed (Kavo)	10

EQ279	handpiece, slow speed, (Midwest)	10
EQ280	light assembly, photopheresis	10
EQ281	motility function testing system, polygraf ID, 8-channel (Medtronic)	7
EQ282	PC projector	5
EQ284	reader software, CASCADE (Caldwell Labs)	5
EQ285	speakers, sound field	5
EQ286	system, phonatory function testing	5
EQ287	system, speech anaysis	5
EQ288	ultrasonic cleaning unit	10
EQ290	actigraphy, monitoring device	5
EQ291	Air Flow System	5
EQ292	Applicator Base Plate	5
EQ293	Arthroscopic Video Equipment	5
EQ294	BreathTrackerDigital SC Instrument, with support stand and patient sar	8
EQ295	camera mount-floor	15
EQ296	cardiac monitor w-treadmill (microvolt t-wave)	10
EQ297	CEM, system	5
EQ298	Coronary CTA Post Process Software	5
EQ299	cross-slide attachment	10
EQ300	cryoablation system, fibroadenoma	3
EQ301	cryoablation system, prostate (w-urethral warmer and US support (Gali	3
EQ302	cryosurgery system (for tumor ablation)	10
EQ303	dermal imaging software	5
EQ304	dermoscopy attachments	5
EQ305	Diabetes education data tracking software	5
EQ307	Electrophysiology, Pulmonary Vein Processing Software	5
EQ308	generator, spine, IDET, w-extension cable	5
EQ309	holter analysys system (w-workstation and back-end cost	5
EQ312	INR analysis and reporting system w-software	5
EQ313	insufflator, CO2, system	5
EQ315	Left Ventricular Function Software	5
EQ317	Monitoring Equipment	5
EQ318	monitoring system, nitric oxide, w-computer (Acerine, NIOX)	5
EQ319	nerve conduction monitoring system, testing device (automated)	7
EQ320	pacemaker interrogation, system	5
EQ321	programmer, VAD	5
EQ322	radiofrequency generator (Angiodynamics), liver RFA	5
EQ323	radiofrequency infusion pump (Angiodynamics)	5
EQ324	speakers, sound field (brainstem implant)	5
EQ325	strobe, 400 watts (Studio)(2)	10
EQ326	system, navigational bronchoscopy (superDimension)	5
EQ327	topography unit,	7
EQ329	ZEPHR impedance / pH reflux monitoring system with data recorder, so	5
EQ330	EEG, digital, testing system (computer hardware, software & camera)	7

EQ332	Renessa Generator	5
EQ333	Urgent PC Stimulator	7
EQ335	WatchPAT 200 Unit with strap, cables, charger, booklet and patient vide	5
EQ336	Oximetry and Airflow Device	5
EQ337	Respiratory Impedance Plethysmography Belts (pair)	5
EQ338	slit-lamp adapter	10
EQ339	manometry accessory cable	5
EQ340	Patient Worn Telemetry System	3
EQ341	Oscillometry	5
EQ343	Radioaerosol Administration System	5
EQ344	keratoconus contact lens fitting set	5
EQ349	Respiratory impedance Plethysmography Belts (pair) (Pediatric)	5
EQ351	Smoke Evacuator(tubing, covering, etc.) with stand	5
EQ352	Data receiver	5
EQ353	Pulse oximeter 920 M Plus	7
EQ354	radiofrequency kit for destruction by neurolytic agent	1
EQ355	optical endomicroscope processor unit system	5
EQ356	kit, probe, radiofrequency, XIi-enhanced RF probe (proxy for catheter, I	5
EQ357	esophageal bougies, set, reusable	5
EQ358	Sleep capnograph, polysomnography (pediatric)	5
EQ359	BIS monitoring system (bioimpedance spectroscopy)	5
EQ360	Ocular Response Analyzer	7
EQ361	Flexible dual-channeled EBUS bronchoscope, with radial probe	5
EQ362	HBOT air break breathing apparatus demand system (hoses, masks, per	15
EQ363	Block face milling machine	5
EQ364	Glass Knife Breaker	5
EQ365	Diamond Milling Tool	5
EQ366	Carbon Coater	5
EQ367	VNG Recording System	5
EQ368	MIST Therapy Cart	5
EQ369	radiofrequency generator, endoscopy	5
EQ371	Breast biopsy device (coil)	10
EQ372	MIST Therapy System	5
EQ373	Applicator (TPV - 200) / Kit	5
EQ374	radiofrequency generator (Gyrus ENT G3 workstation)	5
EQ375	Biopsy Guide	5
EQ376	Knee wedge/foot block system	10
EQ377	Supine Breast/Lung Board	10
EQ378	Hysteroscopic fluid management system	5
EQ379	Hysteroscopic Resection System (control unit, footpiece, handpiece, sh	5
EQ380	flow cytometry analytics software	5
EQ381	IV infusion pump, ambulatory	10
EQ383	reusable shaver blade, 2mm	5
EQ384	Microdebrider handpiece	10

EQ385		Microdebrider console	7
EQ386		Endocavitary US probe	5
EQ387		Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) Kit (less form	10
EQ388		Breast coil	5
EQ389		generator, water thermotherapy procedure	7
EQ390		mfERG and ffERG electrodiagnostic unit	7
EQ391		Contact lens electrode for mfERG and ffERG	7
EQ392		heart failure patient physiologic monitoring equipment package	5
EQ393		tumescent pump	10
EQ394		EEG, digital, prolonged testing system with remote video, for patients h	7
EQ395		Liposuction system	7
ER001		Cobalt-57 Flood Source (47cm dia) (10 mCi)	2
ER003		HDR Afterload System, Nucletron - Oldelft	7
ER005		IMRT CT-based simulator	5
ER006		IMRT physics tools	5
ER006-60	Yes	IMRT physics tools	5
ER012		barometer, aneroid	7
ER013		calibration (AAPM ADCL), ion chamber	5
ER014		chamber, Farmer-type	7
ER016		collimator, medium energy (set of 2)	7
ER019		densitometry unit, fan beam, DXA (w-computer hardward & software)	5
ER022		densitometry unit, peripheral, ultrasound	5
ER024		densitometry unit, whole body, DXA	5
ER025		densitometry unit, whole body, SPA	5
ER026		dose calibration source vial set (Cs137, Co57, and Ba137)	5
ER027		dose calibrator (Atomlab)	5
ER028		electrometer, PC-based, dual channel	5
ER030		film dosimetry equipment-software (RIT)	5
ER031		fluoroscopic system, mobile C-Arm	8
ER032		gamma camera system, single-dual head	5
ER033		gamma counter, automatic	7
ER034		hyperthermia system, RF-deep and microwave	5
ER035		hyperthermia system, ultrasound, external	5
ER036		hyperthermia system, ultrasound, intracavitary	5
ER037		intracavitary applicator set (tandem and ovoids)	4
ER038		isocentric beam alignment device	5
ER038-60	Yes	isocentric beam alignment device	5
ER039		laser targeting system (4 diodes)	5
ER039-60	Yes	laser targeting system (4 diodes)	5
ER040		laser, diode, for patient positioning (Probe)	5
ER040-60	Yes	laser, diode, for patient positioning (Probe)	5
ER041		microtome	7
ER043		microtome, ultra	7
ER044		nuclide rod source set	5

ER045		Superficial radiation therapy system	5
ER046		phantom, 3-D	10
ER047		phantom, QCT densitometry	10
ER050		phantom, solid water calibration check	10
ER051		phantom, water, includes remote motor drive	10
ER052		radiation L-block shield, 2in lead	10
ER053		radiation L-block tabletop shield	10
ER054		radiation survey meter	8
ER055		radiation therapy dosimetry software (Argus QC)	5
ER056		radiation treatment vault	15
ER056-60	Yes	radiation treatment vault	15
ER057		radiation virtual simulation system	5
ER057-60	Yes	radiation virtual simulation system	5
ER058		safe, storage, lead-lined	15
ER060		source, 10 Ci Ir 192	1
ER061		stepper, stabilizer, template (for brachytherapy treatment)	7
ER062		stirrups (for brachytherapy table)	10
ER063		thyroid uptake system	5
ER064		water bath, thermoplastic softener (20in x 12in)	7
ER065		water chiller (radiation treatment)	7
ER065-60	Yes	water chiller (radiation treatment)	7
ER066		well counter	7
ER068		x-ray, dental, intra-oral	5
ER069		x-ray, dental, panoramic	5
ER070		portal imaging system (w-PC work station and software)	5
ER071		x-ray, dental	5
ER072		64 Slice CT Scanner	5
ER072-90	Yes	64 Slice CT Scanner	5
ER073		Area Radiation Monitor	8
ER074		AV projection system (integrated headphone, video goggles, transducer	5
ER075		cardiac coil, 1.5T 8-channel (MR)	5
ER077		image-acquistion software and hardware (Brainwave RealTime, PA, Har	3
ER079		Power Injector for CT Contrast	5
ER081		Calcium Scoring Software	5
ER082		SRS system, Lincac	7
ER083		SRS system, SBRT, six systems, average	7
ER084		T&O Applicator Set	4
ER085		Vag Applicator Set	4
ER086		Ultrasound probe	5
ER087		Low light camera with zoom	5
ER088		Infrared illuminator	5
ER089		IMRT accelerator	7
ER089-60	Yes	IMRT accelerator	7
ER090		Computer system, record and verify, IMRT	5

ER090-60	Yes	Computer system, record and verify, IMRT	5
ER092		ultrasound unit, portable, breast procedures	5
ER094		endoscopic ultrasound processor	5
ER095		transnasal esophagoscope 80K series	5
ER096		linear detector array	5
ER097		gamma camera system, single-dual head SPECT CT	5
ER099		Video system, Ultrasound (processor, digital capture, monitor, printer,	5
ER101		Fibroscan with printer	3
ER103		DBT unit	5
ER108		Ultrasound Contrast Imaging Package	5
ER109		PET Generator Infusion Cart	10
ER110		PET Refurbished Imaging Cardiac Configuration	5
ER111		PET/CT Imaging Camera Cardiac Configuration	5
ER112		Software and hardware package for tumor and other distribution Quant	5
ES001		Albarran deflecting bridge, single channel	3
ES002		anoscope with light source	3
ES003		cart, endoscopy imaging equipment	10
ES004		colposcope	8
ES005		endoscope disinfector, rigid or fiberoptic, w-cart	7
ES006		endoscope forceps, biopsy	3
ES007		endoscope forceps, grasping	3
ES008		endoscope, rigid, cystoscopy	3
ES009		endoscope, rigid, hysteroscopy	3
ES010		endoscope, rigid, laryngoscopy	3
ES011		endoscope, rigid, otology	7
ES012		endoscope, rigid, sigmoidoscopy	3
ES013		endoscope, rigid, sinoscopy	7
ES014		endoscope, ultrasound probe, balloon sheath	5
ES017		fiberscope, flexible, bronchoscopy	3
ES018		fiberscope, flexible, cystoscopy	3
ES019		fiberscope, flexible, cystoscopy, with light source	3
ES020		fiberscope, flexible, rhinolaryngoscopy	3
ES022		fiberscope, flexible, ureteroscopy	3
ES023		resectoscope, continuous flow	3
ES024		urethrotome, Otis	4
ES025		urethrotome, optical	3
ES026		video add-on camera system w-monitor (endoscopy)	5
ES027		video system, FEES (scope, camera, light source, image capture, monito	5
ES028		video system, FEESST (scope, sensory stimulator, camera, light source, i	5
ES029		video system, capsule endoscopy (software, computer, monitor, printer	5
ES031		scope video system (monitor, processor, digital capture, cart, printer, LI	5
ES034		videoscope, gastroscopy	3
ES037		Forcepts, Landolt bipolar coagulation	5
ES039		endoscope, rigid, sinoscopy (SECOND SCOPE)	7

ES040	PROXY endoscope, rigid, sinoscopy (0 degrees)	7
ES041	PROXY endoscope, rigid, sinoscopy (30 degrees)	7
ES042	PROXY endoscope, rigid, sinoscopy (70 degrees)	7
ES043	Video Sigmoidoscope	7
ES047	IVUS system	5
ES048	femtosecond laser	5
ES049	incision programming software	5
ES052	brachytherapy treatment vault	5
ES056	reflectance confocal imaging system	5
ES057	environmental module - bathroom	10
ES058	kit, vision	10
ES065	stroboscopy system	5
ES075	rigid scope, laryngoscopy	3
ES076	rigid scope, colposcopy	8
ES080	non-channeled flexible digital scope, laryngoscopy	3
ES084	channeled flexible digital scope, laryngoscopy	3
ES085	multi-channeled flexible digital scope, flexible sigmoidoscopy	7
ES086	multi-channeled flexible digital scope, colonoscopy	3
ES088	multi-channeled flexible digital scope, esophagoscopy	3
ES092	non-video flexible scope, laryngoscopy	3

Price	Utilization Rate	Minutes Per Year	Cost Per Minute
1,106.50	0.5	150000	0.00438417
549.33	0.5	150000	0.002176547
549.33	0.6	150000	0.001813789
4,589.08	0.5	150000	0.018182839
82,000.00	0.5	150000	0.31069957
36,175.54	0.5	150000	0.1401848
7,100.00	0.5	150000	0.028131593
163,593.00	0.5	150000	0.61985701
163,950.60	0.5	150000	0.621211967
62,964.86	0.5	150000	0.238575077
242,241.02	0.5	150000	0.917855873
193,491.99	0.5	150000	0.73314485
96,810.97	0.5	150000	0.366818615
55,097.00	0.5	150000	0.208763588
13,400.00	0.5	150000	0.05309343
1,916.67	0.5	150000	0.007594209
12,398.34	0.5	150000	0.049124642
1,106.63	0.5	150000	0.004384665
273,896.00	0.5	150000	1.037797189
1,250.00	0.5	150000	0.004952745
1,000.00	0.5	150000	0.003962196
1,000.00	0.6	150000	0.00330183
3,613.16	0.5	150000	0.016792384
3,613.16	0.6	150000	0.013993653
2,386.00	0.5	150000	0.0094538
1,506.00	0.5	150000	0.008725516
950.00	0.5	150000	0.003764086
144,912.00	0.5	150000	0.549074343
1,000.00	0.5	150000	0.002653727
1,000.00	0.5	150000	0.003962196
1,000.00	0.5	150000	0.003962196
696.00	0.5	150000	0.002757689
	0.5	150000	0
774.89	0.5	150000	0.003070266
5,557.00	0.5	150000	0.022017924
13,035.00	0.5	150000	0.051647228
3,511.43	0.5	150000	0.013912961
15,042.30	0.5	150000	0.059600546
106,252.13	0.5	150000	0.402591355
12,031.52	0.5	150000	0.047671243

43,308.12	0.5	150000	0.167824472
9,600.00	0.5	150000	0.038037084
1,150.00	0.5	150000	0.003051785
10,390.71	0.5	150000	0.025311073
2,416.99	0.5	150000	0.005887627
677.83	0.5	150000	0.001798775
1,785.64	0.5	150000	0.004738612
2,538.00	0.5	150000	0.006735158
4,617.86	0.5	150000	0.012254536
5,322.51	0.5	150000	0.011839361
1,542.81	0.5	150000	0.004094183
5,026.81	0.5	150000	0.013339771
1,839.34	0.5	150000	0.004881092
6,018.45	0.5	150000	0.01597132
4,296.33	0.5	150000	0.011401285
2,872.90	0.5	150000	0.006390458
526.78	0.5	150000	0.001171771
1,729.56	0.5	150000	0.004589787
1,279.41	0.5	150000	0.002845912
5,005.01	0.5	150000	0.013281929
4,785.82	0.5	150000	0.012700263
2,414.00	0.5	150000	0.006406096
28,900.00	0.5	150000	0.061574195
3,037.95	0.5	150000	0.006757594
173,701.47	0.5	150000	0.354264749
15,401.09	0.5	150000	0.034258087
582.96	0.5	150000	0.001296739
8,186.01	0.5	150000	0.018208911
7,260.46	0.5	150000	0.016150129
895.00	0.5	150000	0.001990833
6,030.20	0.5	150000	0.016002488
14,000.37	0.5	150000	0.03114233
3,672.05	0.5	150000	0.008168085
7,190.83	0.5	150000	0.01599523
15,576.03	0.5	150000	0.041334524
4,421.95	0.5	150000	0.011734646
8,696.83	0.5	150000	0.019345173
3,198.95	0.5	150000	0.008489129
2,309.82	0.5	150000	0.006129636
1,329.17	0.5	150000	0.003527263
4,189.03	0.5	150000	0.011116537
5,761.55	0.5	150000	0.015289573
33,750.00	0.5	150000	0.071907581
56,250.00	0.5	150000	0.114722073

22,500.00	0.5	150000	0.050048863
32,757.19	0.5	150000	0.102880813
37,169.01	0.5	150000	0.116737051
36,070.76	0.5	150000	0.11328779
1,356,983.76	0.5	150000	5.141637433
1,356,983.76	0.9	150000	2.85646524
1,582,006.75	0.5	150000	5.994253874
1,582,006.75	0.9	150000	3.330141041
1,290,120.61	0.5	150000	4.888291679
186,983.19	0.5	150000	0.70848287
168,214.00	0.5	150000	0.637366067
522,917.63	0.5	150000	1.981344913
383,397.77	0.5	150000	1.452701507
470,912.44	0.5	150000	1.784296253
151,200.00	0.5	150000	0.572899695
3,660.00	0.5	150000	0.014501638
285,000.00	0.5	150000	1.079870458
1,302.18	0.5	150000	0.005159489
15,000.00	0.5	150000	0.059432944
35,000.00	0.5	150000	0.135629451
12,500.00	0.5	150000	0.049527453
3,000.00	0.5	150000	0.011886589
1,000.00	0.5	150000	0.003962196
2,250.00	0.5	150000	0.008914942
200,684.50	0.9	150000	0.422443007
204,214.45	0.5	150000	0.62390241
4,135.23	0.5	150000	0.010973776
889.25	0.5	150000	0.002870172
36,774.23	0.5	150000	0.142504806
4,593.87	0.5	150000	0.014827315
81,812.84	0.5	150000	0.249949168
3,400.00	0.5	150000	0.010973949
672.73	0.5	150000	0.002665488
155,925.00	0.5	150000	0.590802811
22,712.16	0.5	150000	0.045985228
8,460.46	0.5	150000	0.022451743
5,172.20	0.5	150000	0.011505017
3,567.06	0.5	150000	0.007934556
4,524.64	0.5	150000	0.012007169
1,201.35	0.5	150000	0.003188052
5,842.99	0.5	150000	0.015505697
3,806.44	0.5	150000	0.012285788
9,965.80	0.5	150000	0.032165929
396,128.08	0.5	150000	1.210224206

47,807.32	0.5	150000	0.150148902
1,109.25	0.5	150000	0.002943637
2,035.63	0.5	150000	0.005401996
2,315.00	0.5	150000	0.006143377
1,520.00	0.5	150000	0.004033664
37,752.00	0.5	150000	0.118568069
962.50	0.5	150000	0.002554212
21,788.80	0.5	150000	0.070326241
25,227.20	0.5	150000	0.079231315
8,507.80	0.5	150000	0.027460062
17,273.86	0.5	150000	0.055753656
10,595.34	0.5	150000	0.031646819
54,763.03	0.5	150000	0.167308364
1,840.00	0.5	150000	0.005938843
821.62	0.5	150000	0.002651874
7,715.00	0.5	150000	0.024901171
5,383.50	0.5	150000	0.017375957
46,986.50	0.5	150000	0.147570951
2,667.38	0.5	150000	0.008609324
5,629.77	0.5	150000	0.014939863
113,671.50	0.5	150000	0.43070349
496.80	0.5	150000	0.001603471
1,000.00	0.5	150000	0.002653727
38,000.00	0.5	150000	0.119346965
1,843.54	0.5	150000	0.005950253
2,900.00	0.5	150000	0.007695807
662.00	0.5	150000	0.001756767
832.00	0.5	150000	0.00268539
810.00	0.5	150000	0.002149518
7,440.48	0.5	150000	0.01974501
12,042.50	0.5	150000	0.031957491
510.00	0.5	150000	0.00202072
1,232.96	0.5	150000	0.003271933
1,389.00	0.5	150000	0.003686026
7,000.00	0.5	150000	0.018576086
1,149.00	0.5	150000	0.003049132
5,301.27	0.5	150000	0.01406813
3,625.00	0.5	150000	0.009619759
610.00	0.5	150000	0.001618773
760.00	0.5	150000	0.002016832
639.00	0.5	150000	0.001695731
540.00	0.5	150000	0.001433012
1,350.00	0.5	150000	0.004032266
3,777.00	0.5	150000	0.010023125

3,006.00	0.5	150000	0.009702262
9,296.00	0.5	150000	0.030004067
987.00	0.5	150000	0.002619228
4,803.97	0.5	150000	0.012748409
169,401.59	0.5	150000	0.517544497
5,400.86	0.5	150000	0.017431982
8,051.20	0.5	150000	0.031900434
50,000.00	0.5	150000	0.189450957
201,597.00	0.5	150000	0.615905763
19,864.15	0.5	150000	0.078705662
5,458.00	0.5	150000	0.021625667
8,198.11	0.5	150000	0.021755543
15,261.01	0.5	150000	0.06046712
137,520.30	0.5	150000	0.521067031
756.14	0.5	150000	0.002995957
13,119.00	0.5	150000	0.042343304
56,287.73	0.5	150000	0.171966537
5,180.00	0.5	150000	0.016719134
1,195.00	0.5	150000	0.003171203
14,700.00	0.5	150000	0.058244285
2,350.00	0.5	150000	0.007584935
8,649.43	0.5	150000	0.027917177
23,470.71	0.5	150000	0.075754817
86,334.50	0.5	150000	0.26376343
4,546.40	0.5	150000	0.014674109
6,039.20	0.5	150000	0.01949233
2,167.33	0.5	150000	0.006995355
16,869.24	0.5	150000	0.054447688
5,671.00	0.5	150000	0.018303901
17,403.92	0.5	150000	0.06895773
1,506.00	0.5	150000	0.004860814
2,843.45	0.5	150000	0.009177599
3,730.75	0.5	150000	0.012041488
105,745.38	0.25	150000	0.801342502
82,000.00	0.5	150000	0.31069957
17,500.00	0.5	150000	0.05648356
12,500.00	0.5	150000	0.0403454
7,950.00	0.5	150000	0.03149946
46,750.00	0.5	150000	0.146828174
21,000.00	0.5	150000	0.067780272
33,389.29	0.5	150000	0.104866068
11,750.00	0.5	150000	0.035095646
16,188.00	0.5	150000	0.052248907
18,034.37	0.5	150000	0.053866195

20,372.42	0.5	150000	0.054062836
40,926.41	0.5	150000	0.104977602
26,715.50	0.5	150000	0.10352596
33,500.00	0.5	150000	0.105213771
626.50	0.5	150000	0.002022111
27,608.93	0.5	150000	0.086711627
28,625.00	0.5	150000	0.110925515
1,317.50	0.5	150000	0.006123169
2,411.77	0.5	150000	0.006400186
12,241.34	0.5	150000	0.039510549
28,000.00	0.5	150000	0.108503561
540.00	0.5	150000	0.001742921
29,995.00	0.5	150000	0.094205584
2,003.25	0.5	150000	0.00793727
44,681.00	0.5	150000	0.129555695
48,462.32	0.5	150000	0.140519899
55,948.63	0.5	150000	0.157428965
26,875.00	0.5	150000	0.077925948
38,741.51	0.5	150000	0.112333721
575.00	0.5	150000	0.001400662
60,000.00	0.5	150000	0.183308014
6,146.00	0.5	150000	0.016309803
36,000.00	0.5	150000	0.07670142
29,448.25	0.5	150000	0.092488403
15,087.61	0.5	150000	0.048697253
8,035.49	0.5	150000	0.021323985
32,659.81	0.5	150000	0.069584821
1,910.00	0.5	150000	0.006164777
699.95	0.5	150000	0.002259181
604.00	0.5	150000	0.00194949
7,295.00	0.5	150000	0.023545576
765.00	0.5	150000	0.002469138
695.00	0.5	150000	0.002243204
1,695.00	0.5	150000	0.005470836
560.00	0.5	150000	0.001807474
645.00	0.5	150000	0.002081823
1,795.00	0.5	150000	0.005793599
555.00	0.5	150000	0.001791336
1,400.00	0.5	150000	0.004518685
1,776.25	0.5	150000	0.005733081
16,657.46	0.5	150000	0.066000131
1,414.80	0.5	150000	0.003147079
23,625.00	0.5	150000	0.093606886
5,321.51	0.5	150000	0.017175884

4,978.94	0.5	150000	0.013212752
29,862.00	0.5	150000	0.115719047
206,222.78	0.5	150000	0.781382043
6,686.75	0.5	150000	0.021582373
18,913.14	0.5	150000	0.050190301
3,271.45	0.5	150000	0.008681523
1,160.62	0.5	150000	0.003079968
1,529.28	0.5	150000	0.004567752
13,465.00	0.5	150000	0.078013989
80,828.20	0.5	150000	0.269620182
9,000.00	0.5	150000	0.029048688
9,500.00	0.5	150000	0.025210402
558.00	0.5	150000	0.002210906
552.00	0.5	150000	0.001781653
4,237.00	0.5	150000	0.013675477
14,995.00	0.5	150000	0.039792629
22,468.56	0.5	150000	0.072520229
2,394.30	0.5	150000	0.006353817
1,607.50	0.5	150000	0.004265865
7,746.47	0.5	150000	0.025002764
2,652.83	0.5	150000	0.00856237
2,394.30	0.5	150000	0.009486669
8,906.20	0.5	150000	0.023634612
9,543.26	0.5	150000	0.025325194
8,185.00	0.5	150000	0.021720752
600.00	0.5	150000	0.001936579
704.78	0.5	150000	0.002792487
1,795.00	0.5	150000	0.004763439
11,824.63	0.5	150000	0.031379322
7,970.04	0.5	150000	0.046177097
500.00	0.5	150000	0.001493432
906.29	0.5	150000	0.002405046
16,609.07	0.5	150000	0.065808405
25,000.00	0.5	150000	0.066343163
11,375.00	0.5	150000	0.036714314
3,697.71	0.5	150000	0.011934847
15,573.21	0.5	150000	0.050264596
1,950.88	0.5	150000	0.006296707
17,495.00	0.5	150000	0.069318623
12,710.00	0.5	150000	0.028272047
5,146.00	0.5	150000	0.023916379
4,508.00	0.5	150000	0.020951231
5,829.28	0.5	150000	0.023096755
700.00	0.5	150000	0.003253297

888.00	0.5	150000	0.00179793
1,010.27	0.5	150000	0.004002888
8,816.00	0.5	150000	0.028454804
1,798.74	0.5	150000	0.007126963
9,670.45	0.5	150000	0.031212654
1,514.86	0.5	150000	0.004020032
120,633.73	0.5	150000	0.246032908
18,282.63	0.5	150000	0.072439348
7,096.27	0.5	150000	0.018831556
1,120.00	0.5	150000	0.003614948
56,695.60	0.5	150000	0.214820706
3,659.50	0.5	150000	0.009711312
500.00	0.5	150000	0.002323783
1,500.00	0.5	150000	0.00697135
1,630.00	0.5	150000	0.004325574
1,630.00	0.6	150000	0.003604645
1,737.00	0.5	150000	0.005606397
995.00	0.5	150000	0.002971929
586.50	0.5	150000	0.001556411
500.00	0.5	150000	0.001326863
14,117.72	0.5	150000	0.037464569
2,285.48	0.5	150000	0.006065039
1,561.40	0.5	150000	0.004143529
617.65	0.5	150000	0.001639074
1,032.00	0.5	150000	0.005979238
643.75	0.5	150000	0.001708336
677.35	0.5	150000	0.001797502
59,890.00	0.5	150000	0.226924357
69,058.97	0.5	150000	0.261665765
32,595.83	0.5	150000	0.126313
32,900.00	0.5	150000	0.127491684
85,000.00	0.5	150000	0.322066628
53,469.41	0.5	150000	0.202596626
157,790.00	0.5	150000	0.597869332
35,935.19	0.5	150000	0.139253433
78,500.00	0.5	150000	0.297438003
4,750.00	0.5	150000	0.012605201
904.93	0.5	150000	0.002401437
4,672.33	0.5	150000	0.015080567
9,615.29	0.5	150000	0.038097674
1,431.50	0.5	150000	0.003798819
8,810.00	0.5	150000	0.034906949
3,014.93	0.5	150000	0.01194575
555.00	0.5	150000	0.001472818

1,536.63	0.5	150000	0.004077783
1,468.96	0.5	150000	0.003898223
7,800.00	0.5	150000	0.02517553
525,971.25	0.5	150000	1.992915138
1,220.81	0.5	150000	0.003940317
1,177.50	0.5	150000	0.003800532
2,950.00	0.5	150000	0.007828493
4,600.00	0.5	150000	0.012207142
42,057.71	0.5	150000	0.107879436
52,898.46	0.5	150000	0.200433285
3,584.75	0.5	150000	0.011570254
7,047.50	0.5	150000	0.027923578
572.30	0.5	150000	0.001847174
9,000.00	0.5	150000	0.029048688
595.00	0.5	150000	0.002357507
30,498.72	0.5	150000	0.095787607
656.05	0.5	150000	0.001740968
569.89	0.5	150000	0.001702184
7,072.75	0.5	150000	0.028023616
6,600.00	0.5	150000	0.026150495
11,490.00	0.5	150000	0.045525635
11,490.00	0.5	150000	0.045525635
151,480.08	0.5	150000	0.462791892
2,406.50	0.5	150000	0.007767296
1,635.31	0.5	150000	0.00363758
1,583.76	0.5	150000	0.005111809
690.00	0.5	150000	0.001831071
1,675.00	0.5	150000	0.004444992
17,931.25	0.5	150000	0.047584634
78,864.29	0.5	150000	0.263069118
1,975.00	0.5	150000	0.006374573
1,975.00	0.5	150000	0.006374573
1,641.54	0.5	150000	0.005298287
688.50	0.5	150000	0.002727972
7,307.00	0.5	150000	0.023584307
35,136.50	0.5	150000	0.136158406
31,186.50	0.5	150000	0.120851653
33,035.97	0.5	150000	0.128018598
1,234.00	0.5	150000	0.003982898
21,819.46	0.5	150000	0.086452992
45,820.00	0.5	150000	0.177558327
5,000.00	0.5	150000	0.019810981
16,256.62	0.5	150000	0.052470387
6,511.50	0.5	150000	0.017279734

3,600.00	0.5	150000	0.008007818
2,500.00	0.5	150000	0.006634316
22,000.00	0.5	150000	0.087168317
12,125.48	0.5	150000	0.032177717
1,955.00	0.5	150000	0.004348688
550.00	0.5	150000	0.001775198
7,797.06	0.5	150000	0.030893462
3,853.62	0.5	150000	0.010226444
767.48	0.5	150000	0.002036677
1,014.33	0.5	150000	0.003273884
79,959.03	0.5	150000	0.244285509
34,082.69	0.5	150000	0.107043824
9,528.32	0.5	150000	0.03075392
5,654.83	0.5	150000	0.015006372
4,653.45	0.5	150000	0.01389922
5,559.64	0.5	150000	0.014753756
21,799.81	0.5	150000	0.086375109
28,183.67	0.5	150000	0.109215307
13,937.08	0.5	150000	0.05522146
4,213.00	0.5	150000	0.016692733
138,856.41	0.5	150000	0.526129591
35,805.77	0.5	150000	0.138751899
3,555.52	0.5	150000	0.011475912
12,117.77	0.5	150000	0.048012985
45,291.52	0.5	150000	0.175510409
88,397.43	0.5	150000	0.33493954
4,094.08	0.5	150000	0.013214198
8,500.00	0.5	150000	0.027434872
722.80	0.5	150000	0.002863875
1,427.45	0.5	150000	0.003788053
2,680.00	0.5	150000	0.008650054
725.00	0.5	150000	0.002340033
725.00	0.5	150000	0.002340033
1,063.10	0.5	150000	0.003431296
120,480.00	0.5	150000	0.675738706
1,692.48	0.5	150000	0.006705938
1,595.00	0.5	150000	0.005148073
46,799.00	0.5	150000	0.181352076
12,800.00	0.5	150000	0.04131369
995.00	0.5	525600	0.00112511
5,332.50	0.5	150000	0.014150997
5,292.61	0.5	150000	0.014045145
437,500.00	0.5	150000	1.657695878
738.25	0.5	150000	0.001959102

817.32	0.5	150000	0.002168949
1,748.00	0.5	150000	0.004638714
30,190.00	0.5	150000	0.094818023
3,666.95	0.5	150000	0.014529193
3,485.37	0.5	150000	0.013809702
1,775.00	0.5	150000	0.007032898
7,000.00	0.5	150000	0.027735374
20,360.68	0.5	150000	0.080673
895.00	0.5	150000	0.002375085
1,599.00	0.5	150000	0.006335552
1,100.00	0.5	150000	0.004358416
4,382.00	0.5	150000	0.017362344
41,757.00	0.5	150000	0.161813685
13,726.38	0.5	150000	0.040998823
2,300.00	0.5	150000	0.005116106
41,680.00	0.5	150000	0.106910591
209,117.00	0.5	150000	0.792348317
65,000.00	0.5	150000	0.246286245
500.00	0.5	150000	0.001326863
24,950.00	0.5	150000	0.144556184
215,000.00	0.5	150000	1.205875014
42,486.55	0.5	150000	0.108979429
4,500.00	0.5	150000	0.017829883
650.00	0.5	150000	0.002575428
500.00	0.5	150000	0.001981098
91,516.00	0.5	150000	0.346755894
28,299.00	0.5	150000	0.109662224
26,044.01	0.5	150000	0.100923839
20,205.00	0.5	150000	0.080056175
7,472.05	0.5	150000	0.029605709
45,000.00	0.5	150000	0.174380723
126,000.00	0.5	150000	0.477416413
39,200.00	0.5	150000	0.151904985
3,005.00	0.5	150000	0.009699034
123,250.00	0.5	150000	0.46699661
20,835.98	0.5	150000	0.082556242
90,748.05	0.5	150000	0.343846099
5,995.00	0.5	150000	0.023753366
1,775.00	0.5	150000	0.007032898
1,500.00	0.5	150000	0.00398059
180,606.69	0.5	150000	0.684322194
41,468.61	0.5	150000	0.130240866
22,250.00	0.5	150000	0.088158866
42,597.91	0.5	150000	0.133787679

9,995.00	0.5	150000	0.039602151
1,500.00	0.5	150000	0.004841448
1,237.50	0.5	150000	0.004903218
1,195.00	0.5	150000	0.004734825
278.50	0.5	150000	0.001103472
820.00	0.5	150000	0.002176056
1,500.00	0.5	150000	0.005943294
23,515.50	0.5	525600	0.038882685
18,952.50	0.5	150000	0.075093524
1,591.63	0.5	150000	0.006306331
899.00	0.5	150000	0.003562014
199.75	0.5	150000	0.000791449
1,895.87	0.5	150000	0.007511809
20,000.00	0.5	525600	0.022615275
3,005.40	0.5	150000	0.009700328
2,695.00	0.5	150000	0.040425
	0.5	150000	0
2,695.00	0.5	150000	0.010678119
	0.5	150000	0
4,308.82	0.5	150000	0.017072388
4,996.53	0.5	150000	0.019797232
12,000.00	0.5	150000	0.038731584
160,260.00	0.5	150000	0.607228209
986.00	0.5	150000	0.002193252
18,139.00	0.5	150000	0.071870278
9,585.14	0.5	150000	0.037978206
1,714.00	0.5	150000	0.006791204
22,540.08	0.5	150000	0.08930822
29,607.50	0.5	150000	0.114732828
1,250.00	0.5	150000	0.004952745
72,832.34	0.5	150000	0.275963112
12,238.00	0.5	150000	0.032476305
28,028.77	0.5	150000	0.108615031
9,770.00	0.5	150000	0.038710657
14,976.28	0.5	150000	0.059338972
7,000.00	0.5	150000	0.027735374
6,218.39	0.5	150000	0.016501917
5,773.15	0.5	150000	0.015320361
12,992.22	0.5	150000	0.051477707
19,772.25	0.5	150000	0.078341535
20,400.00	0.5	150000	0.080828803
2,920.48	0.5	525600	0.002211799
790.00	0.5	150000	0.003130135
4,760.00	0.5	150000	0.012631738

9,034.00	0.5	150000	0.029158428
16,146.00	0.5	150000	0.06397362
971.30	0.5	150000	0.002577565
83,200.00	0.5	150000	0.315246393
27,538.00	0.5	150000	0.086488861
102,400.00	0.5	150000	0.312845678
1,440.00	0.5	150000	0.00464779
1,000.00	0.5	525600	0.001130764
1,750.00	0.5	150000	0.004644021
26,410.95	0.5	150000	0.082949124
22,039.05	0.5	150000	0.071133943
2,113.00	0.5	150000	0.017099177
253,787.39	0.5	150000	0.775354376
975,000.00	0.5	150000	3.69429367
78,600.00	0.5	150000	0.297816905
78,600.00	0.6	150000	0.248180754
587.50	0.5	150000	0.001896234
500.00	0.5	150000	0.001981098
1,765.32	0.5	150000	0.005697787
14,000.00	0.5	150000	0.045186848
73,226.12	0.5	150000	0.277455169
7,266.38	0.5	150000	0.028790839
52,032.38	0.5	150000	0.197151696
17,500.00	0.5	150000	0.069338434
1,159.00	0.5	150000	0.004592185
7,240.28	0.5	150000	0.02868742
9,600.45	0.5	150000	0.038038875
30,840.00	0.5	150000	0.119508922
108,692.19	0.5	150000	0.305839442
565,000.00	0.5	150000	2.140795819
24,119.56	0.5	150000	0.077849064
790,353.00	0.5	150000	2.994662652
360,000.00	0.5	150000	1.364046894
250,000.00	0.5	150000	0.947254787
10,321.50	0.5	150000	0.047969861
995.00	0.5	150000	0.003942385
995.00	0.6	150000	0.003285321
7,476.67	0.5	150000	0.02962402
7,476.67	0.6	150000	0.024686683
47,819.67	0.5	150000	0.185307289
47,819.67	0.6	150000	0.154422741
15,295.02	0.5	150000	0.049366687
34,091.06	0.5	150000	0.107070119
1,783.17	0.5	150000	0.007065256

208,937.50	0.5	150000	0.791668188
2,793.17	0.5	150000	0.0074123
5,100.67	0.5	150000	0.013535774
7,608.18	0.5	150000	0.020190029
40,402.77	0.5	150000	0.103634461
3,854.91	0.5	150000	0.010229884
725.00	0.5	150000	0.001923952
1,023.25	0.5	150000	0.003056293
21,000.00	0.5	150000	0.083206121
773,104.00	0.6	150000	1.313956941
773,104.00	0.6	150000	1.313956941
784,312.44	0.5	150000	2.97177486
784,312.44	0.6	150000	2.47647905
8,387.50	0.5	150000	0.018657104
45,326.00	0.5	150000	0.673846533
18,550.00	0.5	150000	0.059872574
5,494.34	0.5	150000	0.014580484
15,903.57	0.5	150000	0.063013073
1,250.81	0.5	150000	0.004037154
17,751.67	0.6	150000	0.047746539
17,751.67	0.6	150000	0.047746539
3,450.00	0.5	150000	0.01113533
4,128.57	0.5	150000	0.016358185
24,405.00	0.5	150000	0.096697399
489,940.00	0.5	150000	1.856392042
104,005.45	0.5	150000	0.394078657
1,262,991.79	0.5	150000	4.785500089
1,262,991.79	0.9	150000	2.65861116
4,408.98	0.5	150000	0.013169011
49,679.10	0.5	150000	0.192512842
48,580.00	0.5	150000	0.188253678
108,807.00	0.5	150000	0.610268105
42,254.56	0.5	150000	0.163741778
55,000.00	0.5	150000	0.208396053
4,272,550.00	0.5	150000	13.05321095
3,486,860.92	0.5	150000	10.65282586
57,652.00	0.5	150000	0.257738636
27,553.00	0.5	150000	0.125605949
0.00	0.5	150000	0
5,945.00	0.5	150000	0.023555257
0.00	0.5	150000	0
2,821,374.73	0.5	150000	8.619676675
2,821,374.73	0.6	150000	7.183063896
153,980.44	0.5	150000	0.58343484

153,980.44	0.6	150000	0.4861957
37,618.14	0.5	150000	0.145775063
65,973.36	0.5	150000	0.249974319
0.00	0.5	150000	0
48,268.75	0.5	150000	0.187047533
464,428.95	0.5	150000	1.759730198
13,379.57	0.5	150000	0.053012482
148,080.15	0.5	150000	0.830540221
383,932.37	0.5	150000	1.454727109
3,254.13	0.5	150000	0.012893482
47,052.80	0.5	150000	0.120692002
425,000.00	0.9	150000	0.894629521
1,232,226.44	0.9	150000	2.593849765
40,535.75	0.5	150000	0.157081186
988.00	0.5	150000	0.005724309
10,075.71	0.5	150000	0.058377002
3,715.25	0.5	150000	0.009859257
9,692.02	0.5	150000	0.028948747
30,638.65	0.5	150000	0.096227093
1,243.33	0.5	150000	0.007203649
745.67	0.5	150000	0.004320289
5,780.21	0.5	150000	0.033489583
6,295.62	0.5	150000	0.036475761
3,178.08	0.5	150000	0.018413248
3,675.84	0.5	150000	0.011864265
841.38	0.5	150000	0.004874817
3,240.90	0.5	150000	0.010460428
5,680.40	0.5	150000	0.02250686
15,790.72	0.5	150000	0.091488818
7,203.51	0.5	150000	0.041735975
9,082.50	0.5	150000	0.052622507
5,572.07	0.5	150000	0.032283675
14,350.05	0.5	150000	0.083141814
8,474.90	0.5	150000	0.049102155
1,697.50	0.5	150000	0.007889245
1,881.00	0.5	150000	0.010898204
9,514.13	0.5	150000	0.037696856
21,675.00	0.5	150000	0.085880603
25,420.25	0.5	150000	0.098506717
10,937.70	0.5	150000	0.043337304
36,306.00	0.5	150000	0.140690367
27,582.01	0.5	150000	0.157245269
	0.5	150000	0
2,414.17	0.5	150000	0.007792052

2,414.17	0.5	150000	0.007792052
2,414.17	0.5	150000	0.007792052
2,414.17	0.5	150000	0.007792052
19,308.56	0.5	150000	0.062320914
125,398.65	0.5	150000	0.475137873
293,000.00	0.5	150000	1.110182611
10,012.50	0.5	150000	0.03967149
184,057.13	0.5	150000	0.697395971
240,939.85	0.5	150000	0.912925713
25,000.00	0.5	150000	0.066343163
410.00	0.5	150000	0.001088028
17,950.28	0.5	150000	0.071122516
3,966.08	0.5	150000	0.022978813
14,500.00	0.5	150000	0.04330952
21,485.51	0.5	150000	0.124483501
18,694.39	0.5	150000	0.108312212
17,360.00	0.5	150000	0.056031692
38,058.81	0.5	150000	0.216973632
34,585.35	0.5	150000	0.197171404
5,078.04	0.5	150000	0.029421326

Codes Impacted by CMS 90 % Utilization Rate Assumption		Codes Imp
CPT Code	Description	CPT Code
70336	Mri, temporomandibular joint(s)	G6003
70450	Ct head/brain w/o dye	G6004
70460	Ct head/brain w/ dye	G6005
70470	Ct head/brain w/o & w/ dye	G6006
70480	Ct orbit/ear/fossa w/o dye	G6007
70481	Ct orbit/ear/fossa w/ dye	G6008
70482	Ct orbit/ear/fossa w/o & w/ dye	G6009
70486	Ct maxillofacial w/o dye	G6010
70487	Ct maxillofacial w/ dye	G6011
70488	Ct maxillofacial w/o & w/ dye	G6012
70490	Ct soft tissue neck w/o dye	G6013
70491	Ct soft tissue neck w/ dye	G6014
70492	Ct soft tissue neck w/o & w/ dye	G6015
70496	Ct angiography, head	
70498	Ct angiography, neck	
70540	Mri orbit/face/neck w/o dye	
70542	Mri orbit/face/neck w/ dye	
70543	Mri orbit/face/neck w/o & w/dye	
70544	Mr angiography head w/o dye	
70545	Mr angiography head w/dye	
70546	Mr angiography head w/o & w/dye	
70547	Mr angiography neck w/o dye	
70548	Mr angiography neck w/dye	
70549	Mr angiography neck w/o & w/dye	
70551	Mri brain w/o dye	
70552	Mri brain w/dye	
70553	Mri brain w/o & w/dye	
70554	Fmri brain by tech	
71250	Ct thorax w/o dye	
71260	Ct thorax w/ dye	
71270	Ct thorax w/o & w/ dye	
71275	Ct angiography, chest	
71550	Mri chest w/o dye	
71551	Mri chest w/ dye	
71552	Mri chest w/o & w/ dye	
71555	Mri angio chest w/ or w/o dye	
72125	CT neck spine w/o dye	
72126	Ct neck spine w/dye	
72127	Ct neck spine w/o & w/dye	
72128	Ct chest spine w/o dye	
72129	Ct chest spine w/dye	
72130	Ct chest spine w/o & w/dye	
72131	Ct lumbar spine w/o dye	
72132	Ct lumbar spine w/dye	
72133	Ct lumbar spine w/o & w/dye	

72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spone w/o&w/dye
72191	Ct angiography, pelv w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye
72198	Mri angio pelvis w/ or w/o dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye
73218	Mri upper extr w/o dye
73219	Mri upper extr w/dye
73220	Mri upper extremity w/o & w/dye
73221	Mri joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
73225	Mr angio upr extr w/o&w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
73725	Mr angio lower ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
74174	Ct angiography, abdomen and pelvis w/o & w/ dye
74175	Ct angiography, abdom w/o & w/ dye
74176	Ct abdomen and pelvis w/o dye
74177	Ct abdomen and pelvis w/dye

74178	Ct abdomen and pelvis w/ and w/o dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
74185	Mri angio, abdom w/ or w/o dye
74261	Ct colonography, w/o dye
74262	Ct colonography, w/ dye
74712	Mri fetal sngl/1st gestation
74713	Mri fetal ea addl gestation
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Cardiac mri w/stress img & dye
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76380	CAT scan follow up study
77058	Mri, one breast
77059	Mri, broth breasts
77078	Ct bone density, axial
77084	Magnetic image, bone marrow

acted by CMS 60 % Utilization Rate Assumption	Codes Imp
Description	CPT Code
Radiation treatment deliver	G0166
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation treatment deliver	
Radiation tx delivery imrt	

acted by CMS 25 % Utilization Rate Assumption

Description

External counterpulsation, per treatment session

RUC Practice Expense Spreadsheet Formulas		Default
PRE-SERVICE PERIOD: Starts following visit when decision for surgery or procedure made.		
CA001	Complete pre-service diagnostic and referral forms	
CA002	Coordinate pre-surgery services (including test results)	
CA003	Schedule space and equipment in facility	
CA004	Provide pre-service education/obtain consent	
CA005	Complete pre-procedure phone calls and prescription	
CA006	Confirm availability of prior images/studies	
CA007	Review patient clinical extant information and questionnaire	
CA008	Perform regulatory mandated quality assurance activity (pre-service)	
	Other activity: please include short clinical labor description here and type new in column A	
SERVICE PERIOD: Starts when patient enters office/facility for surgery/procedure:		
Pre-Service (of service period)		
CA009	Greet patient, provide gowning, ensure appropriate medical records are available	X
CA010	Obtain vital signs	X
CA011	Provide education/obtain consent	X
CA012	Review requistion, assess for special needs	X
CA013	Prepare room, equipment and supplies	X
CA014	Confirm order, protocol exam	X
CA015	Setup scope (nonfacility setting only)	X
CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	X
CA017	Sedate/apply anesthesia	X
	Other activity: please include short clinical labor description here and type new in column A	
Intra-service (of service period)		
CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100% of physician intra-service time)	X
CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67% of physician intra-service time)	X
CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other% of physician intra-service time)	X
CA021	Perform procedure/service---NOT directly related to physician work time	X
	Other activity: please include short clinical labor description here and type new in column A	
Post-Service (of service period)		
CA022	Monitor patient following procedure/service, multitasking 1:4	
CA023	Monitor patient following procedure/service, no multitasking	
CA024	Clean room/equipment by clinical staff	X
CA025	Clean scope	
CA026	Clean surgical instrument package	
CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	
CA028	Review/read post-procedure x-ray, lab and pathology reports	
CA029	Check dressings, catheters, wounds	X
CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	
CA031	Review examination with interpreting MD/DO	
CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	
CA033	Perform regulatory mandated quality assurance activity (service period)	
CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	

CA035	Review home care instructions, coordinate visits/prescriptions	
CA036	Discharge day management	
	Other activity: please include short clinical labor description here and type new in column A	
POST-SERVICE PERIOD: Starts when patient leaves office/facility		
CA037	Conduct patient communications	
CA038	Coordinate post-procedure services	
CA039	Post-operative visits (total time)	
Pathology clinical labor activities		
PA001	Accession and enter information	
PA002	Acquire image(s) and print	
PA003	Assist pathologist	
PA004	Cleaning	
PA005	Disengage instrument(s)	
PA006	Engage instrument(s)	
PA007	Examine and screen	
PA008	File specimen, supplies, and other materials	
PA009	Manage pre-evaluation activities	
PA010	Prepare and analyze specimen	
PA011	Prepare slides	
PA012	Prepare supplies	
PA013	Record results	

Office Visits	Monitoring	Highly Technical	Scope	Scope Systems	Scope Accessories	Instruments Packs	PACS	Lab
Never in formulas								
X						X	X	
X						X	X	
X						X	X	
X						X	X	
X		X	X	X	X	X	X	
X			X	X	X	X	X	
X			X	X	X	X	X	
X		X	X	X	X	X	X	
X			X	X	X	X	X	
X		X	X	X	X	X	X	
X		X	X	X	X	X	X	
X		X	X	X	X	X	X	
X		X			X	X	X	
	4X							
	X							
X		X		X			X	
			X					
						X		
X							X	
							X	
							X	
							X	

Never in formulas								
X								
No formulas								

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, e/m visit	**SA047**	**pack**		**4.1755**
cover, thermometer probe		item	1	
drape, non-sterile, sheet 40in x 60in		item	1	
gloves, non-sterile		pair	2	
gown, patient		item	1	
paper, exam table		foot	7	
patient education booklet		item	1	
pillow case		item	1	
specula tips, otoscope		item	1	
swab-pad, alcohol		item	2	
tongue depressor		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**2.1122**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (staple)	**SA052**	**pack**		**4.992**
kit, staple removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (suture)	**SA054**	**pack**		**4.8353**
kit, suture removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (suture & staple)	**SA053**	**pack**		**5.95**
kit, staple removal		kit	1	

kit, suture removal	kit	1
povidone soln (Betadine)	ml	10
gauze, sterile 4in x 4in	item	2
gloves, sterile	pair	1
steri-strip (6 strip uou)	item	2
swab-pad, alcohol	item	2
tape, surgical paper 1in (Micropore)	inch	12
tincture of benzoin, swab	item	1

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, basic injection	**SA041**	**pack**		**11.365**
applicator, sponge-tipped		item	3	
bandage, strip 0.75in x 3in		item	1	
cap, surgical		item	1	
drape, sterile barrier 16in x 29in		item	1	
drape, sterile, for Mayo stand		item	1	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	2	
gown, staff, impervious		item	1	
gown, surgical, sterile		item	1	
lidocaine 1%-2% inj (Xylocaine)		ml	5	
mask, surgical		item	1	
needle, 18-27g		item	2	
povidone soln (Betadine)		ml	10	
syringe 3ml		item	1	
underpad 2ftx3ft (Chux)		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, moderate sedation	**SA044**	**pack**		**17.6208**
angiocatheter 14g-24g		item	1	
bandage, strip 0.75in x 3in		item	1	
catheter, suction		item	1	
dressing, 4in x 4.75in (Tegaderm)		item	1	
electrode, ECG (single)		item	3	
electrode, ground		item	1	
gas, oxygen		liter	200	
gauze, sterile 4in x 4in		item	4	
gloves, sterile		pair	1	
gown, surgical, sterile		item	1	
iv infusion set		item	1	
kit, iv starter		kit	1	
oxygen mask (1) and tubing (7ft)		item	1	
pulse oximeter sensor probe wrap		item	1	
stop cock, 3-way		item	1	
swab-pad, alcohol		item	2	
syringe 1ml		item	1	

syringe-needle 3ml 22-26g	item	2	
tape, surgical paper 1in (Micropore)	inch	12	
tourniquet, non-latex 1in x 18in	item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning and disinfecting, endoscope	**SA042**	**pack**		**17.654**
gloves, non-sterile		pair	4	
gown, staff, impervious		item	1	
face shield, splash protection		item	1	
biohazard bag		item	1	
gauze, sterile 4in x 4in (10 pack uou)		item	1	
alcohol isopropyl 70%		ml	60	
cleaning brush, endoscope		item	1	
glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)		oz	32	
glutaraldehyde test strips (Cidex, Metrex)		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning, surgical instruments	**SA043**	**pack**	1	**7.1568**
gloves, non-sterile		pair	2	
gown, staff, impervious		item	1	
face shield, splash protection		item	1	
autoclave bag		item	1	
autoclave tape		yd	0.33	
enzymatic detergent		oz	1	
cleaning brush, instruments		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care, neurosurgical	**SA056**	**pack**		**6.203**
kit, staple removal		kit	1	1.203
kit, suture removal		kit	1	1.054
povidone soln (Betadine)		ml	20	0.009
gauze, sterile 4in x 4in		item	2	0.159
gloves, sterile		pair	1	0.84
steri-strip (6 strip uou)		item	2	1.116
swab-pad, alcohol		item	2	0.013
tape, surgical paper 1in (Micropore)		inch	12	0.002
tincture of benzoin, swab		item	1	0.32

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care, craniotomy	**SA055**	**pack**		**7.3**
kit, staple removal		kit	1	1.203
kit, suture removal		kit	1	1.054
povidone soln (Betadine)		ml	20	0.009
gauze, sterile 4in x 4in		item	4	0.159
gloves, sterile		pair	1	0.84
bandage, Kling, non-sterile 2in		item	1	0.363

steri-strip (6 strip uou)		item	2	1.116
swab-pad, alcohol		item	2	0.013
tape, surgical paper 1in (Micropore)		inch	60	0.002
tincture of benzoin, swab		item	2	0.32

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, pelvic exam	**SA051**	**pack**		**5.919**
lubricating jelly (K-Y) (5gm uou)		item	1	
pad, feminine mini		item	1	
swab, procto 16in		item	2	
specula, vaginal		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, urology cystoscopy visit	**SA058**	**pack**		**46.9387**
drape-pack, cystoscopy		pack	1	
povidone soln (Betadine)		ml	10	
tubing, irrigation (cysto)		item	1	
gloves, non-sterile		pair	1	
gloves, sterile		pair	1	
lidocaine 2% jelly, topical (Xylocaine)		ml	10	
sanitizing cloth-wipe (patient)		item	5	
sodium chloride 0.9% irrigation (500-1000ml uou)		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, ophthalmology visit (no-dilation)	**SA050**	**pack**		**1.5688**
Cotton tipped applicators		item	2	
fluorescein strips		item	1	
gloves, non-sterile		pair	2	
proparacaine 0.5% ophth (Ophthaine, Alcaine)		ml	0.1	
paper, chinrest		item	1	
swab-pad, alcohol		item	2	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, ophthalmology visit (w-dilation)	**SA082**	**pack**		**2.4752**
Cotton tipped applicators		item	2	
fluorescein strips		item	1	
gloves, non-sterile		pair	2	
tetracaine or proparacaine		ml	0.1	
tropicamide 1% ophth (Mydriacyl)		ml	0.1	
phenylephrine 2.5% ophth (Mydfin)		ml	0.1	
paper, chinrest		item	1	
swab-pad, alcohol		item	2	
post-mydriatic spectacles		Item	1	
rev-eyes 0.5% ophth		ml	0.1	

DESCRIPTION	Code	Unit	Item Qty	Unit price

pack, ocular photodynamic therapy	SA049	kit		19.5938
syringe 10-12ml		item	3	
needle, 18-27g		item	5	
syringe 30 ml		item	1	
dextrose 5% inj (250ml uou)		item	1	
swab-pad, alcohol		item	6	
iv safety catheter with Y adapter (Intima)		item	1	
post-mydriatic spectacles		pair	1	
Infusion Line Diagram		item	1	no charge
Patient Guide to Visudyne		item	1	no charge
wristband, patient ID		item	1	
iv PCA extension set		item	1	
syringe filter, sterile 1.2micron (Acrodisc)		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, drape, ortho, small	**SA081**	**pack**		**1.409**
drape-towel, sterile 18inx26in		item	4	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, drape, ortho, large	**SA080**	**pack**		**39.8095**
drape, sterile, for Mayo stand		item	1	
drape, sterile, u-shape		item	1	
drape, sterile, three-quarter sheet		item	1	
bandage, Esmarch-Martin, sterile 3in x 9ft		item	1	
drape, sterile, hand-upper extremity		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, protective, ortho, small	**SA084**	**pack**		**4.8282**
gloves, non-sterile		pair	2	
gloves, sterile		pair	2	
gown, staff, impervious		item	1	
mask, surgical, with face shield		item	1	
cap, surgical		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, protective, ortho, large	**SA083**	**pack**		**9.6015**
gloves, non-sterile		pair	2	
gloves, sterile		pair	4	
gown, staff, impervious		item	2	
mask, surgical, with face shield		item	2	
shoe covers, surgical		pair	2	
cap, surgical		item	1	

Tray Description and Typical Commercial Contents

tray, amniocentesis
Marked Spinal Needle with stylet (20g x 3-1/2"), spinal needle with stylet (20g x 3-1/2"), lock-tip syringe (20 and 5cc), lidocaine hydrochloride (Usp, 1%, 5ml), 3 prelabled specimen tubes with cap (10ml), prep cup, 3 swab sticks, 15cm ruler, (3) 3" x 3" gauze sponges, towel, fenestrated drape, puncture site bandage, and sterilization indicator.

tray, arthrogram
25 Ga x 5/8" needle, 21 Ga x 1-1/2" needle , 20 Ga x 1-1/2" needle , 18 Ga x 1-1/2" needle, 50/60 cc Plastic syringe, Luer Lock , 10 cc Plastic syringes, Luer Lock (2), 1% Lidocaine HCl, 5 mL, Removable prep cup, Extension tubing (20"), 3 x 3 Gauze sponges (5), Fenestrated drape, Disposable towel, Applicators (3), Puncture site bandage, Sterile indicator, Hospital wrap

tray, biopsy procedure
0.9% Sodium Chloride, 5mL, Specimen tubes and caps (2) , Slides, fully frosted (2), frosted end (2), 25 Ga x 5/8" needle , 22 Ga x 1-1/2" needle , 18 Ga x 2" blunt needle , 10 cc Plastic Syringes, Luer Lock (2) , No. 11 scalpel assembly , Needle stop , PVP Swabsticks (triples), Alcohol Wipe , 1% Lidocaine HCl, 5 mL (2 ampules) , 3" x 3" Gauze (3), Disposable Towel , Fenestrated drape , Puncture site bandage , 8" paper ruler, Sterile indicator , Hospital wrap

tray, bone marrow biopsy-aspiration
Hospital wrap, Three povidone-iodine swab sticks (1% available iodine), Towel , Fenestrated drape , Syringe, 5cc with 20G x 1 1/2" needle , Syringe, 20cc ,Needles, 25G x 5/8" and 21G x 1 1/2" , Lidocaine hydrochloride, USP, 1% (10mg/mL), 5mL , Scalpel blade , Two specimen tubes containing edetate potassium , 10 frosted slides, 1" x 3" , Amber specimen bottle and label , Stirring rod , Five gauze pads , Elastic bandage

tray, catheter insertion (w-o catheter)
CSR wrap , Anatomically shaped basin, 1200cc , Water-resistant absorbent underpad , One pair latex exam gloves , Fenestrated drape , Prepping balls ,Plastic forceps , 10% povidone-iodine solution, 1 oz. , Lubricating jelly, 2.7g , Sterile specimen container

tray, epidural
5cc luer taper glass syringe, 3cc syringe, 20cc lock-tip syringe, 1 Each needle 25g x 5/8", 21g x 1-1/2" and 18g x 1-1/2", 15g x 2-1/2" filter aspirating needle, lidocaine HCL (USP, 1%, 5ml), 60ml removable medicine cup, prep cup, 3 prep swabs, (3) 3" x 3" gauze sponges, towel, fenestrated drape, sterilization indicator, hospital wrap.

tray, lumbar puncture
Syringe and needle, lidocaine hydrochloride (Usp, 1%, 2ml), 4 prelabled specimen tubes with cap (10ml), prep cup, 3 swab sticks, (3) 2" x 2" gauze sponges, towel, fenestrated drape, puncture site bandage, sterilization indicator, And hospital wrap.

tray, myelogram
5cc syringe with 25g x 5/8" needle, 22g x 1-1/2" needle, lidocaine hydrochloride (USP, 1%, 5ml), 5" & 20" extension tubes, 3 prelabled specimen tubes with cap (10ml), 3 swab sticks, (3) 3" x 3" gauze sponges, antiseptic prep well, towel, fenestrated drape, puncture site bandage, hospital wrap.

tray, surgical skin prep, sterile
(2) absorbent blotting towels, (2) patient underdrapes, (2) cotton tipped applicators, (1) pair latex procedure gloves, (1) hospital wrap, (1) 110ml bottle PVP-I scrub solution, (1) 155ml packet PVP-I topical solution, (3) sponge sticks, (6) small foam winged sponges

tray, shave prep
2 compartment tray; absorbent towels (2); disposable double edged stainless steel comb/comb razor; gauze sponges (2); presoaped (Castile) foam sponge; underpad; cotton tipped applicators (2)

tray, spinal anesthesia

WHITACRE 25GA 3.5IN INTRO, LIDOCAINE1%/LIDOCAINE 5% IN GLUCOSE 7.5% EPINEPHRINE 1MG, PVP PREP SPONGE, GZ, DRAPE, 5ML GLASS SYR, LUER SLIP 3ML PLST SYR, 25GA SKIN WHEAL NDL

tray, suturing

(1) CSR overwrap, (1) Halsey floor grade 5" needle holder, (1) floor grade straight 4.5" Ins scissors, (1) adson tissue forceps, (2) medicine cups 2oz., (8) 4" x 4" gauze sponges, (5) 2" x 2" gauze sponges, (1) polylined fenstrated drape, (1) absorbent towel

tray, thoracentesis

60cc Luer Lock Syringe, 5cc Syringe 25G x 5/8" Needle, 22G x 11/2" Needle, Lidocaine Hydrochloride, (USP, 1%, 5mL), Three-Way Stopcock Drainage Tube, Fluid Collection Bag, (3) Prelabeled Specimen Tubes with Caps (10mL), Fenestrated Drape, (2) PVP SwabSticks, Gauze Sponges 3"x3", Antiseptic Prep, Drape/Towel, Puncture Site Bandage, And Hospital Wrap

tray, Circumcision

Scalpel, #10, Probe w/Eye, (2) Straight Mosquito Hemostats, (1) Curved Mosquito Hemostat OR Scissors, S/B Adson Dressing Forceps, PVP 1 oz. Prep Packet, (10) Gauze Sponges – 3X3 12 ply, Fenestrated or Towel, Vaseline Gauze, Blue Linen or Towel, Medicine Cup- 2 oz, Gloves non-sterile, (2) Safety Pins-#2

kit, iv starter

1 tourniquet

1 alcohol prep pad

1 PVP ointment

1 PVP prep pad

2 gauze sponges (2"x2")

1 bandage (1"x3")

1 sm roll surgical tape

1 pr gloves

1 underpad 2ft x 3ft (Chux)

Code	Unit	Price
SA059	tray	17.4447
SA060	tray	21.47
SA061	tray	16.3825
SA062	tray	36.8675
SA063	tray	3.4195
SA064	tray	22.5267
SA065	tray	17.724
SA066	tray	23.0592
SA088	tray	5.936
SA067	tray	1.6765
SA068	tray	22.164

SA069	tray	8.9723

SA070	tray	37.269

SA086	tray	24.7644

SA019	kit	1.4675

DESCRIPTION	Code	Unit price
Basic Radiology Room	**EL012**	**$157,366.59**
X-Ray Machine		
Camera		

DESCRIPTION	Code	Unit price
Radiographic-Flouroscopic Room	**EL014**	**$445,290.82**
Radiographic machine		
Camera		

DESCRIPTION	Code	Unit price
Mammography Room	**EL013**	**$168,214**
Mammography unit		124,900
Reporting System		16,690
Mammography phantom		674
Densitometer		3,660
Sensitometer		2,750
Desktop PC for monitoring		1,840
Film Processor		17,700

DESCRIPTION	Code	Unit price
Computed Tomography (CT) Room	**EL007**	**$1,320,491.88**
(16-slice CT scanner with power injector and monitoring system)		

DESCRIPTION	Code	Unit price
Magnetic Resonance (MR) Room	**EL008**	**$1,593,503.38**
(1.5T MR scanner with power injector and monitoring system)		

DESCRIPTION	Code	Unit price
Lane, Exam (Oph)	**EL005**	**$33,811.17**
Chair with headrest, exam, reclining		
ID refraction desk		
Applanation Tonometer (H-S R900)		
Wheelchair access slide		
Slit lamp (incl. 3-mirror lens;Hruby lens; room light control box with wire kit)		
Trial lens set +/- cyl incl; prisms; cross cyl; frame; retinoscopy rack		
Projector (incl. mirror set and projector screen)		
Keratometer w-arm counterbalance		
Ophthalmoscope (direct), retinscope (Incl. transilluminator and 3 recharge handles) (Welch-Allyn)		
Phoropter + cylinder with 3-arm stand		
Ophthalmoscope (indirect), with power source and 2 lens		

DESCRIPTION	Code	Unit price
Lane, Screening (Oph)	**EL006**	**$32,267.05**
Chair with headrest, exam, reclining		
ID refraction desk		

Applanation Tonometer (H-S R900)
Wheelchair access slide
Slit lamp (incl. 3-mirror lens;Hruby lens; room light control box with wire kit)
Trial lens set +/- cyl incl; prisms; cross cyl; frame; retinoscopy rack
Projector (incl. mirror set and projector screen)
Keratometer w-arm counterbalance
Ophthalmoscope (direct), retinscope (Incl. transilluminator and 3 recharge handles) (Welch-Allyn)
Phoropter + cylinder with 3-arm stand

DESCRIPTION	Code	Unit price
Angiography Room	**EL011**	**$1,338,468.30**

100 KW at 100 kV (DIN6822) generator
C-arm single plane system, ceiling mounted, integrated multispace
T motorized rotation, multiple operating modes
real-time digital imaging
40 cm image intensifier at 40/28/20/14cm
30 x 38 image intensifier dynamic flat panel detector
floor-mounted patient table with floating tabletop designed for angiographic exams and interventions (with pei
18 in TFT monitor
network interface (DICOM)
Careposition: radiation free positioning of collimators
Carewatch: acquisition and monitoring of configurable dose area product
Carefilter: Cu-prefiltration
DICOM HIS / RIS
Control room interface
Injector, Provis
Shields, lower body and mavig
Leonardo software
Fujitsu-Siemens high performance computers
Color monitors
Single modules for dynamic replay and full format images
Prepared for internal networking and Siemens remote servicing, both hardware and software

stepping for image intensifiers 13in+)

$ 369,945 General Ultrasound Room, General

$220,000	GE Logic 9 ultrasound system (H4902SG)
$18,000	transducer, 3-8MHz matrix array convex (H40412LC)
$650	probe starter kit for H40412LD: bracket, needle guides, probe covers (E8385RF)
$18,000	transducer, 5-13MHz linear matrix array (H40412LD)
$650	probe starter kit for H40412LD: bracket, needle guides, probe covers (E8385RF)
$12,000	transducer, 4-10MH micro convex probe (H40412LE)
$11,000	transducer, 4-10MHz probe (H40412LG)
$10,000	transducer, 2-5MHz probe (H4901PE)
$12,500	software, B-flow (H4901BF)
$5,500	software, DICOM (H4901DM)
$8,000	software, LOGIQ View (h4901LW)
$4,900	VHS video recorder (Sony SVO-9500MD/2)
$6,500	digital printer (Sony UPD21)
$1,995	monochorome thermal printer (Sony UPD895)
$5,250	ultrasound table (E8375F)
$35,000	compound imaging

Options priced, but not included in room total

$77,000	5 year service contract @ $15,400 per year
$900	HAG Capisco Ergo Chair for sonographer
$14,000	5-12 MHz electronic linear array probe
$11,000	3-7 MHz wide band, multi freq linear array probe
$9,500	4-10 MHz wide band, multi freq microconvex array probe
$9,500	2-5 Mhz sector transducer
$9,500	3-7 MHz wide band, multi freq phased array probe

$35,712 **Nicojet VasoGuard P84 (PPG & lower extremity):**

-Vascoguard II, main station with cart, keyboard, LCD monitor, deskje
doppler and probe holder
-4 & 8 MHz CW doppler probes
-umbilical hose-arm assembly
-4x PPG probes, digit clips, probe cups, probe fixing bands
-2x 17cm thigh cuffs
-8x12 cm pressure cuffs
-4x12 cm pressure cuffs, long
-10x10 cm pressure cuffs
-2x 6.5 cm pressure cuffs
-2x1.9 cm digit cuffs, coiled hose, PVR
-2x1.9 & 2.5 cm pressure cuffs with Y hose assemble
-5x2.5 cm disposable penile cuffs
installation and 2 year parts and labor warranty

$57,340 **Nicolet Pioneer TC 8080 (transcranial)**

-TC8080, main station with cart, keyboard, footswitch, speakers, hea
remote control, monitor, deskjet printer, probe connectors
-Monitoring module 4 active channels

-Advanced emboli detection
-20 MHz microvascular with 2 probes and isolation pod
-M-mode display software
-1.6 MHz PW monitoring/handheld transducer
-2 MHz PW standard transducer
-2 MHz monitoring transducer 15mm
-Isolation transformer
-Welder fixation, bilater
-brow cushions, welder fixation, set of 5
-Aaslid TCD simulator

$3,495 **Atrium Medical Vaslab -** software add-on for data collection, database maintenanc and accreditation processing.

$466,492 **Ultrasound Room, Vascular**

Contains: General Ultrasound Room, General
Nicojet VasoGuard P84 (PPG & lower extremity):
Nicolet Pioneer TC 8080 (transcranial)
Atrium Medical Vaslab - software add-on for data collection, databas and accreditation processing.

Default
Office Visits
Monitoring
Highly Technical
Scope
Scope Systems
Scope Accessories
Instrument Packs
PACS
Other Formula

AMA/Specialty Society RVS Update Committee Summary of Recommendations
010-Day Global Period Services with > 1 Office Visit

October 2020

Treatment of Foot Infection – Tab 14

In October 2019, the RUC identified CPT code 28002 *Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space* via the 010-day global period service with more than one office visit and Medicare utilization greater than 1,000 screen. Codes 28001 and 28003 were added as family codes for review. When considering typical patient vignettes for a RUC survey, the stakeholder societies noted that these three major surgical procedures did not have a consistent global period; 28001 and 28002 have a 010-day global period and 28003 has a 90-day global period. The specialty societies and the RUC also noted that code 28002 had over 60% of claims in the inpatient setting, however, code 28002 only included 0.5 x 99238 which corresponds to same-day outpatient status. The specialty societies determined that there is a significant heterogeneity in the complexity of the patient population for this family of codes so as to make it problematic to identify the typical patient for the purpose of estimating typical hospital and office visits in a global period; the severity of underlying co-morbidities will require differing number and level of follow-up care and patient presentation can change from year to year. Based on this information, the specialty societies sent a request to CMS through AMA staff to change the global period assignment for all three codes to 000-day. The societies indicated that a 000-day global assignment will provide more accurate reporting of post-operative work for this multi-modal family of codes. CMS did not respond to this request and a survey was conducted for all three codes as 000-day global. In January 2020, the RUC recommended this service be surveyed for April 2020; this issue was postponed until the October 2020 RUC meeting.

28001 ***Incision and drainage, bursa, foot***
The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28001 and determined that the survey median work RVU of 2.00 for podiatrists with 60 minutes total time appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 20 minutes intra-service time, and 15 minutes immediate post-service time. The RUC noted that this service is primarily performed by podiatrists (99%) in the non-facility setting (2019 Medicare data), supporting the use of the median response rate of podiatrists to assign a value. The RUC also noted and discussed the bimodal distribution of the survey data; the responses from the orthopaedic surgeons suggest a different patient population and possibly different physician work that the specialty societies could consider in future coding recommendations. The RUC noted supporting reference services that have the same intra-service time and similar total time: CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU = 2.00, 20 minutes intra-service time and 57 minutes total time) and 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU = 2.00, 20 minutes of intra-service time and 58 minutes total time). **The RUC recommends a work RVU of 2.00 for CPT code 28001.**

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28002 ***Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space***
The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28002 and determined that the survey median of 3.73 work RVUs slightly overestimated the work required to perform this service. The RUC recommended a direct work RVU crosswalk to CPT code 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy;* (work RVU = 3.50, 15 minutes of pre-service evaluation time, 8 minutes of pre-service positioning time, 13 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 20 minutes of immediate post-service time) as it has the same intra-service time. The RUC noted that although 31287 had less total time than 28002, the intensity of 31287 was greater, lending support for crosswalking the work RVU of 31287 to 28002. The RUC recommends 30 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 20 minutes of immediate post-service time. The RUC noted that because CPT code 28002 is typically performed in the facility setting, there was not a bimodal patient distribution to consider. For additional support, the RUC referenced CPT code 41530 *Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session* (work RVU = 3.50, 20 minutes intra-service time and 95 minutes total time) and 52334 *Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde* (work RVU = 3.37, 30 minutes intra-service time and 75 min total time). **The RUC recommends a work RVU of 3.50 for CPT code 28002.**

28003 ***Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas***
The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28003 and determined that the survey median work RVU of 5.28 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, and 20 minutes of immediate post-service time.

The RUC noted that there was again a bimodal distribution in the survey responses comparing podiatrists to orthopaedic surgeons; while this might represent different patient populations and different physician work for the two specialties, the specialty societies' expert panel recommended the combined median work RVU recommendation. The specialty societies indicated, and the RUC agreed, that CPT code 28003 is appropriately more work than 28001 and 28002 because it is a more complex procedure involving multiple and deeper tissue and sinus tract exploration. The RUC compared CPT code 28003 to the top two key reference services CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU = 4.10, total time of 116 minutes, pre-service evaluation time of 33 minutes, pre-service positioning time of 3 minutes, pre-service scrub/dress/wait time of 15 minutes, intra-service time of 45 minutes, and immediate post-service time of 20 minutes) and CPT code 20245 *Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)* (work RVU = 6.00, total time of 160 minutes, pre-service evaluation time of 40 minutes, pre-service positioning time of 15 minutes, pre-service scrub/dress/wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 30 minutes). Both of these codes bracket the recommended work RVU of 5.28 for code 28803. This work RVU recommendation is supported by MPC code 36475 *Endovenous*

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ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated (work RVU = 5.30), which has the same intra-service time of 45 minutes and 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.35), which has a slightly higher work RVU, the same intra-service time of 45 minutes and only 5 minutes more total time. **The RUC recommends a work RVU of 5.28 for CPT code 28003.**

Practice Expense

The Practice Expense Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in the global period for these three codes. The pre-service clinical staff times for CPT code 28003 were adjusted to the 000-day standard for Extensive Use of Clinical Staff in the facility setting to account for the global period change from 090-day to 000-day. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
28001	Incision and drainage, bursa, foot	~~010~~ 000	2.00
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	~~010~~ 000	3.50
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	~~090~~ 000	5.28

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28001 Tracking Number

Original Specialty Recommended RVU: **2.48**
Presented Recommended RVU: **2.48**
RUC Recommended RVU: **2.00**

Global Period: 000 Current Work RVU: **2.78**

CPT Descriptor: Incision and drainage, bursa, foot

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with a painful, inflamed and infected bursa plantar to the fifth metatarsal head. An incision and drainage of the bursa is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review and update H&P. Meet with patient and family to review planned procedure and postoperative management. Review informed consent with patient. Verify all required equipment, instruments and supplies are available. Monitor and/or assist with patient positioning. Assess position of the extremities and head; adjust as needed. Place foam pad under nonoperative leg to minimize pressure on heel. Place the patient's operative leg properly on the table and position with proper bolstering to aid surgical exposure and prevent leg from externally rotating. Indicate areas of skin to be prepared. Place an ankle tourniquet. Prepare the leg and foot. Scrub and gown. Drape the leg and foot. Elevate the operative leg with a black foam ramp pad to above heart level and exsanguinate the leg. Inflate the pneumatic tourniquet. Perform surgical time out with operating surgical team.

Description of Intra-Service Work: A linear incision is made over the plantar lateral aspect of the fifth metatarsal head. Using blunt dissection the infected bursa is freed from the surrounding soft tissues and excised. The excised tissue is sent to pathology. The wound bed is inspected for remnants of bursal tissue or sinus tracts. Cultures are obtained and sent to pathology. The area is copiously lavaged. After hemostasis is achieved, the tourniquet is deflated and blood supply to this area is checked. The wound is then left open and packed with an appropriate dressing.

Description of Post-Service Work: Apply a dressing and splint, as required. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Dictate operative report and copy referring physician(s). Discuss management of medical comorbidities with medical physician. Evaluate vascular status. Examine patient, assess for bleeding. Assess circulation, sensation, and motor function of operated extremity. Assess pain scores. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Coordinate care as necessary with other physicians (eg, endocrinology, PCP). Chart patient progress notes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD					
Specialty Society(ies):	APMA, AAOS, AOFAS					
CPT Code:	28001					
Sample Size:	1872	**Resp N:**	164			
Description of Sample:	Random selection from society membership databases					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**5.00**	12.00	200.00
Survey RVW:		0.75	1.43	**2.48**	3.00	6.20
Pre-Service Evaluation Time:				**25.00**		
Pre-Service Positioning Time:				**6.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		2.00	15.00	**20.00**	26.00	60.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	28001	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11042	000	1.01	**RUC Time**

CPT Descriptor Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11043	000	2.70	**RUC Time**

CPT Descriptor Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	44,367

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52281	000	2.75	**RUC Time**	62,618

CPT Descriptor 2 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female

Other Reference CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 58 **% of respondents:** 35.3 **%**

Number of respondents who choose 2nd Key Reference Code: 40 **% of respondents:** 24.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 28001	Top Key Reference CPT Code: 11042	2nd Key Reference CPT Code: **11043**
Median Pre-Service Time	25.00	11.00	41.00
Median Intra-Service Time	20.00	15.00	30.00
Median Immediate Post-service Time	15.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**36.00**	**86.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	2%	10%	50%	31%	7%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	16%	43%	41%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	14%	55%	31%
Physical effort required	5%	76%	19%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	16%	50%	34%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	55%	23%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	63%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	60%	23%
Physical effort required	15%	60%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	53%	35%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Global Period

Code 28002 was identified by the RUC Relativity Assessment Workgroup through a screen of 10-day global codes with utilization greater than 1,000 and more than one postoperative visit. Codes 28001 and 28003 were added as family codes.

When considering typical patient vignettes for a RUC survey, the stakeholder societies noted that these three major surgical procedures did not have a consistent global period; 28001 and 28002 have a 10-day global period and 28003 has a 90-day global period. The stakeholder societies and the RAW also noted that code 28002 had over 60% of claims in the inpatient setting, however, code 28002 only included 0.5 x 99238 which corresponds to same-day outpatient status.

The societies believe that there is a significant heterogeneity in the complexity of the patient population for this family of codes so as to make in problematic to identify the typical patient for the purpose of estimating typical hospital and office visits in a global period; the severity of underlying co-morbidities will require differing levels of follow-up care. Based on this information, the stakeholder societies sent a request to CMS through AMA staff to change the global period assignment for all three codes to 0-day. The societies argued that a 0-day global assignment will provide more accurate reporting of postoperative work for this multi-modal family of codes. CMS did not object and a survey was conducted for all three codes as 0-day global.

Flawed Methodology of Previous Valuation

28001: The current work RVU for code 28001 is based on the Harvard study. The Harvard-assigned total pre-operative time of 10 minutes is insufficient to evaluate the patient and prepare supplies and anesthesia for the procedure. No time was allowed for positioning and draping the patient's extremity. No time was allowed for administration of anesthesia and/or a block, waiting for the anesthetic effect and time for the physician and staff to scrub and gown. It is also possible that some of the time for these activities were included in the Harvard study intra-time, but there is no way of knowing because there were not clear definitions about—for example—whether anesthesia time belonged in the pre- or intra-service period in the Harvard study. The RUC process did not clearly define specific activities for pre-time until packages were developed in 2007. In fact, many codes before 2007 included such activities and positioning and local anesthetic in the intra-service period. In addition, the pre- and post-operative Harvard data are based on an algorithm and not direct survey. Finally, the postoperative assignment of one 99212 office visit is inconsistent with the typical monitoring of a patient with a bursa infection requiring incision and drainage. For these reasons, we believe that the work and time for 28001 was underestimated by Harvard.

Change in Patient Population

Poorly controlled blood sugar that occurs in diabetes can limit blood flow to the lower legs and foot, causing nerve damage that people with the disease may not sense until problems have already developed. People with advanced diabetes may develop wounds or sores that do not readily heal and that may become infected requiring incision and drainage. Diabetic patients typically have co-morbidities and increasingly present with compromised vasculature and wounds that are resistant to antibiotics. Although there have been advances in medical care and prevention of foot disease (ie, drugs, aggressive wound care, and emphasis on foot care) wound infections are common and can be serious is not aggressively treated and closely monitored.

Survey Process

A survey request was sent to a random selection of surgeons and podiatrists from the membership databases of the APMA, AOFAS, and AAOS. In April 2020, the societies noted that the number of responses from APMA was low compared with the orthopaedic surgeon response rate. The letter to the RUC stated that the low response rate may have been the result of the emergence of the pandemic during the survey effort and the fact that it would have been inappropriate to send reminders to members as the Covid-19 crisis was front and center in the United States health care system and professional societies were using their communication platforms to relay critical and time-sensitive updates to their membership. It was noted that the atypical low response rate from APMA might be due to their members understandably focusing their time and efforts on reshaping their practices to provide services to patients while keeping patients and staff safe. Although the minimum number of total surveys were received, the societies requested and the RUC agreed to postpone review of these family of codes until the Fall 2020 RUC meeting. This postponement would allow APMA to continue to collect survey responses by sending a reminder email request once it was felt an appropriate use of the society resources and physician time after the pandemic had slowed its spread in the United States and physician practices and communications were not consumed by the pandemic. The AAOS and AOFAS closed their survey and only APMA continued to survey by sending reminders to the initial randomly selected list of surveyees (ie, no new surveyees were added). This effort increased the APMA response of 25 to 84, which is greater than the total of

the two orthopaedic surgeon societies combined. The RUC Summary Excel file presents the survey statistics for orthopaedic surgery, podiatry and for both specialties combined.

Recommendation - 28001

Work RVU: The survey median work RVU of 2.48 is recommended for 28001.

Pre-time Package 6: *Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect*
Positioning: Add 2 minutes to the package time to account for placing foam padding under the nonoperative leg to minimize pressure on heel; placing the patient's operative leg properly on the table and positioning with proper bolstering to aid surgical exposure and to prevent the leg from externally rotating; indicating areas of skin to be prepared and draped; and placing an ankle tourniquet.

Post-time Package: Not applicable for procedure typically performed in the non-facility setting.

Key Reference Comparison

KRS code 11042 is typically reported for debridement of a lower extremity ulcer in an outpatient wound clinic requiring minimal local anesthesia. Debridement is tedious work, but not intensive or complex. The typical 11042 wound is open but not infected, and a simple topical dressing is applied. In comparison, 28001 requires more complex decisions regarding assessment of the extent of the infection, planning of the incision, irrigation and drainage of the infected bursa and packing of the surgical site.

KRS 11043 is typically reported for debridement of a lower extremity ulcer, however, the depth of the ulcer is similar to the I&D of the bursa of the foot, making these two codes good comparators for relative work.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	**1.01**	0.037	36	11	15	10
28001	Incision and drainage, bursa, foot	**2.48**	0.083	60	25	20	15
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	**2.70**	0.051	86	41	30	15

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level	**2.29**	0.047	49	24	15	10
28001	Incision and drainage, bursa, foot	**2.48**	0.083	60	25	20	15
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	**2.75**	0.060	46	16	20	10

Other Comparison

For CY 2021, CMS finalized coding and RVU changes for the office and other outpatient evaluation and management (E/M) codes. This includes the ability to select a level of code based on total time alone, including both face-to-face and non-face-to-face time of the physician and/or other qualified health care provider on the date of the encounter. As shown in the table below, the recommended work RVU for 28001 is less than the work RVU for 99215, even though the total time is greater.

When reporting an office/outpatient E/M code using time, there is no restriction on the level of medical decision making required. Even without consideration of time, the patient undergoing 28001 easily meets the medical decision making elements associated with 99215 (high number/complexity of problem(s) addressed and high risk of complications and/or morbidity or mortality of patient management).

The recommended work RVU of 2.48 is conservative and supported in comparison to office/outpatient E/M code 99215.

CPT	DESCRIPTOR	RVW	TOTAL TIME
28001	Incision and drainage, bursa, foot	2.48	60

99215*	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, **40-54 minutes of total time is spent on the date of the encounter**	**2.80**	40-54

*CY 2021

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28001

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,770
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty podiatry Frequency 3600 Percentage 95.49 %

Specialty orthopaedic surgery Frequency 100 Percentage 2.65 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 28001

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28002 Tracking Number Original Specialty Recommended RVU: **3.73**
Presented Recommended RVU: **3.73**
Global Period: 000 Current Work RVU: **5.34** RUC Recommended RVU: **3.50**

CPT Descriptor: Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old neuropathic, diabetic male presents with an open wound on the plantar aspect of the foot, with surrounding fluctuance. An incision and drainage of a single bursal space below the fascia is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review results of preadmission testing including laboratory tests and imaging. Review and update H&P. Write orders for preoperative medications. Meet with patient and family to review planned procedure and postoperative management. Review informed consent with patient. Verify all required equipment, instruments and supplies are available. Monitor and/or assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head; adjust as needed. Place foam pad under nonoperative leg to minimize pressure on heel. Place the patient's operative leg properly on the table and position with proper bolstering to aid surgical exposure and prevent leg from externally rotating. Indicate areas of skin to be prepared. Place an ankle tourniquet. Prepare the leg and foot. Scrub and gown. Drape the leg and foot. Elevate the operative leg with a black foam ramp pad to above heart level and exsanguinate the leg. Inflate the pneumatic tourniquet. Perform surgical time out with operating surgical team.

Description of Intra-Service Work: An incision is made on the plantar aspect of the foot and extended to the central compartment of the foot, being careful to avoid any damage to the plantar nerves, flexor tendons, or short tendons as well as the vascular structure of the foot. The central compartment is widely opened, purulence drained, the compartment is irrigated, and débrided and any non-viable tissue is removed. Cultures are obtained and sent to pathology. After hemostasis is achieved, the tourniquet is deflated and blood supply to this area is checked. The wound is then left open and packed with an appropriate dressing.

Description of Post-Service Work: Apply a dressing and splint, as required. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia, and type and dosing of antibiotic. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Discuss management of medical comorbidities with medical physician. Evaluate vascular status and intake and output. Examine patient, assess for bleeding. Assess circulation, sensation, and motor function of operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Coordinate care as necessary with other physicians (eg, endocrinology, PCP). Answer nursing and other staff questions. Chart patient progress notes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD					
Specialty Society(ies):	APMA, AAOS, AOFAS					
CPT Code:	28002					
Sample Size:	1872	**Resp N:**	164			
Description of Sample:	Random selection from society membership databases					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	4.00	**8.00**	15.00	150.00
Survey RVW:		1.20	2.80	**3.73**	4.72	8.95
Pre-Service Evaluation Time:				**30.00**		
Pre-Service Positioning Time:				**8.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		8.00	20.00	**30.00**	40.00	65.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	28002	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11043	000	2.70	**RUC Time**

CPT Descriptor Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11044	000	4.10	**RUC Time**

CPT Descriptor Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
10030	000	2.75	**RUC Time**	8,525

CPT Descriptor 1 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37191	000	4.46	**RUC Time**	25,555

CPT Descriptor 2 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Other Reference CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 63 **% of respondents:** 38.4 **%**

Number of respondents who choose 2nd Key Reference Code: 28 **% of respondents:** 17.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 28002	Top Key Reference CPT Code: 11043	2nd Key Reference CPT Code: **11044**
Median Pre-Service Time	50.00	41.00	51.00
Median Intra-Service Time	30.00	30.00	45.00
Median Immediate Post-service Time	20.00	15.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**100.00**	**86.00**	**116.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	2%	3%	38%	51%	6%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	49%	48%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	52%	44%

Physical effort required	3%	56%	41%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	46%	49%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	36%	46%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	43%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	64%	36%
Physical effort required	4%	57%	39%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	29%	71%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Global Period

Code 28002 was identified by the RUC Relativity Assessment Workgroup through a screen of 10-day global codes with utilization greater than 1,000 and more than one postoperative visit. Codes 28001 and 28003 were added as family codes.

When considering typical patient vignettes for a RUC survey, the stakeholder societies noted that these three major surgical procedures did not have a consistent global period; 28001 and 28002 have a 10-day global period and 28003 has a 90-day global period. The stakeholder societies and the RAW also noted that code 28002 had over 60% of claims in the inpatient setting, however, code 28002 only included 0.5 x 99238 which corresponds to same-day outpatient status.

The societies believe that there is a significant heterogeneity in the complexity of the patient population for this family of codes so as to make in problematic to identify the typical patient for the purpose of estimating typical hospital and office visits in a global period; the severity of underlying co-morbidities will require differing levels of follow-up care. Based on this information, the stakeholder societies sent a request to CMS through AMA staff to change the global period assignment for all three codes to 0-day. The societies argued that a 0-day global assignment will provide more accurate reporting of postoperative work for this multi-modal family of codes. CMS did not object and a survey was conducted for all three codes as 0-day global.

Flawed Methodology of Previous Valuation

28002: In 2010, CMS identified code 28002 as potentially misvalued through a site-of-service anomaly screen based on early 2009 claims data that showed 49.2% of Medicare patients were inpatient. The current 2019 data indicate over 60% inpatient. Because CMS considered the code an outpatient procedure, the RUC only allowed 0.5 x 99238 for facility work and recommended the survey 25th percentile. This resulted in an underestimation of work and time. Prior to 2010, the service was misvalued based on a 1995 survey by pediatricians who do not perform this service. Specifically the RUC accepted the pediatrician survey data, including operative time and inpatient visits, but did not accept the pediatrician recommended work RVU because no compelling evidence was provided. Code 28002 clearly has had a flawed methodology employed in both prior reviews by the RUC.

Change in Patient Population

Poorly controlled blood sugar that occurs in diabetes can limit blood flow to the lower legs and foot, causing nerve damage that people with the disease may not sense until problems have already developed. People with advanced diabetes may develop wounds or sores that do not readily heal and that may become infected requiring incision and drainage. Diabetic patients typically have co-morbidities and increasingly present with compromised vasculature and wounds that are resistant to antibiotics. Although there have been advances in medical care and prevention of foot disease (ie, drugs, aggressive wound care, and emphasis on foot care) wound infections are common and can be serious is not aggressively treated and closely monitored.

Survey Process

A survey request was sent to a random selection of surgeons and podiatrists from the membership databases of the APMA, AOFAS, and AAOS. In April 2020, the societies noted that the number of responses from APMA was low compared with the orthopaedic surgeon response rate. The letter to the RUC stated that the low response rate may have been the result of the emergence of the pandemic during the survey effort and the fact that it would have been inappropriate to send reminders to members as the Covid-19 crisis was front and center in the United States health care system and professional societies were using their communication platforms to relay critical and time-sensitive updates to their membership. It was noted that the atypical low response rate from APMA might be due to their members understandably focusing their time and efforts on reshaping their practices to provide services to patients while keeping patients and staff safe. Although the minimum number of total surveys were received, the societies requested and the RUC agreed to postpone review of these family of codes until the Fall 2020 RUC meeting. This postponement would allow APMA to continue to collect survey responses by sending a reminder email request once it was felt an appropriate use of the society resources and physician time after the pandemic had slowed its spread in the United States and physician practices and communications were not consumed by the pandemic. The AAOS and AOFAS closed their survey and only APMA continued to survey by sending reminders to the initial randomly selected list of surveyees (ie, no new surveyees were added). This effort increased the APMA response of 25 to 84, which is greater than the total of the two orthopaedic surgeon societies combined. The RUC Summary Excel file presents the survey statistics for orthopaedic surgery, podiatry and for both specialties combined.

Recommendation - 28002

Work RVU: The survey median work RVU of 3.73 is recommended for 28002.

Pre-time Package 3: *Straightforward Patient/Difficult Procedure*
Positioning: Add 3 minutes to the package time to account for padding of bony prominences and application of thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; placing foam padding under nonoperative leg to minimize pressure on heel; placing the patient's operative leg properly on the table and positioning with proper bolstering to aid surgical exposure and prevent the leg from externally rotating; indicate areas of skin to be prepared and draped; and placing an ankle tourniquet.

Post-time Package 9B: General Anesthesia or Complex Regional Block/Complex Procedure
Package time reduced to be consistent with survey median postoperative time.

Key Reference Comparison

KRS 11043 is typically reported for debridement of a lower extremity ulcer for chronic wounds. This code is typically reported in nursing facilities and the patient's home. Tedious debridement of a chronic wound is less intense and complex than I&D below fascia as described by 28002 and therefore 11043 should have a lower IWPUT and lower work RVU than 28002. In addition, the typical patient for 28002 is in a hospital with inpatient status due to the severe nature of the infection in comparison to the typical patient for 11043 in a nursing facility or home.

KRS 11044 is typically reported for debridement of a lower extremity ulcer or pressure ulcer. The dominant site of service is nursing facility, although the patient almost equally can be treated in an office, outpatient hospital, or inpatient setting. In comparison with 28002, debridement is tedious and may take more time than 28002, but the patient presentation for 28002 is more complex and intense (ie, greater IWPUT).

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	**2.70**	0.051	86	41	30	15
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	**3.73**	0.079	100	50	30	20
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	**4.10**	0.061	118	51	45	20

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous	**2.75**	0.060	76	26	30	20
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	**3.73**	0.079	100	50	30	20
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	**4.46**	0.119	73	28	30	15

Other Comparison

For CY 2021, CMS finalized coding and RVU changes for the office and other outpatient evaluation and management (E/M) codes. This includes the ability to select a level of code based on total time alone, including both face-to-face and non-face-to-face time of the physician and/or other qualified health care provider on the date of the encounter. As shown in the table below, the recommended work RVU for 28002 is less than 99215 plus 99XXX x 3 which represents similar total time. Specifically, 99215 x 1 plus 99XXX x 3 represents 99 minutes of total time and a work RVU of 4.63.

The recommended work RVU of 3.73 is significantly (25%) less than what could be reported for an office visit for the same amount of time. This comparison of a surgical procedure to a common office-based service (>10 million Medicare claims) more than supports the work RVU recommendation of 3.73 for 28002.

CPT	DESCRIPTOR	RVW	TOTAL TIME
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	**3.73**	**100**
99215*	Office or other outpatient visit for the evaluation and management of an established patient,	**2.80**	40-54

	which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, **40-54 minutes of total time is spent on the date of the encounter**		
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15

*CY 2021

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28002

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6661
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty podiatry Frequency 5800 Percentage 87.07 %

Specialty orthopaedic surgery Frequency 580 Percentage 8.70 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 28002

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28003 Tracking Number Original Specialty Recommended RVU: **5.28**
Presented Recommended RVU: **5.28**
Global Period: 000 Current Work RVU: **9.06** RUC Recommended RVU: **5.28**

CPT Descriptor: Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male neuropathic, diabetic male presents with a hot, swollen, and erythematous foot with a draining plantar ulceration. A sterile probe reveals tracking from plantar to dorsal. An incision and drainage of multiple areas below the fascia is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review results of preadmission testing including laboratory tests and imaging. Review and update H&P. Write orders for preoperative medications. Meet with patient and family to review planned procedure and postoperative management. Review informed consent with patient. Verify all required equipment, instruments and supplies are available. Monitor and/or assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head; adjust as needed. Place foam pad under nonoperative leg to minimize pressure on heel. Place the patient's operative leg properly on the table and position with proper bolstering to aid surgical exposure and prevent leg from externally rotating. Indicate areas of skin to be prepared. Place an ankle tourniquet. Prepare the leg and foot. Scrub and gown. Drape the leg and foot. Elevate the operative leg with a black foam ramp pad to above heart level and exsanguinate the leg. Inflate the pneumatic tourniquet. Perform surgical time out with operating surgical team. (Note: additional re-positioning, re-prepping and re-draping will occur during the procedure.)

Description of Intra-Service Work: An incision is made on the plantar aspect of the foot and the non-viable margins of the ulceration are excised. The incision is extended to the plantar medial compartment of the foot, being careful to avoid any damage to the plantar nerves, flexor tendons, or short tendons as well as the vascular structures of the foot. The medial plantar compartment is widely opened, irrigated, and debrided and any non-viable tissue is removed. A separate dorsal incision is made to expose the infected dorsal medial compartment. The incision is deepened being careful to avoid any damage to the nerves, extensor tendons, or short tendons as well as the vascular structures of the foot. Cultures are obtained and sent to pathology. After hemostasis is achieved, the tourniquet is deflated and blood supply to the area is assessed. The wound is vigorously irrigated. The wound is then left open and packed with an appropriate dressing.

Description of Post-Service Work: Apply a dressing and splint, as required. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia, and type and dosing of antibiotic. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Discuss management of medical comorbidities with medical physician. Evaluate vascular status and intake and output. Examine patient, assess for bleeding. Assess circulation, sensation, and motor function of operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and

family questions. Coordinate care as necessary with other physicians (eg, endocrinology, PCP). Answer nursing and other staff questions. Chart patient progress notes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD					
Specialty Society(ies):	APMA, AAOS, AOFAS					
CPT Code:	28003					
Sample Size:	1872	**Resp N:**	164			
Description of Sample:	Random selection from society membership databases					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**5.00**	15.00	125.00
Survey RVW:		2.00	4.19	**5.28**	7.01	11.95
Pre-Service Evaluation Time:				**40.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		12.00	35.00	**45.00**	60.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	28003	**Recommended Physician Work RVU: 5.28**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11044	000	4.10	**RUC Time**

CPT Descriptor Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20245	000	6.00	**RUC Time**

CPT Descriptor Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36475	000	5.30	**RUC Time**	109,583

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52351	000	5.75	**RUC Time**	22,929

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

Other Reference CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 64 **% of respondents:** 39.0 **%**

Number of respondents who choose 2nd Key Reference Code: 37 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 28003	Top Key Reference CPT Code: 11044	2nd Key Reference CPT Code: **20245**
Median Pre-Service Time	65.00	51.00	70.00
Median Intra-Service Time	45.00	45.00	60.00
Median Immediate Post-service Time	20.00	20.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**130.00**	**116.00**	**160.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	2%	3%	27%	47%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	30%	66%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	34%	59%
Physical effort required	5%	38%	58%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	31%	64%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	5%	51%	38%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	24%	70%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	19%	68%
Physical effort required	8%	32%	59%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	16%	81%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Global Period

Code 28002 was identified by the RUC Relativity Assessment Workgroup through a screen of 10-day global codes with utilization greater than 1,000 and more than one postoperative visit. Codes 28001 and 28003 were added as family codes.

When considering typical patient vignettes for a RUC survey, the stakeholder societies noted that these three major surgical procedures did not have a consistent global period; 28001 and 28002 have a 10-day global period and 28003 has a 90-day global period. The stakeholder societies and the RAW also noted that code 28002 had over 60% of claims in the inpatient setting, however, code 28002 only included 0.5 x 99238 which corresponds to same-day outpatient status.

The societies believe that there is a significant heterogeneity in the complexity of the patient population for this family of codes so as to make in problematic to identify the typical patient for the purpose of estimating typical hospital and office visits in a global period; the severity of underlying co-morbidities will require differing levels of follow-up care. Based on this information, the stakeholder societies sent a request to CMS through AMA staff to change the global period assignment for all three codes to 0-day. The societies argued that a 0-day global assignment will provide more accurate reporting of postoperative work for this multi-modal family of codes. CMS did not object and a survey was conducted for all three codes as 0-day global.

Flawed Methodology of Previous Valuation

28003: In 2010, CMS identified code 28002 as potentially misvalued through a site-of-service anomaly screen and code 28003 was added as a family code for review. In considering the specialty recommended work RVU for 28003, the RUC focused on the difference in intra-service time for 28003 compared with the key reference code 28046 and disregarded the difference in postoperative work, both in terms of the number and level of postoperative visits. This flawed review resulted in a recommendation to maintain the current work RVU even though the total time for the reference code was almost identical to 28003. The RUC recommendation also resulted in an IWPUT of almost zero – something the RUC would recognize today as a flawed value.

Change in Patient Population

Poorly controlled blood sugar that occurs in diabetes can limit blood flow to the lower legs and foot, causing nerve damage that people with the disease may not sense until problems have already developed. People with advanced diabetes may develop wounds or sores that do not readily heal and that may become infected requiring incision and drainage. Diabetic patients typically have co-morbidities and increasingly present with compromised vasculature and wounds that are resistant to antibiotics. Although there have been advances in medical care and prevention of foot disease (ie, drugs, aggressive wound care, and emphasis on foot care) wound infections are common and can be serious is not aggressively treated and closely monitored.

Survey Process

A survey request was sent to a random selection of surgeons and podiatrists from the membership databases of the APMA, AOFAS, and AAOS. In April 2020, the societies noted that the number of responses from APMA was low compared with the orthopaedic surgeon response rate. The letter to the RUC stated that the low response rate may have been the result of the emergence of the pandemic during the survey effort and the fact that it would have been inappropriate to send reminders to members as the Covid-19 crisis was front and center in the United States health care system and professional societies were using their communication platforms to relay critical and time-sensitive updates to their membership. It was noted that the atypical low response rate from APMA might be due to their members understandably focusing their time and efforts on reshaping their practices to provide services to patients while keeping patients and staff safe. Although the minimum number of total surveys were received, the societies requested and the RUC agreed to postpone review of these family of codes until the Fall 2020 RUC meeting. This postponement would allow APMA to continue to collect survey responses by sending a reminder email request once it was felt an appropriate use of the society resources and physician time after the pandemic had slowed its spread in the United States and physician practices and communications were not consumed by the pandemic. The AAOS and AOFAS closed their survey and only APMA continued to survey by sending reminders to the initial randomly selected list of surveyees (ie, no new surveyees were added). This effort increased the APMA response of 25 to 84, which is greater than the total of the two orthopaedic surgeon societies combined. The RUC Summary Excel file presents the survey statistics for orthopaedic surgery, podiatry and for both specialties combined.

Recommendation - 28003

Work RVU: The survey median work RVU of 5.28 is recommended for 28003.

Pre-time Package 4: *Difficult Patient/Difficult Procedure*
Positioning: Add 7 minutes to the package time to account for padding of bony prominences and application of thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; placing foam padding under nonoperative leg to minimize pressure on heel; placing the patient's operative leg properly on the table and positioning with proper bolstering to aid surgical exposure and prevent the leg from externally rotating; indicate areas of skin to be prepared and draped; and placing an ankle tourniquet. In addition, re-positioning, and additional prepping, draping and stabilizing will be required to accommodate the multiple I&D sites.

Post-time Package 9B: General Anesthesia or Complex Regional Block/Complex Procedure
Package time reduced to be consistent with survey median postoperative time.

Key Reference Comparison

KRS 11044 is typically reported for debridement of a lower extremity ulcer or pressure ulcer. The dominant site of service is nursing facility, although the patient almost equally can be treated in an office, outpatient hospital, or inpatient setting. In comparison with 11044 , the patient presentation for 28003 is more complex and intense (ie, greater IWPUT) due to the typical patient being inpatient and more acutely ill, the infection and involvement of tissue being more wide-spread within multiple compartments of the foot requiring deep space inspection and drainage, rather than more localized as seen with 11044.

KRS 20245 is a similar code in that the typical patient will have an infection. A deep bone biopsy will require more intra-time compared with 28003 because of a deeper dissection (typical patient involves the ischio-acetabular region of the left hemipelvis). However, 28003 is more complex compared with 20245 which is a diagnostic biopsy in which only a small portion of tissue is being removed for the biopsy, versus making multiple incisions, draining purulence, inspecting, and removing all non-viable tissue from multiple compartments, leaving large surgical sites packed open.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	**4.10**	0.061	118	51	45	20
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	**5.28**	0.080	130	65	45	20
20245	Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)	**6.00**	0.066	160	70	60	30

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	**5.28**	0.080	130	65	45	20
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	**5.30**	0.109	89	34	40	15
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	**5.75**	0.095	118	53	45	20

Other Comparison

For CY 2021, CMS finalized coding and RVU changes for the office and other outpatient evaluation and management (E/M) codes. This includes the ability to select a level of code based on total time alone, including both face-to-face and non-face-to-face time of the physician and/or other qualified health care provider on the date of the encounter. As shown in the table below, the recommended work RVU for 28003 is less than 99215 plus 99XXX x 5 which represents similar total time. Specifically, 99215 x 1 plus 99XXX x 5 represents 129 minutes of total time and a work RVU of 5.85.

The recommended work RVU of 5.28 is 10% less than what could be reported for an office visit for the same amount of time. This comparison of a surgical procedure to a common office-based service (>10 million Medicare claims) more than supports the work RVU recommendation of 5.28 for 28003.

CPT	DESCRIPTOR	RVW	TOTAL TIME
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	**5.28**	**130**
99215*	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical	**2.80**	40-54

	decision making. When using time for code selection, **40-54 minutes of total time is spent on the date of the encounter**		
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15
99XXX*	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	**0.61**	15

*CY 2021

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28003

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,470
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty podiatry Frequency 4400 Percentage 80.43 %

Specialty orthopaedic surgery Frequency 400 Percentage 7.31 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 28803

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Treatment of Foot Infection

TAB: 6

							RVW					Total	PRE			INTRA					POST					POST-OFFIC		12 Month Svy Experience					
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	32	31	38	39	13	12	MIN	25th	MED	75th	MAX	TYP?
REF1	11042	0	Debridement, subcutaneous tissue (include	58	0.037	0.028			1.01			36	9	1	1			15			10												
REF2	11043	0	Debridement, muscle and/or fascia (include	40	0.051	0.031			2.70			86	33	3	5			30			15												
current	28001	10	Incision and drainage, bursa, foot		0.060	0.041			2.78			67	10	0	0			31			10					1							
SVY	28001	0	Incision and drainage, bursa, foot	164	0.069	0.033	0.75	1.43	2.48	3.00	6.20	76	25	6	10	2	15	20	26	60	15							0	3	5	12	200	90%
			podiatry	*84*	*0.046*	*0.027*	*0.75*	*1.25*	*2.00*	*2.86*	*5.30*	*75*	*25*	*5*	*10*	*2*	*12*	*20*	*25*	*60*	*15*							*0*	*3*	*10*	*20*	*200*	*90%*
			orthopaedic surgery	*80*	*0.075*	*0.034*	*1.00*	*1.54*	*2.70*	*3.15*	*6.20*	*80*	*25*	*10*	*10*	*4*	*15*	*20*	*30*	*45*	*15*							*0*	*2*	*5*	*10*	*50*	*89%*
REC	28001	0	Incision and drainage, bursa, foot		0.059	0.033			2.00			60	17	3	5			20			15												
COMP	19283	0	Placement of breast localization device(s) (eg, clip, metallic pellet,		0.063	0.035			2.00			57	13	3	6			20			15												
COMP	49084	0	Peritoneal lavage, including imaging guidance, when performed		0.061	0.034			2.00			58	15	3	5			20			15												

							RVW					Total	PRE			INTRA					POST					POST-OFFIC		12 Month Svy Experience					
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	32	31	38	39	13	12	MIN	25th	MED	75th	MAX	TYP?
REF1	11043	0	Debridement, muscle and/or fascia (include	63	0.051	0.031			2.70			86	33	3	5			30			15												
REF2	11044	0	Debridement, bone (includes epidermis, de	28	0.061	0.035			4.10			116	33	3	15			45			20												
CURRENT	28002	10	Incision and drainage below fascia, with or		0.048	0.033			5.34			163	30	3	15			30			20			0.5		2							
SVY	28002	0	Incision and drainage below fascia, with or	164	0.077	0.036	1.20	2.80	3.73	4.72	8.95	103	30	8	15	8	20	30	40	65	20							0	4	8	15	150	96%
			podiatry	*84*	*0.074*	*0.036*	*1.20*	*2.75*	*3.60*	*4.56*	*8.00*	*101*	*30*	*6*	*15*	*8*	*21*	*30*	*40*	*60*	*20*							*0*	*3*	*9*	*20*	*150*	*94%*
			orthopaedic surgery	*80*	*0.081*	*0.037*	*1.40*	*2.84*	*3.90*	*5.00*	*8.95*	*105*	*30*	*10*	*14.5*	*8*	*20*	*30*	*45*	*65*	*20*							*0*	*4*	*7*	*10*	*50*	*98%*
REC	28002	0	Incision and drainage below fascia, with or wit		0.072	0.035			3.50			100	30	5	15			30			20												
XWALK	31287	0	Nasal/sinus endoscopy, surgical, with sp		0.081	0.041			3.50			86	15	8	13			30			20												

							RVW					Total	PRE			INTRA					POST					POST-OFFIC		12 Month Svy Experience					
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	32	31	38	39	13	12	MIN	25th	MED	75th	MAX	TYP?
REF1	11044	0	Debridement, bone (includes epidermis, de	64	0.061	0.035			4.10			116	33	3	15			45			20												
REF2	20245	0	Biopsy, bone, open; deep (eg, humeral sha	37	0.066	0.038			6.00			160	40	15	15			60			30												
CURRENT	28003	90	Incision and drainage below fascia, with or		0.007	0.028			9.06			323	33	3	15			53			20	1	1	1.0		3	2						
SVY	28003	0	Incision and drainage below fascia, with or	164	0.080	0.041	2.00	4.19	5.28	7.01	11.95	130	40	10	15	12	35	45	60	120	20							0	2	5	15	125	95%
			podiatry	*84*	*0.070*	*0.037*	*2.00*	*4.10*	*4.88*	*6.90*	*10.90*	*133*	*40*	*9*	*15*	*15*	*30*	*45*	*60*	*90*	*24*							*0*	*2*	*5*	*20*	*125*	*92%*
			orthopaedic surgery	*80*	*0.096*	*0.047*	*2.45*	*4.30*	*6.00*	*7.15*	*11.95*	*129*	*39*	*10*	*15*	*12*	*35*	*45*	*60*	*120*	*20*							*0*	*3*	*8*	*12*	*40*	*99%*
REC	28003	0	Incision and drainage below fascia, with or wit		0.080	0.041			5.28			130	40	10	15			45			20												

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2020

CPT Code	Long Descriptor	Global Period
28001	Incision and drainage, bursa, foot	~~010~~ 000
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	~~010~~ 000
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	~~090~~ 000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
28001	A 60-year-old female presents with a painful, inflamed and infected bursa plantar to the fifth metatarsal head. An incision and drainage of the bursa is performed.
28002	A 55-year-old neuropathic, diabetic male presents with an open wound on the plantar aspect of the foot, with surrounding fluctuance. An incision and drainage of a single bursal space below the fascia is performed.
28003	A 55-year-old male neuropathic, diabetic male presents with a hot, swollen, and erythematous foot with a draining plantar ulceration. A sterile probe reveals tracking from plantar to dorsal. An incision and drainage of multiple areas below the fascia is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Advisors and their coding and reimbursement committee members reviewed the current inputs based on 10-day and 90-day global (ie, including postoperative office visits) and adjusted inputs as needed.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Current code details are used for reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   28001 – No

   28002 – Mixed. The Medicare billed-with data provided for the Oct 2020 RUC meeting is based on the 2018 5% beneficiary file and shows 52% of 62 claims were reported with an E/M in the office setting. However, the Medicare billed-with data provided for the Apr 2020 RUC meeting, which was based on the 2017 5% beneficiary file showed 38% of 40 claims were reported with an E/M in the office setting. We do not believe that such low claims data (less than 100) should be considered valid. We also disagree that either of these statistics (2017 or 2018) represents the typical patient who is non-Medicare

aged and will be an established patient for whom the physician is continually monitoring lower extremity wounds. For these patients, a separately identifiable and distinct E/M service on the day of the operation would not typically be required.

28003 - No

2017 Medicare data:

CPT Code	5% File (Non-Fac ONLY; Global + TC)	% Billed with Office E/M *(ALL; Global+26)*	% Billed with Office E/M *Non-Fac ONLY; Global + TC)*
28001	120	28%	35%
28002	40	6%	38%
28003	21	3%	14%

2018 Medicare data:

CPT Code	5% File (Non-Fac ONLY; Global + TC)	% Billed with Office E/M *(ALL; Global+26)*	% Billed with Office E/M *Non-Fac ONLY; Global + TC)*
28001	146	28%	30%
28002	62	12%	52%
28003	<11	3%	n/a

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

		NonFAC	FAC
28001	podiatry	99%	96%
28002	podiatry	97%	88%
28003	podiatry	55%	79%

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

5 minutes for 5 or more vitals (blood pressure, pulse, weight, temperature, respiration rate)

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

			28001		28002		28003		
Row	Code	Activity	current	rec	current	rec	current	rec	comments
15	CA001	Complete pre-service diagnostic and referral forms	**5**	**0**	**5**	**5**	**5**	**5**	28001: N/A 28002 and 28003: Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
16	CA002	Coordinate pre-surgery services (including test results)	**3**	**0**	**3**	**3**	**10**	**3**	28001: N/A 28002 and 28003: Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information from other providers. Enter and record all clinical updates in EHR.
17	CA003	Schedule space and equipment in facility		**0**		**0**	**0**	**0**	28001: N/A 28002 and 28003: N/A
18	CA004	Provide pre-service education/obtain consent	**3**	**0**	**7**	**7**	**10**	**7**	28001: N/A 28002 and 28003: Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions
19	CA005	Complete pre-procedure phone calls and prescription		**0**		**3**	**10**	**3**	28001: N/A 28002 and 28003: Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission family/caregiver questions. Enter and record in EHR.

   b. Service period (includes pre, intra and post):

			28001		28002		28003		
Row	Code	Activity	current	rec	current	rec	current	rec	comments
		Pre-Service (of service period)							
24	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	**5**	**3**	**5**	**3**	**5**	**3**	28001. 28002, 28003: 3 minute standard
25	CA010	Obtain vital signs	**3**	**5**	**3**	**5**	**5**	**5**	28001. 28002, 28003:

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

			28001		28002		28003		
Row	Code	Activity	current	rec	current	rec	current	rec	comments
									5 minutes for 5 or more vitals (blood pressure, pulse, weight, temperature, respiration rate)
26	CA011	Provide education/obtain consent		**2**					28001: Education provided after arrival to office (ie, not provided in pre-service period. 28002, 28003: N/A, education provided in pre-service period.
27	CA013	Prepare room, equipment and supplies	**2**	**2**	**2**	**2**	**5**	**2**	28001. 28002, 28003: Standard time. Set up instruments, suction supplies and equipment, cautery supplies and equipment, etc.
28	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	**2**	**2**	**3**	**2**	**2**	**2**	28001. 28002, 28003: Standard time. Set up injection supplies and assist physician with positioning.
29	CA017	Sedate/apply anesthesia	**2**	**2**	**2**	**2**	**2**	**2**	28001. 28002, 28003: Standard time. Assist MD during injection of local anesthetic
		Intra-service (of service period)							
31	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)		**20**		**30**	**53**	**45**	28001. 28002, 28003: Assist MD 100%. Assist with suctioning/irrigation during procedure, hand off instruments and supplies. Obtain additional supplies as needed.
32	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	**21**		**40**				N/A, see CA018
		Post-Service (of service period)							
35	CA022	Monitor patient following procedure/service, multitasking 1:4				**2**		**2**	28001: N/A 28002, 28003: Patient will typically be monitored for at least 10-15 minutes after being returned to supine from prone. Cleaning room for 3 minutes reduces time to 7-12 minutes. Assuming clinical staff can multitask and check on patient 1:4 for remainder of time, then 2-3 additional minutes applies. We are recommending 2 minutes.
36	CA023	Monitor patient following procedure/service, no multitasking	**2**		**2**		**2**		N/A, see CA022
37	CA024	Clean room/equipment by clinical staff	**3**	**3**	**3**	**3**	**3**	**3**	28001. 28002, 28003: Standard time. Clean suction, cautery equipment and supplies. Safely dispose of all hazardous

			28001		28002		28003		
Row	Code	Activity	current	rec	current	rec	current	rec	comments
									waste. Log and return injection vial to medication cart/room.
38	CA026	Clean surgical instrument package	**10**	**10**	**10**	**10**	**15**	**15**	28001, 28002: Standard time basic pack 28003: Standard time medium pack
39	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions		**2**		**2**	**3**	**2**	28001. 28002, 28003: Staff will label, package, and document specimen for transport to lab
40	CA029	Check dressings, catheters, wounds	**3**	**1**	**3**	**1**	**3**	**1**	28001. 28002, 28003: Prior to and after patient gets dressed, check dressings. Reapply tape as needed.
41	CA035	Review home care instructions, coordinate visits/prescriptions		**2**		**2**		**2**	28001. 28002, 28003: Reinforce MD instructions about care of wound, activity, bathing, etc.
		End: Patient leaves office/facility							

c. Post-service period:

			28001		28002		28003		
Row	Code	Activity	current	rec	current	rec	current	rec	comments
		Pre-Service (of service period)							
46	CA037	Conduct patient communications		**3**		**3**		**3**	28001. 28002, 28003: Clinical staff will communicate with patient / respond to patient questions regarding care of wound and dressings and pain control.
50	CA039	99212 27 minutes	**1**				**2**		Delete – global change to 000
51	CA039	99213 36 minutes			**2**		**3**		Delete – global change to 000

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Clinical staff will be available throughout the procedure to circulate and provide clean supplies and instruments, assist with equipment needs, and assist with maintaining patient's extremity position or repositioning.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
64	SA048	pack, minimum multi-specialty visit	pack	2	1	3	1	6	1	standard pack applies
65		*paper, exam table 7 foot*								
66		*gloves, non-sterile 2 pair*								
67		*gown, patient 1 item*								
68		*pillow case 1 item*								
69		*cover, thermometer probe 1 item*								
70	SB024	gloves, sterile	pair		4		4		4	double glove – both MD and staff (2x2=4)
71	SB027	gown, staff, impervious	item		2		2		2	MD and staff
72	SB033	mask, surgical	item		2		2		2	MD and staff
73	SB039	shoe covers, surgical	pair		2		2		2	MD and staff
74	SB001	cap, surgical	item		2		2		2	MD and staff
75	SB012	drape, sterile, for Mayo stand	item		1		1		1	Mayo stand needed for instruments and supplies
76	SB015	drape, sterile, u-shape	item		1		1		1	drape to isolate foot

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
77	SG015	bandage, Esmarch-Martin, sterile 3in x 9ft	item		1		1		1	tourniquet
78	SB020	drape-towel, sterile OR blue (2 pk uou)	item		1		1		1	draping and blotting irrigation throughout procedure
79	SB016	drape-cover, sterile, OR light handle	item		1		1	2	1	OR light in procedure room
80	SA088	tray, surgical skin prep, sterile	tray	1	1	1	1	1	1	Pre-packaged for skin prep
81		*(2) absorbent blotting towels*								
82		*(2) patient underdrapes,*								
83		*(2) cotton tipped applicators*								
84		*(1) pair latex procedure gloves,*								
85		*(1) hospital wrap*								
86		*(1) 110ml bottle PVP-I scrub solution*								
87		*(1) 155ml packet PVP-I topical solution*								
88		*(3) sponge sticks*								
89		*(6) small foam winged sponges*								
90	SJ025	ethyl chloride spray	oz	1	0	1	0			delete - not typical for these procedures
91	SC029	needle, 18-27g	item	2	2	2	2	2	2	one to draw and one to inject (different gage needles)
92	SC051	syringe 10-12ml	item	1	1	1	1	1	1	for local anesthetic
93	SH047	lidocaine 1%-2% inj (Xylocaine)	ml	10	10	10		10		only for 28001 (see SH047 for 28002, 28003)
94	SH021	bupivacaine 0.25% inj (Marcaine)	ml		0		10		10	28001: N/A 28002, 28003: Marcaine typical for below facia I&D
95	SJ053	swab-pad, alcohol	item	1	1	1	1		1	wipe top of anesthetic vial
96	SF020	cautery, monopolar, pencil-handpiece	item		0		1	1	1	only applies to 28002 and 28003
97	SF021	cautery, patient ground pad w-cord	item		0		1	1	1	only applies to 28002 and 28003
98	SF033	scalpel with blade, surgical (#10-20)	item	1	1	1	2	2	2	required for performance of the procedure
99	SF036	suture, nylon, 3-0 to 6-0, c	item	1	0	1	0		0	delete - wounds are packed, not closed
100	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	item	1	1	1	1	1	1	for irrigation of wound(s)

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
101	SJ010	basin, emesis	item					1	0	delete - replaced with irrigation basin
102	SJ009	basin, irrigation	item	1	1	1	1	1	1	irrigation basin used to dispose of contaminated supplies
103	SJ011	bulb syringe (Asepto)	item	1	0	1	0	1	0	delete - replaced with 50-60 ml syringe
104	SC056	syringe 50-60ml	item		1		1		1	large volume syringe used for irrigation
105	SG016	bandage, Kerlix, sterile 4.5in	item	1	1	1	1	1	1	final protective wrap
106	SG040	dressing, 5in x 9in (Adaptic)	item	1	0	1	1		1	only for 28002 and 28003
107	SG055	gauze, sterile 4in x 4in	item	6	4	1	0	1	0	only for 28001
108	SG056	gauze, sterile 4in x 4in (10 pack uou)	item		0	1	1	1	1	only for 28002 and 28003
109	SG062	packing, gauze plain 0.25-0.50in (5 yd uou)	item		0	0.03	1.00		1.00	28001: N/A 28002, 28003: This item is a "unit of use" suppliy, must discard remainder.
110	SG079	tape, surgical paper 1in (Micropore)	inch	6	12	6	12	6	18	to tape gauze over wound(s) and Kerlix
111	SA043	pack, cleaning, surgical instruments	pack	1	1	1	1	1	1	standard for cleaning instruments
112	SL036	cup, biopsy-specimen sterile 4oz	item		1		1		1	specimen sent for culture
113	SA054	pack, post-op incision care (suture)	pack	1	0	1	0			delete pack - individual items identified above
114		~~*kit, suture removal, kit, 1*~~								
115		~~*povidone soln (Betadine), ml, 10*~~								
116		~~*gauze, sterile 4in x 4in, item, 2*~~								
117		~~*gloves, sterile, pair, 1*~~								
118		~~*steri strip (6 strip uou), item, 2*~~								
119		~~*swab pad, alcohol, item, 2*~~								
120		~~*tape, surgical paper 1in (Micropore), inch, 12*~~								
121		~~*tincture of benzoin, swab, item, 1*~~								
122	SA080	pack, drapes, ortho, large	pack	1	0	1	0	1	0	delete pack - individual items identified above
123		~~*drape, sterile, for Mayo stand, item, 1*~~								
124		~~*drape, sterile, u-shape, item, 1*~~								

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 28001, 28002, 28003
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
125		~~drape, sterile, three-quarter sheet, item, 1~~								
126		~~bandage, Esmarch-Martin, sterile 3in x 9ft, item, 1~~								
127		~~drape, sterile, hand-upper extremity, item, 1~~								
128	SA083	pack, protective, ortho, large	pack					1	0	delete pack - individual items identified above
129		~~gloves, non-sterile, pair, 2~~								
130		~~gloves, sterile, pair, 4~~								
131		~~gown, staff, impervious, item, 2~~								
132		~~mask, surgical, with face shield, item, 2~~								
133		~~shoe covers, surgical, pair, 2~~								
134		~~cap, surgical, item, 1~~								
135	SA084	pack, protective, ortho, small	pack	1	0	1	0			delete pack - individual items identified above
136		~~gloves, non-sterile, pair, 2~~								
137		~~gloves, sterile, pair, 2~~								
138		~~gown, staff, impervious, item, 1~~								
139		~~mask, surgical, with face shield, item, 1~~								
140		~~cap, surgical, item, 1~~								

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
143	EF031	table, power	Default	80	40	139	48	260.5	63	=+24+25+26+27+28+29+

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

				28001		28002		28003		
Row	Code	Activity	Item	current	rec	current	rec	current	rec	comments
										31+32+33+37+40
144	EF014	light, surgical	Default	55	40	69	48	260.5	63	=+24+25+26+27+28+29+31+32+33+37+40
145	EF015	mayo stand		55	40	69	48	98	63	=+24+25+26+27+28+29+31+32+33+37+40
146	EQ137	instrument pack, basic ($500-$1499)	Instrument Packs	55	46		54			=+24+25+26+27+28+29+31+32+33+38
147	EQ138	instrument pack, medium ($1500 and up)	Instrument Packs			69		98	74	=+24+25+26+27+28+29+31+32+33+38
148	EQ110	electrocautery-hyfrecator, up to 45 watts	Default				48	98	63	=+24+25+26+27+28+29+31+32+33+37+40 =+24+25+26+27+28+29+31+32+33+37+40
149	EQ235	suction machine (Gomco)						98	0	DELETE
150	EQ168	light, exam		27		72				DELETE

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

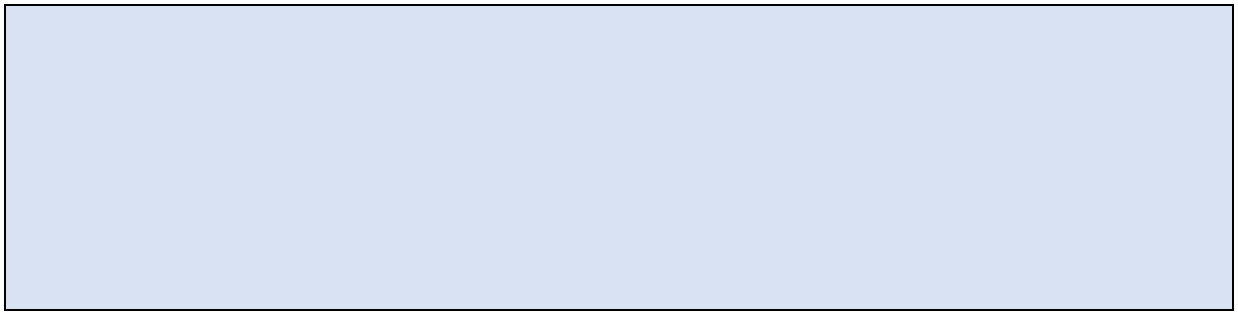
22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at

samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).



FACILITY DIRECT PE INPUTS

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2020

CPT Code	Long Descriptor	Global Period
28001	Incision and drainage, bursa, foot	~~010~~ 000
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	~~010~~ 000
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	~~090~~ 000

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
28001	A 60-year-old female presents with a painful, inflamed and infected bursa plantar to the fifth metatarsal head. An incision and drainage of the bursa is performed.
28002	A 55-year-old neuropathic, diabetic male presents with an open wound on the plantar aspect of the foot, with surrounding fluctuance. An incision and drainage of a single bursal space below the fascia is performed.
28003	A 55-year-old male neuropathic, diabetic male presents with a hot, swollen, and erythematous foot with a draining plantar ulceration. A sterile probe reveals tracking from plantar to dorsal. An incision and drainage of multiple areas below the fascia is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Advisors and their coding and reimbursement committee members reviewed the current inputs based on 10-day and 90-day global (ie, including postoperative office visits) and adjusted inputs as needed.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Current code details are used for reference.

3. Is this code(s) typically reported with an E/M service?

   no

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   28001, Minimal use of clinical staff.
   28002, Extensive use of clinical staff: is a major procedure that is typically performed in a facility inpatient setting under regional block or general anesthesia. The change to a 0-day global was requested to account for variable postoperative care and in no way changes the major procedure pre-service clinical staff work that is typical for major procedures.
   28003 is a major procedure that is typically performed in a facility inpatient setting under general

anesthesia. The change to a 0-day global was requested to account for variable postoperative care and in no way changes the major procedure pre-service clinical staff work that is typical for major procedures. Therefore, we are recommending the 90-day global major surgery pre-service standard for the facility setting.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms	These patients will have been followed by PCPs and have failed medical management. Clinical staff will obtain and complete pre-service diagnostic and referral forms
Coordinate pre-surgery services (including test results)	Prior to surgery, clinical staff will obtain all prior records including medications and tests and work with surgeon to obtain new more current tests and images as needed to be certain patient is cleared for surgery.
Schedule space and equipment in facility	Clinical staff will schedule and confirm availability of all necessary equipment and instruments.
Provide pre-service education/obtain consent	Clinical staff will provide education to the patient and family, reinforcing the surgeon's communications about surgical risks, benefits and postoperative recover.
Complete pre-procedure phone calls and prescription	Clinical staff will confirm with the patient and family the surgeon's orders for any changes in medication for comorbid diseases and antibiotics prior to admission for surgery.

   b. Service period (includes pre, intra and post):

N/A - Delete time – discharge management not allowed for 0-day global codes.

   c. Post-service period:

Conduct patient communications	The procedures are inpatient or at least overnight when performed in the facility setting and therefore clinical staff will not be contacting the patient on the same date as surgery

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

CPT CODE(S): 28001, 28002, 28003
SPECIALTY SOCIETY(IES): APMA, AAOS, AOFAS
PRESENTER(S): Brooke Bisbee, DPM; Peter Mangone, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2						28001		28001		28002		28002		28003		28003	
3		*RUC Collaboration Website*				Incision and drainage, bursa, foot		Incision and drainage, bursa, foot		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	
4	Clinical Activity Code	Meeting Date: 10/2020 Revision Date (if applicable): Tab: 14 Specialty: APMA, AOFAS, AAOS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute												
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				10	10	0	0	10	10	0	0	90	90	0	0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 124.40	$ 33.91	$ 75.33	$ 5.55	$ 154.80	$ 52.31	$ 105.25	$ 11.10	$ 221.18	$ 105.63	$ 113.47	$ 11.10
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	91.0	69.0	57.0	15.0	160.0	108.0	85.0	30.0	295.0	234.0	105.0	30.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	11.0	30.0	0.0	15.0	15.0	30.0	18.0	30.0	35.0	60.0	18.0	30.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	53.0	12.0	54.0	0.0	73.0	6.0	64.0	0.0	98.0	12.0	84.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	27.0	27.0	3.0	0.0	72.0	72.0	3.0	0.0	162.0	162.0	3.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER				$ 33.67	$ 25.53	$ 21.09	$ 5.55	$ 59.20	$ 39.96	$ 31.45	$ 11.10	$ 109.15	$ 86.58	$ 38.85	$ 11.10
13		PRE-SERVICE PERIOD															
14		Start: Following visit when decision for surgery/procedure made															
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5	5	0	3	5	5	5	5	5	5	5	5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	3	10	0	3	3	10	3	10	10	20	3	10
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		5	0	3		5	0	5	0	8	0	5
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	3	7	0	3	7	7	7	7	10	20	7	7
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		3	0	3		3	3	3	10	7	3	3
20		End: When patient enters office/facility for surgery/procedure															
21		SERVICE PERIOD															
22		Start: When patient enters office/facility for surgery/procedure:															
23		Pre-Service (of service period)															
24	CA009	Greet patient, provide gowning, ensure appropriate medical	L037D	RN/LPN/MTA	0.37	5		3		5		3		5		3	
25	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	3		5		3		5		5		5	
26	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			2									
27	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2		2		2		5		2	
28	CA016	Prepare, set-up and start IV, initial positioning and monitoring	L037D	RN/LPN/MTA	0.37	2		2		3		2		2		2	
29	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37	2		2		2		2		2		2	
30		Intra-service (of service period)															
31	CA018	Assist physician or other qualified healthcare professional---	L037D	RN/LPN/MTA	0.37			20				30		53		45	
32	CA019	Assist physician or other qualified healthcare professional---	L037D	RN/LPN/MTA	0.37	21				40							
34		Post-Service (of service period)															
35	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37							2				2	
36	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37	2				2				2			
37	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3		3		3		3		3	
38	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37	10		10		10		10		15		15	
39	CA027	Complete post-procedure diagnostic forms, lab and x-ray	L037D	RN/LPN/MTA	0.37			2				2		3		2	
40	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	3		1		3		1		3		1	
41	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			2				2				2	
42	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a	12	n/a		n/a	6	n/a		n/a	12	n/a	
43		End: Patient leaves office/facility															
44		POST-SERVICE PERIOD															
45		Start: Patient leaves office/facility															
46	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37			3				3				3	
48		*Office visits: List Number and Level of Office Visits*	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
49		99211 16 minutes	16														
50		99212 27 minutes	27			1	1							2	2		
51		99213 36 minutes	36							2	2			3	3		
52		99214 53 minutes	53														
53		99215 63 minutes	63														
54	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	27.0	27.0	0.0	0.0	72.0	72.0	0.0	0.0	162.0	162.0	0.0	0.0
61		End: with last office visit before end of global period															

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**28001**		**28001**		**28002**		**28002**		**28003**		**28003**	
3		***RUC Collaboration Website***				Incision and drainage, bursa, foot		Incision and drainage, bursa, foot		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 14 Specialty: APMA, AOFAS, AAOS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**												
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**10**	**10**	**0**	**0**	**10**	**10**	**0**	**0**	**90**	**90**	**0**	**0**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 124.40**	**$ 33.91**	**$ 75.33**	**$ 5.55**	**$ 154.80**	**$ 52.31**	**$ 105.25**	**$ 11.10**	**$ 221.18**	**$ 105.63**	**$ 113.47**	**$ 11.10**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**91.0**	**69.0**	**57.0**	**15.0**	**160.0**	**108.0**	**85.0**	**30.0**	**295.0**	**234.0**	**105.0**	**30.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**30.0**	**0.0**	**15.0**	**15.0**	**30.0**	**18.0**	**30.0**	**35.0**	**60.0**	**18.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**12.0**	**54.0**	**0.0**	**73.0**	**6.0**	**64.0**	**0.0**	**98.0**	**12.0**	**84.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**27.0**	**3.0**	**0.0**	**72.0**	**72.0**	**3.0**	**0.0**	**162.0**	**162.0**	**3.0**	**0.0**
62	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**													
63		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 88.80**	**$ 7.85**	**$ 53.19**	**$ -**	**$ 92.10**	**$ 10.93**	**$ 72.43**	**$ -**	**$ 104.96**	**$ 15.41**	**$ 72.47**	**$ -**
64	SA048	pack, minimum multi-specialty visit	3.0815	pack		**2**	**1**	**1**		**3**	**2**	**1**		**6**	**5**	**1**	
65		*paper, exam table 7 foot*															
66		*gloves, non-sterile 2 pair*															
67		*gown, patient 1 item*															
68		*pillow case 1 item*															
69		*cover, thermometer probe 1 item*															
70	SB024	gloves, sterile	0.875	pair				**4**				**4**				**4**	
71	SB027	gown, staff, impervious	1.186	item				**2**				**2**				**2**	
72	SB033	mask, surgical	0.153	item				**2**				**2**				**2**	
73	SB039	shoe covers, surgical	0.219	pair				**2**				**2**				**2**	
74	SB001	cap, surgical	0.6745	item				**2**				**2**				**2**	
75	SB012	drape, sterile, for Mayo stand	1.379	item				**1**				**1**				**1**	
76	SB015	drape, sterile, u-shape	8.8935	item				**1**				**1**				**1**	
77	SG015	bandage, Esmarch-Martin, sterile 3in x 9ft	5.8625	item				**1**				**1**				**1**	
78	SB020	drape-towel, sterile OR blue (2 pk uou)	1.2435	item				**1**				**1**				**1**	
79	SB016	drape-cover, sterile, OR light handle	1.0795	item				**1**				**1**		**2**		**1**	
80	SA088	tray, surgical skin prep, sterile	5.1074	tray		**1**		**1**		**1**		**1**		**1**		**1**	
81		*(2) absorbent blotting towels*															
82		*(2) patient underdrapes,*															
83		*(2) cotton tipped applicators*															
84		*(1) pair latex procedure gloves,*															
85		*(1) hospital wrap*															
86		*(1) 110ml bottle PVP-I scrub solution*															
87		*(1) 155ml packet PVP-I topical solution*															
88		*(3) sponge sticks*															
89		*(6) small foam winged sponges*															
90	SJ025	ethyl chloride spray	5.2855	oz		**1**				**1**							
91	SC029	needle, 18-27g	0.0645	item		**2**		**2**		**2**		**2**		**2**		**2**	
92	SC051	syringe 10-12ml	0.197	item		**1**		**1**		**1**		**1**		**1**		**1**	
93	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0475	ml		**10**		**10**		**10**				**10**			
94	SH021	bupivacaine 0.25% inj (Marcaine)	0.377	ml				**0**				**10**				**10**	
95	SJ053	swab-pad, alcohol	0.0265	item		**1**		**1**		**1**		**1**				**1**	
96	SF020	cautery, monopolar, pencil-handpiece	5.154	item				**0**				**1**		**1**		**1**	
97	SF021	cautery, patient ground pad w-cord	5.045	item				**0**				**1**		**1**		**1**	
98	SF033	scalpel with blade, surgical (#10-20)	0.867	item		**1**		**1**		**1**		**2**		**2**		**2**	
99	SF036	suture, nylon, 3-0 to 6-0, c	2.8055	item		**1**		**0**		**1**		**0**				**0**	
100	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	2.707	item		**1**		**1**		**1**		**1**		**1**		**1**	
101	SJ010	basin, emesis	0.233	item										**1**		**0**	
102	SJ009	basin, irrigation	1.771	item		**1**		**1**		**1**		**1**		**1**		**1**	
103	SJ011	bulb syringe (Asepto)	1.415	item		**1**				**1**				**1**			
104	SC056	syringe 50-60ml	1.0055	item				**1**				**1**				**1**	
105	SG016	bandage, Kerlix, sterile 4.5in	1.166	item		**1**		**1**		**1**		**1**		**1**		**1**	
106	SG040	dressing, 5in x 9in (Adaptic)	1.679	item		**1**		**0**		**1**		**1**				**1**	
107	SG055	gauze, sterile 4in x 4in	0.1745	item		**6**		**4**		**1**		**0**		**1**		**0**	
108	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.999	item				**0**		**1**		**1**		**1**		**1**	
109	SG062	packing, gauze plain 0.25-0.50in (5 yd uou)	2.9015	item				**0**		**0.03**		**1.00**				**1.00**	
110	SG079	tape, surgical paper 1in (Micropore)	0.006	inch		**6**		**12**		**6**		**12**		**6**		**18**	
111	SA043	pack, cleaning, surgical instruments	8.9745	pack		**1**		**1**		**1**		**1**		**1**		**1**	
112	SL036	cup, biopsy-specimen sterile 4oz	0.4865	item				**1**				**1**				**1**	
113	SA054	pack, post-op incision care (suture)	4.7635	pack		**1**	**1**			**1**	**1**						
114		~~*kit, suture removal, kit, 1*~~															
115		~~*povidone soln (Betadine), ml, 10*~~															
116		~~*gauze, sterile 4in x 4in, item, 2*~~															
117		~~*gloves, sterile, pair, 1*~~															
118		~~*steri strip (6 strip uou), item, 2*~~															
119		~~*swab-pad, alcohol, item, 2*~~															
120		~~*tape, surgical paper 1in (Micropore), inch, 12*~~															
121		~~*tincture of benzoin, swab, item, 1*~~															
122	SA080	pack, drapes, ortho, large	38.973	pack		**1**				**1**				**1**			
123		~~*drape, sterile, for Mayo stand, item, 1*~~															
124		~~*drape, sterile, u-shape, item, 1*~~															
125		~~*drape, sterile, three-quarter sheet, item, 1*~~															
126		~~*bandage, Esmarch-Martin, sterile 3in x 9ft, item, 1*~~															
127		~~*drape, sterile, hand-upper extremity, item, 1*~~															
128	SA083	pack, protective, ortho, large	10.021	pack										**1**			
129		~~*gloves, non-sterile, pair, 2*~~															
130		~~*gloves, sterile, pair, 4*~~															
131		~~*gown, staff, impervious, item, 2*~~															
132		~~*mask, surgical, with face shield, item, 2*~~															
133		~~*shoe covers, surgical, pair, 2*~~															
134		~~*cap, surgical, item, 1*~~															

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**28001**		**28001**		**28002**		**28002**		**28003**		**28003**	
3		***RUC Collaboration Website***				Incision and drainage, bursa, foot		Incision and drainage, bursa, foot		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 14 Specialty: APMA, AOFAS, AAOS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**												
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**10**	**10**	**0**	**0**	**10**	**10**	**0**	**0**	**90**	**90**	**0**	**0**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 124.40**	**$ 33.91**	**$ 75.33**	**$ 5.55**	**$ 154.80**	**$ 52.31**	**$ 105.25**	**$ 11.10**	**$ 221.18**	**$ 105.63**	**$ 113.47**	**$ 11.10**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**91.0**	**69.0**	**57.0**	**15.0**	**160.0**	**108.0**	**85.0**	**30.0**	**295.0**	**234.0**	**105.0**	**30.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**30.0**	**0.0**	**15.0**	**15.0**	**30.0**	**18.0**	**30.0**	**35.0**	**60.0**	**18.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**12.0**	**54.0**	**0.0**	**73.0**	**6.0**	**64.0**	**0.0**	**98.0**	**12.0**	**84.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**27.0**	**3.0**	**0.0**	**72.0**	**72.0**	**3.0**	**0.0**	**162.0**	**162.0**	**3.0**	**0.0**
135	SA084	pack, protective, ortho, small	5.2155	pack		**1**				**1**							
136		~~*gloves, non-sterile, pair, 2*~~															
137		~~*gloves, sterile, pair, 2*~~															
138		~~*gown, staff, impervious, item, 1*~~															
139		~~*mask, surgical, with face shield, item, 1*~~															
140		~~*cap, surgical, item, 1*~~															
141	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**												
142		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 1.93**	**$ 0.53**	**$ 1.05**	**$ -**	**$ 3.50**	**$ 1.43**	**$ 1.37**	**$ -**	**$ 7.07**	**$ 3.64**	**$ 2.15**	**$ -**
143	EF031	table, power	6030.195	Default	0.016	**80**	**27**	**40**		**139**	**72**	**48**		**260.5**	**162.5**	**63**	
144	EF014	light, surgical	2872.8985	Default	0.00639	**55**		**40**		**69**		**48**		**260.5**	**162.5**	**63**	
145	EF015	mayo stand	526.782		0.00117	**55**		**40**		**69**		**48**		**98**		**63**	
146	EQ137	instrument pack, basic ($500-$1499)	500	Instrument	0.00232	**55**		**46**				**54**					
147	EQ138	instrument pack, medium ($1500 and up)	1500	Instrument	0.00697					**69**				**98**		**74**	
148	EQ110	electrocautery-hyfrecator, up to 45 watts	906.29	Default	0.00241							**48**		**98**		**63**	
149	EQ235	suction machine (Gomco)	767.478	Default	0.00204									**98**		**0**	
150	EQ168	light, exam	1431.5035		0.0038	**27**	**27**			**72**	**72**						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued

October 2020

Needle Biopsy of Lymph Nodes – Tab 15

CPT code 38505 *Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)* was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC recommended to survey for October 2020.

Compelling Evidence
The specialty societies provided compelling evidence and the RUC agreed that the work has changed for CPT code 38505 based on change in dominant specialty now reporting this service. Based on Medicare utilization data from 1993, the dominant specialty for 38505 was Otolaryngology, followed by General Surgery, and subsequently followed by Diagnostic Radiology. Most recent Medicare utilization data from 2019 indicates Diagnostic Radiology as the dominant specialty at 77% followed by Interventional Radiology at 13%. Additionally, the RUC proposed that there was compelling argument for a change in procedure as this service now involves larger tissue samples as well as a change in technology. Improved treatment options for oncology patients based on molecular markers and closer interval follow-up has increased the importance of tissue sampling. Improvements in technology allowing larger core biopsy sample sizes has increased the utility of needle core biopsy as an alternative to open surgical biopsy or excision. Needle biopsy of lymph nodes requires careful attention to adjacent vascular structures and other surrounding anatomy. In the typical case of jugular chain node biopsy, the physician must take care to avoid injuring the jugular vein and vagal nerve with needle placement.

38505 ***Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)***
The RUC reviewed the survey results of 62 radiologists and interventional radiologists and recommends the survey 25th percentile work RVU of 1.59 for CPT code 38505. The RUC recommends 13 minutes pre-service evaluation time, 1 minute positioning, 5 minutes scrub, dress and wait time, 20 minutes intra-service time and 10 minutes immediate post-service time. The survey total time differs by one minute compared to the total Harvard time. The Harvard time was established prior to the development of pre and post-service time packages. However, the Harvard times should not be compared to the new survey time because that time does not represent how this service is now performed and the type of physician performing it. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and valuation are inappropriately low for a surgical procedure (0.0231), which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times. Additionally, the pre- and post-operative work were computed by algorithm.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared CPT code 38505 to the top key reference service, CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 25 minutes intra-service time and 50 minutes total time), which have nearly identical total times. These procedures are very similar in that they both typically involve needle biopsy of small structures in the neck, requiring attention to vascular structures and the lung apices. Most of the survey respondents that selected this reference code characterized CPT code 38505 as requiring more mental effort and judgement than CPT code 60100 and reported CPT code 38505 as somewhat more intense/complex overall than CPT code 60100. Thyroid biopsies are typically performed on relatively healthy patients while lymph node biopsies are frequently performed in patients with malignancy or infection. The similarity of these procedures with nearly identical total times supports nearly identical work values. The second top key reference service code, CPT code 20225 *Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)* (work RVU = 2.45 and 30 minutes intra-service time) has a higher work RVU, but also more total time. CPT code 20225 describes a deep biopsy which requires both more time and is more intense than a lymph node biopsy and is appropriately valued higher than 38505.

For additional support, the RUC compared CPT code 38505 to MPC codes 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 1.75, 15 minutes intra-service time and 40 minutes total time) and 90945 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional* (work RVU = 1.56, 27 minutes intra-service time and 47 minutes total time). CPT code 38505 requires more intra-service and total time to perform than MPC code 36556. However, because CPT code 36556 is typically performed in the inpatient setting for acute indications such as sepsis, the intensity of the service is greater and accounts for the higher work value of 1.75. MPC code 90945 has 7 more intra-service minutes, but nearly identical total time compared to 38505. A portion of the intra-service time for 90945 is spent supervising dialysis, which is less intense than the intra-service work of 38505. The higher intensity of 38505 accounts for the differences in intra-service time but similar values. **The RUC recommends a work RVU of 1.59 for CPT code 38505.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty societies.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	000	1.59

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38505 Tracking Number Original Specialty Recommended RVU: **1.59**
Presented Recommended RVU: **1.59**
Global Period: 000 Current Work RVU: **1.14** RUC Recommended RVU: **1.59**

CPT Descriptor: Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old woman presents with a palpable cervical lymph node. Lymph node needle biopsy is performed with imaging guidance (separately reported).

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Obtain and review patient order, clinical history, and laboratory studies (i.e., coagulation studies). Confirm appropriateness of imaging guidance and determine appropriate protocol and approach. Review medications, specifically for potential antiplatelet or anticoagulation agents. Review allergies, specifically to local anesthetic agents. Arrange for intra-procedure cytology assessment, as needed. Communicate with patient and/or family to explain procedural risks and benefits and to obtain informed consent. Position patient based on lymph node location, with attention to proximity of major vascular structures and organs. Ensure all instruments and equipment needed for the procedure are available. Perform surgical time out. Prepare and drape patient.

Description of Intra-Service Work: After images are checked for appropriate position and proposed percutaneous tract, the entry site is infiltrated with local anesthetic. Under imaging guidance, navigate needle position to the desired site of biopsy. Coaxial system can be used, as necessary. If necessary, administer additional local anesthetic in sensitive areas. Acquire biopsy specimens as appropriate for the lesion and pathology requirements. As needed, submit tissue to the pathologist for initial assessment to confirm adequacy of biopsy. Submit additional samples for microbiologic study, as necessary. Once adequate biopsy material is obtained, withdraw the equipment and close the wound as necessary.

Description of Post-Service Work: Apply sterile dressings and complete appropriate post-procedure monitoring (vital signs, procedure site, etc.). Communicate (including written and oral reports and orders) with family and other health care professionals immediately following procedure. In the case of biopsies in proximity to major vessels or nerves, carefully monitor neurovascular functions and hemodynamic status. Review pre- and intra-scan images. Interpret all images resulting from the study including dedicated review of the target(s) as well as all visualized viscera, vasculature, and soft tissues. Assess for complications or other unexpected findings. Compare to all pertinent available prior studies. Dictate report for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD; Curtis Anderson, MD; Minhaj S. Khaja, MD					
Specialty Society(ies):	ACR, SIR					
CPT Code:	38505					
Sample Size:	900	**Resp N:**	62			
Description of Sample:	The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform abdominal, breast, and women's imaging, in addition to interventional radiology procedures). The SIR surveyed a random sample of 150 physicians of their membership in total.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	**20.00**	50.00	250.00
Survey RVW:	0.65	1.59	**1.70**	2.00	5.00
Pre-Service Evaluation Time:			**23.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	15.00	**20.00**	25.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	38505	**Recommended Physician Work RVU: 1.59**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
60100	000	1.56	**RUC Time**

CPT Descriptor Biopsy thyroid, percutaneous core needle

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20225	000	2.45	**RUC Time**

CPT Descriptor Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	409,595

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90945	000	1.56	**RUC Time**	165,382

CPT Descriptor 2 Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 41 **% of respondents:** 66.1 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 9.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 38505	Top Key Reference CPT Code: 60100	2nd Key Reference CPT Code: **20225**
Median Pre-Service Time	19.00	15.00	19.00
Median Intra-Service Time	20.00	25.00	30.00
Median Immediate Post-service Time	10.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**49.00**	**50.00**	**64.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	39%	54%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	44%	54%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	51%	46%
Physical effort required	0%	66%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	51%	41%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	33%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	83%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	50%	33%
Physical effort required	50%	50%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	17%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT code 38505 (*Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)*) was identified on the screen for Harvard codes with Medicare utilization over 30,000. The American College of Radiology (ACR) and Society of Interventional Radiology (SIR) surveyed this code for the October 2020 RUC meeting and convened an expert panel of physicians familiar with this service to review the survey data.

Needle biopsy of lymph nodes is an important tool in evaluating patients presenting with adenopathy predominantly in the cervical, axillary, and inguinal regions. Management plans for these patients depend on whether pathology from the enlarged nodes indicates malignant, infectious, or inflammatory cells. Improved treatment options for oncology patients based on molecular markers and closer interval follow-up has increased the importance of tissue sampling. Improvements in technology allowing larger core biopsy sample sizes has increased the utility of needle core biopsy as an alternative to open surgical biopsy or excision. Needle biopsy of lymph nodes requires careful attention to adjacent vascular structures and other surrounding anatomy. In the typical case of jugular chain node biopsy, the physician must take care to avoid injuring the jugular vein and vagal nerve with needle placement.

Survey Process

The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who indicated that they perform abdominal, breast, and women's imaging in addition to interventional radiology procedures). The SIR surveyed a random sample of 150 physicians of their membership.

Work RVU and Time Recommendations

The expert panel recommends the 25th survey percentile value at 1.59 work RVU with survey times of 19 minutes pre-service, 20 minutes intra-service, and 10 minutes post-service. This includes pre-service package 1 and post-service package 7A.

Compelling Evidence

We are requesting an increase in value for CPT code 38505, which is currently Harvard-valued. An increase in value for this code is justified by the survey data, comparisons with both KRS codes, and to maintain relativity within the RBRVS. We are requesting compelling evidence based on change in dominant specialty, which is billing CPT code 38505. Based on Medicare utilization data from 1993, the dominant specialty for 38505 was Otolaryngology, followed by General Surgery, and subsequently followed by Diagnostic Radiology. Most recent utilization data from 2017 indicates Diagnostic Radiology as the dominant specialty at 77% followed by Interventional Radiology at 13%. Additionally, there is a compelling argument for a change in procedure as well as a change in technology for this service. As stated previously in the "Background" section, improved treatment options for oncology patients has increased the significant of tissue sampling and improvements in technology have allowed larger core biopsy sample sized to be obtained, thus increasing the utility of needle core biopsy overall.

Key Reference Services for 38505

Our recommended work RVU of 1.59 compares favorably to the most commonly chosen key reference service, CPT code 60100 *(Biopsy thyroid, percutaneous core needle)*, valued at 1.56 RVU which has nearly identical total times. These procedures are very similar in that they both typically involve needle biopsy of small structures in the neck, requiring attention to vascular structures and the lung apices. The majority of our survey respondents characterized 38505 as requiring more mental effort and judgement than 60100 and reported 38505 as somewhat more intense/complex overall than 60100. Thyroid biopsies are typically performed on relatively healthy patients while lymph node biopsies are frequently performed in patients with malignancy or infection. The similarity of these procedures with nearly identical total times supports nearly identical RVU. The second key reference service code, 20225 *(Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur))*, has a higher 2.45 RVU, but also more total time. 20225 describes a deep biopsy which requires both more time and is more intense than a lymph node biopsy, and is appropriately valued higher than 38505.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
60100	Biopsy thyroid, percutaneous core needle	1.56	15	25	10	50	0.040
38505	**Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)**	**1.59**	**19**	**20**	**10**	**49**	**0.051**
20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)	2.45	19	30	15	64	0.059

MPC Codes for 38505

Our recommendation for CPT code 38505 compares favorably to the MPC codes 36556 and 90945:

CPT code 38505 has more intraservice and more total time than MPC code 36556 *(Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older)*. However, because 36556 is typically performed in the inpatient setting for acute indications such as sepsis, the intensity of the service is greater and accounts for the higher RVU of 1.75.

MPC code 90945 *(Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional)* has 7 more intraservice minutes and nearly identical total time compared to 38505. A portion of the intraservice time for 90945 is spent supervising dialysis, which is less intense than the intraservice work of 38505. The higher intensity of 38505 accounts for the differences in intraservice time with very similar RVUs between the two codes.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
90945	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	1.56	10	27	10	47	0.041
38505	**Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)**	**1.59**	**19**	**20**	**10**	**49**	**0.051**
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	1.75	20	15	5	40	0.084

Summary:

In summary, our expert panel recommends the 25th survey percentile value for CPT code 38505 at 1.59 work RVU with service period times of 19, 20, and 10 minutes. This includes pre-service package 1 and post-service package 7A. The recommended value compares favorably with the key reference services, 60100 and 20225 and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 38505 (Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)) is typically reported with CPT code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) at the same time. The societies adjusted the recommendations for physician work and practice expense inputs to reflect any duplication in services between 38505 and the imaging guidance code.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38505

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100752
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 38505 is estimated to be provided 100,752 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 77851 Percentage 77.26 %

Specialty Interventional Radiology Frequency 13299 Percentage 13.19 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,584 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 38505 is estimated to be provided 33,584 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 25950 Percentage 77.26 %

Specialty Interventional Radiology Frequency 4433 Percentage 13.19 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38505

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Needle Biopsy of Lymph Nodes
TAB: 15

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	60100	000	Biopsy thyroid, percutaneous core needle	41	0.040			1.56			50	15					25			10					
2nd REF	20225	000	Biopsy, bone, trocar, or needle; deep (eg, vertebral body,	6	0.059			2.45			64	7	6	6			30			15					
HARVARD	38505	000	Biopsy or excision of lymph node(s); by needle, superficial		0.023			1.14			50	11					28			11					
SURVEY	38505	000	Biopsy or excision of lymph node(s); by needle, superficial	62	0.040	0.65	1.59	1.70	2.00	5.00	63	23	5	5	5	15	20	25	60	10	0	12	20	50	250
REC	38505	000	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)		0.051			1.59			49	13	1	5			20			10					

SS Rec Summary

ISSUE: Excision of bone

TAB: 84

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11
1st REF	11111	000	xyz	30	0.029			4.25			131	5	5	5			30			5				1	1.0				1			
2nd REF	22222	000	def	15	0.055			5.15			137	10	5	5			35			5					1.0				1	1		
CURRENT	55555	000	abc		0.053			5.00			133	17					27			8				1	1.0				1			
SVY	55555	000	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0				1			
REC	55555	000	abc		0.020			4.25			142	17	1	3			30			10				1	1.0				1			

FACILITY DIRECT PE INPUTS **CPT CODE(S): 38505**

SPECIALTY SOCIETY(IES): ACR, SIR

PRESENTER(S): Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD; Curtis Anderson, MD; Minhaj S Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
38505	A 58-year-old woman presents with a palpable cervical lymph node. Lymph node needle biopsy is performed with imaging guidance (separately reported).

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology and Society of Interventional Radiology convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for Needle Biopsy of Lymph Nodes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   CPT code 38505 is a current code. As such, we included the existing direct practice expense inputs for this code on the PE spreadsheet. In addition, we included CPT code 20220 *(Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs))* as a reference code as it is a recent code which our societies consider to be clinically similar and comparable to CPT code 38505. We also added CPT code 76942 *(Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation)* as a reference code as 38505 is billed together 62% of the time with 76942 as found in the Billed Together Data document "13-Codes billed with for October 2020 RUC meeting".

3. Is this code(s) typically reported with an E/M service?

   CPT code 38505 is not typically reported with an E/M service (4%).

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   n/a

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   n/a

PRESENTER(S): Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD; Curtis Anderson, MD; Minhaj S Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Clinical staff will complete pre-service diagnostic and referral forms, coordinate pre-service services (including test results), schedule the room and equipment, schedule space and equipment in facility, provide pre-service education to patient, and complete pre-procedure phone calls and prescription as needed.

   b. Service period (includes pre, intra and post):

n/a

   c. Post-service period:

Clinical staff performs patient communications including home-care and follow-up as needed.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

n/a

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

n/a

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

n/a

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 38505**

SPECIALTY SOCIETY(IES): ACR, SIR

PRESENTER(S): Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD; Curtis Anderson, MD; Minhaj S Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
38505	A 58-year-old woman presents with a palpable cervical lymph node. Lymph node needle biopsy is performed with imaging guidance (separately reported).

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology and Society of Interventional Radiology convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for Needle Biopsy of Lymph Nodes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   CPT code 38505 is a current code. As such, we included the existing direct practice expense inputs for this code on the PE spreadsheet. In addition, we included CPT code 20220 *(Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs))* as a reference code as it is a recent code which our societies consider to be clinically similar and comparable to CPT code 38505. We also added CPT code 76942 *(Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation)* as a reference code as 38505 is billed together 62% of the time with 76942 as found in the Billed Together Data document "13-Codes billed with for October 2020 RUC meeting"

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   CPT code 38505 is not typically reported with an E/M service (4%).
   CPT code 38505 is not typically reported with an E/M service in the nonfacility (20%).

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Diagnostic Radiology is the dominant provider in both the nonfacility at 66% and the global at 77%.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

n/a

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

The increase in aggregate practice expense is due to a change in the procedure as it is typically performed. Previously, core needle biopsy was performed routinely when biopsy was indicated with excisional biopsy being reserved when more tissue was needed for more extensive tissue analysis. With improved Fine Needle Aspiration (FNA) tissue analysis, more and more evaluations of pathologic lymph nodes are being performed with FNA and core biopsy is reserved for inconclusive FNA samples or for evaluation of suspected lymphoma. Because of this, it is now typical for biopsy specimens to be obtained with a coaxial biopsy set (introducer needle with biopsy gun that obtains samples through the needle) because of the need for samples to be submitted in formalin for histology and immunohistochemistry as well as in RPMI or saline for flow cytometry. The new coaxial biopsy set (SC108) replaces the old breast prostate biopsy device (SC032). Other reductions in supply costs did not completely offset the increase in cost of the biopsy device.
In addition, there has been a change in performing specialty for 38505. Due to this, there has been the addition of equipment utilization to include a portable ultrasound machine. Previously, excisional biopsy was the typical procedure and was performed by ENT and General Surgery. Now, the predominant specialty is Diagnostic Radiology and it is typical to perform this procedure with ultrasound imaging. That equipment needs to be present for the entire procedure, not just for the guidance portion covered under the 76942 code.
There is also a recommended increase in pre-service staff time. Currently, there is no pre-service clinical staff time included in this code, which we feel is inappropriate. Below are the requested minutes for each activity with the justification:

CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	**3**	**All requested biopsies must be reviewed for completeness of request, medical notes and ordered tests.**
CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	**3**	**All biopsies require pre-procedure labs, which may be available with ordering physician or other provider. Staff must call to get these results.**

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	**3**	**Educate patient on length and nature of procedure. Ask questions about contraindicated medications or information that might not be in medical notes.**
CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	**3**	**Confirm antiplatelet/ anticoagulation medications stopped. Confirm patient arrival time and transportation if needed.**

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Prior to 2018, no time was allocated to CA010 for CPT code 38505. We are requesting 5 minutes for CA010, which indicates a vital sign standard of level 2 (4-6 vitals). The specialties are requesting 5 minutes to obtain temperature, blood pressure, heart rate, O2 saturation, respiratory rate and weight on our patients prior to biopsy procedures. These vital signs are performed typically and therefore, the standard 5 minutes are requested.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Clinical staff will complete pre-service diagnostic and referral forms, coordinate pre-service services (including test results), schedule the room and equipment, provide pre-service education to patient, and complete pre-procedure phone calls and prescription as needed.

   b. Service period (includes pre, intra and post):

Pre-service: Clinical staff will obtain level 2 vital signs upon patient arrival to radiology department.
Intra-service: Clinical staff is assisting with monitoring the patient, obtaining representative images and opening supplies for the scrubbed physician, as well as circulating and handling specimens as they are obtained.
Post-service: Clinical staff helps to clean room/equipment and monitor patient and patient dressings post procedure

   c. Post-service period:

Clinical staff performs patient communications including home-care and follow-up as needed.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

The nurse blend assists the MD in performing the procedure by handing products to the performing physician, operating the ultrasound equipment by storing images, and adjusting settings as needed. The staff assists the patient as needed for comfort. Finally, the staff receives samples as they are obtained and places each sample in their specific media. The staff is required to be present throughout the intra-service period as the non-sterile assistant to the procedure.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

n/a

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Coaxial biopsy set- This supply item was recently approved by CMS in the CY 2021 MPFS Proposed Rule (supply item SC108) in relation to the lung biopsy code 324X0. This product includes an introducer needle (with sharp stylet) and a biopsy gun device that obtains the sample through the introducer needle without requiring multiple passes through the skin and adjacent structures to obtain several samples.

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

1. **SA041- pack, basic injection:**

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, basic injection	**SA041**	**pack**		**11.365**
applicator, sponge-tipped		item	3	
bandage, strip 0.75in x 3in		item	1	
cap, surgical		item	1	
drape, sterile barrier 16in x 29in		item	1	
drape, sterile, for Mayo stand		item	1	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	2	
gown, staff, impervious		item	1	
gown, surgical, sterile		item	1	
lidocaine 1%-2% inj (Xylocaine)		ml	5	
mask, surgical		item	1	
needle, 18-27g		item	2	
povidone soln (Betadine)		ml	10	
syringe 3ml		item	1	
underpad 2ftx3ft (Chux)		item	1	

2. **SA048- pack, minimum multi-specialty visit:**

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**2.1122**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

	EF014	light, surgical	Default formula	
	EF015	mayo stand	Default formula	
	EF018	stretcher	Monitoring formula	
	EF031	table, power	Default formula	
	EQ250	ultrasound unit, portable	Default formula	

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

The specialties wish to clarify some of the inputs we are requesting.

SB034	mask, surgical, with face shield	One mask is included in SA041 for RN. Another is needed for MD with face shield.
SB039	shoe covers, surgical	One pair of shoe covers is needed for MD.
SF033	scalpel with blade, surgical (#10-20)	Need scalpel to nick skin for biopsy gun
SG074	steri-strip (6 strip uou)	One pack to close incision
SJ007	bacitracin oint (0.9gm uou)	For incision/dressing
SJ010	basin, emesis	For povidone to go into to use sponge applicators.
SK075	skin marking pen, sterile (Skin Skribe)	After ultrasound is done, prep site is marked with pen.
SL035	cup, biopsy-specimen non-sterile 4oz	For Sterile biopsy sample in Saline/RPMI
SM012	disinfectant spray (Transeptic)	To clean table/mayo stand
SM021	sanitizing cloth-wipe (patient)	To clean patient after biopsy
SC108	Coaxial Biopsy Set	Typical device used in this procedure

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE**		**REFERENCE**		**CURRENT**		**RECOMMENDED**	
2						**76942**		**20220**		**38505**		**38505**	
3		***RUC Collaboration Website***				Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **(October 2017)**		Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs) **(January 2019)**		Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary) **(February 2003)**		Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary) **(October 2020)**	
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 15** **Specialty: ACR, SIR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 20.57**	**$ -**	**$ 154.15**	**$ 7.40**	**$ 59.24**	**$ 12.21**	**$ 98.85**	**$ 7.40**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**29.0**	**0.0**	**58.0**	**20.0**	**47.0**	**33.0**	**60.0**	**20.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**0.0**	**12.0**	**17.0**	**0.0**	**30.0**	**12.0**	**17.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**0.0**	**43.0**	**0.0**	**47.0**	**0.0**	**45.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**3.0**	**3.0**	**0.0**	**3.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 10.73**	**$ -**	**$ 21.46**	**$ 7.40**	**$ 14.43**	**$ 12.21**	**$ 22.20**	**$ 7.40**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery/procedure made**											
15	CA001	Complete pre-service diagnostic and referral	L037D	RN/LPN/MTA	0.37			**3**	**3**		**5**	**3**	**3**
16	CA002	Coordinate pre-surgery services (including test	L037D	RN/LPN/MTA	0.37			**3**	**3**		**10**	**3**	**3**
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				**5**		**5**		**5**
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37			**3**	**3**		**7**	**3**	**3**
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37			**3**	**3**		**3**	**3**	**3**
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37	**2**							
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		**End: When patient enters office/facility for surgery/procedure**											
30		**SERVICE PERIOD**											
31		**Start: When patient enters office/facility for surgery/procedure:**											
32		**Pre-Service (of service period)**											
33	CA001	Complete pre-service diagnostic and referral forms								**5**			
34	CA004	Provide pre-service education/obtain consent								**3**			
35	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37			**3**				**3**	
36	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37			**5**				**5**	
37	CA011	Provide education/obtain consent											
38	CA012	Review requisition, assess for special needs											
39	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	**2**		**2**		**2**		**2**	
40	CA014	Confirm order, protocol exam											
41	CA015	Setup scope (nonfacility setting only)											
42	CA016	Prepare, set-up and start IV, initial positioning	L037D	RN/LPN/MTA	0.37	**2**		**2**		**2**		**2**	
43	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					**2**			
50		**Intra-service (of service period)**											
51	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN/MTA	0.37			**20**		**19**		**20**	
52	CA019	Assist physician or other qualified healthcare											
53	CA020	Assist physician or other qualified healthcare											
54	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	**15**							
61		**Post-Service (of service period)**											
62	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37			**5**		**5**		**5**	
63	CA023	Monitor patient following procedure/service, no											
64	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	**3**		**3**		**3**		**3**	
65	CA025	Clean scope											
66	CA026	Clean surgical instrument package											
67	CA027	Complete post-procedure diagnostic forms, lab	L037D	RN/LPN/MTA	0.37			**2**		**3**		**2**	
68	CA028	Review/read post-procedure x-ray, lab and											
69	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37			**1**				**1**	
70	CA030	Technologist QC's images in PACS, checking for	L037D	RN/LPN/MTA	0.37	**2**							
71	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37	**2**							
72	CA032	Scan exam documents into PACS. Complete	L037D	RN/LPN/MTA	0.37	**1**							
73	CA033	Perform regulatory mandated quality assurance											
74	CA034	Document procedure (nonPACS) (e.g. mandated											
75	CA035	Review home care instructions, coordinate	L037D	RN/LPN/MTA	0.37					**3**		**2**	
76	CA036	Discharge day management				**n/a**		**n/a**		**n/a**		**n/a**	
83		**End: Patient leaves office/facility**											
84		**POST-SERVICE PERIOD**											
85		**Start: Patient leaves office/facility**											
86	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37			**3**	**3**		**3**	**3**	**3**
87	CA038	Coordinate post-procedure services											
101		**End: with last office visit before end of global**											

	A	B	D	E	F	G	H	I	J	K	L	M	N
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5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 20.57**	**$ -**	**$ 154.15**	**$ 7.40**	**$ 59.24**	**$ 12.21**	**$ 98.85**	**$ 7.40**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**29.0**	**0.0**	**58.0**	**20.0**	**47.0**	**33.0**	**60.0**	**20.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**0.0**	**12.0**	**17.0**	**0.0**	**30.0**	**12.0**	**17.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**0.0**	**43.0**	**0.0**	**47.0**	**0.0**	**45.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**3.0**	**3.0**	**0.0**	**3.0**	**3.0**	**3.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 5.04**	**$ -**	**$ 131.58**	**$ -**	**$ 43.31**	**$ -**	**$ 70.54**	**$ -**
104	SA041	pack, basic injection	11.06	pack						**1**		**1**	
106	SA048	pack, minimum multi-specialty visit	3.0815	pack				**1**				**1**	
108	SA062	tray, bone marrow biopsy-aspiration	39.265	tray				**1**					
109	SA069	tray, suturing	8.9515	tray				**1**					
110	SB001	cap, surgical	0.6745	item				**1**				**1**	
111	SB005	cover-condom, transducer or ultrasound probe	2.405	item		**1**							
112	SB012	drape, sterile, for Mayo stand	1.379	item				**1**					
113	SB016	drape-cover, sterile, OR light handle	1.0795	item				**1**				**1**	
114	SB024	gloves, sterile	0.875	pair				**1**					
115	SB027	gown, staff, impervious	1.186	item				**1**					
116	SB033	mask, surgical	0.153	item				**1**					
117	SB034	mask, surgical, with face shield	1.2395	item				**1**				**1**	
118	SB039	shoe covers, surgical	0.219	pair				**1**				**1**	
119	SB044	underpad 2ft x 3ft (Chux)	0.275	item				**1**					
120	SC032	needle, biopsy for breast-prostate core sample	30.81	item						**1**			
121	SC051	syringe 10-12ml	0.197	item				**1**				**1**	
122	SC077	needle, bone biopsy	68.5	item				**1**					
123	SF033	scalpel with blade, surgical (#10-20)	0.867	item						**1**		**1**	
124	SF036	suture, nylon, 3-0 to 6-0, c	2.8055	item				**1**					
125	SG074	steri-strip (6 strip uou)	1.328	item								**1**	
126	SG079	tape, surgical paper 1in (Micropore)	0.006	inch						**6**			
127	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	0.072	ml				**5**					
128	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0475	ml									
129	SJ033	lubricating jelly (Surgilube)	0.5355	oz		**4**							
130	SJ007	bacitracin oint (0.9gm uou)	0.1105	item						**1**			
131	SJ010	basin, emesis	0.233	item						**1**		**1**	
132	SJ053	swab-pad, alcohol	0.0265	item						**2**			
133	SK075	skin marking pen, sterile (Skin Skribe)	1.334	item				**1**				**1**	
134	SL035	cup, biopsy-specimen non-sterile 4oz	0.1385	item						**1**		**1**	
135	SM012	disinfectant spray (Transeptic)	0.039	ml		**10**						**1**	
136	SM021	sanitizing cloth-wipe (patient)	0.0535	item		**2**						**1**	
137	NEW	*Coaxial Biopsy Set*	49	item								**1**	
138	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
139		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 4.79**	**$ -**	**$ 1.11**	**$ -**	**$ 1.50**	**$ -**	**$ 6.11**	**$ -**
140	ED050	Technologist PACS workstation	5557		0.02202	**15**							
141	ED053	Professional PACS Workstation	15042.3		0.0596	**19**							
142	EF008	chair with headrest, exam, reclining	5322.511		0.01184					**47**			
143	EF014	light, surgical	2872.899	Default	0.00639			**36**				**36**	
144	EF015	mayo stand	526.782	Default	0.00117			**36**		**47**		**36**	
145	EF018	stretcher	5005.011	Monitoring	0.01328			**20**				**20**	
146	EF031	table, power	6030.195	Default	0.016			**36**				**36**	
147	EQ138	instrument pack, medium ($1500 and up)	1500		0.00697					**47**			
148	EQ170	light, fiberoptic headlight w-source	3014.932		0.01195					**47**			
149	EQ250	ultrasound unit, portable	35805.77	Default	0.13875	**24**						**36**	
150		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*											

AMA/Specialty Society RVS Update Committee Summary of Recommendations
010-Day Global Period Services with > 1 Office Visit

October 2020

Placement/ Removal of Seton – Tab 16

In October 2019, the RUC identified CPT code 46020 via the 010-day global period service with more than one office visit. In January 2020, the RUC recommended for this service to be surveyed for April 2020 and CPT code 46030 was added for review since it is part of the same code family. This issue was postponed until October 2020 RUC meeting.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence that codes 46020 and 46030 are potentially misvalued based on flawed assumptions and a flawed valuation methodology when 46020 was last reviewed 20 years ago and a change in the specialty performing 46030 from when it was last reviewed during the Harvard study. For CPT code 46020, the specialties provided historical documents that showed how the RUC survey at that time requested physician time and visit information for *both* the survey code and the key reference code that was chosen. The data from that the survey time for the key reference code 46230 is almost identical to the survey time for code 46020. The RUC concurred with the specialties that the original valuation for new code 46020 used a flawed methodology that resulted in undervaluation because the recommendation was based on comparison of time data for 46230 collected via survey as a reference code that was significantly greater than the actual Harvard time. The time and visit data differences were not appropriately compared nor was the resulting IWPUT. Even though the pre-, intra-, and post-work were clearly significantly greater (an approximate 70% differential), a value was assigned that was minimally greater (14%). In 2001, the RUC modified the standard survey templates to remove the question asking for reference code times due to the question's lack of utility. Separately, the standard reference service list (RSL) for all colorectal surveys in 2000 included codes spanning all global periods. At that time, only three codes were included on the RSL had a 10-day global period—all of these were Harvard codes—and the survey instructions were clear that the survey respondent should pay attention to the global period when selecting a reference code.

For 46030, the Harvard physician work survey only captured data from 17 responses which were all general surgeons and only for intraoperative work. The pre- and post-operative work were computed by algorithm. Now, colorectal surgery is the dominant provider. The RUC accepted compelling evidence for code 46030 based on a change in the specialty performing the procedure and the current dominant specialty not having been involved in the prior review process.

46020 ***Placement of seton***
The RUC reviewed the survey results from 110 colorectal and general surgeons and recommends the survey median work RVU of 3.50 for CPT code 46020. The RUC recommends 30 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service

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scrub/dress/wait, 30 minutes of intra-service time and 20 minutes of immediate post-service time. The additional positioning time relative to the standard package is due to the additional time needed to place the patient prone jackknife with the appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape. The RUC noted that the current times for this service are 20 years old and not valid for comparison due to the flawed assumptions detailed above. The IWPUT for the current times are not much higher than that of scrub/dress/wait IWPUT, which strongly implies the current times are highly inflated relative to the current work RVU and not valid for comparison to the new times.

The specialty noted and the RUC agreed that the global period change from 010-day global to 000-day global was warranted as followup care of the patient will be highly variable, based on the complexity of the fistula and comorbid conditions (eg, Crohn's). A seton is typically placed under anesthesia in an OR and is typically left in place for 8-12 weeks (or indefinitely in some cases), with the purpose of providing controlled abscess drainage, thereby allowing all the inflammation to subside and form a solid tract of scar along a fistula tract.

To justify a work value of 3.50, the RUC compared the survey code to 2nd key reference code 45380 *Colonoscopy, flexible; with biopsy, single or multiple* (work RVU= 3.56, intra-service time of 28 minutes, total time of 65 minutes) and noted that both services have similar intra-service times and should be valued similarly. Code 45380 is typically performed under moderate sedation with the patient self-positioning on their left side. The greater preoperative time for 46020 is related to anesthesia, positioning, and evaluation of a patient with an active disease (Crohn's) prior to surgery. Like CPT code 46020, time is needed to traverse a "tract" (fistula versus colon). Postoperative time for CPT code 45380 may be less than CPT code 46020 due to the differences in anesthesia recovery. The RUC also compared the survey code to CPT code 43194 *Esophagoscopy, rigid, transoral; with removal of foreign body(s)* (work RVU= 3.51, intra-service time of 30 minutes, total time of 107 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 3.50 for CPT code 46020.**

46030 ***Removal of anal seton, other marker***
The RUC reviewed the survey results from 110 colorectal and general surgeons and recommends the survey median work RVU of 2.00 for CPT code 46030. The RUC recommends 17 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 15 minutes of immediate post-service time. The additional positioning time relative to the standard package is due to the additional time needed to place the patient prone jackknife with the appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and valuation are inappropriately low for a major surgical procedure, which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times. The Harvard study physician work survey for this code only captured data from 17 responses which were all general surgeons and only for intraoperative work. The pre- and post-operative work were computed by algorithm.

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The specialty noted and the RUC agreed that the global period change from 010-day global to 000-day global was warranted as follow-up care of the patient will be highly variable. Sometimes removal of a seton may not require an E/M post-op visit related to the removal of the seton or that visit may occur more than 10 days after the procedure.

To justify a work value of 2.00, the RUC compared the survey code to MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU= 1.90, intra-service time of 15 minutes, total time of 45 minutes) and note that although both services have identical intra-service times, the survey code involves much more total time. The RUC also compared the survey code to CPT code 15040 *Harvest of skin for tissue cultured skin autograft, 100 sq cm or less* (work RVU= 2.00, intra-service time of 15 minutes, total time of 60 minutes) and noted that both services involve identical intra-service times and similar total times. **The RUC recommends a work RVU of 2.00 for CPT code 46030.**

Practice Expense

The Practice Expense Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in global periods. The pre-service clinical staff times for CPT code 46030 were adjusted to the standard for Extensive Use of Clinical Staff in the facility setting to more appropriately account for the global period change from 010-day to 000-day. Also, the supply inputs were modified to remove SB018 *drape-sleeve, sterile, for handpiece*. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
46020	Placement of seton	~~010~~ 000	3.50
46030 (f)	Removal of anal seton, other marker	~~010~~ 000	2.00

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:46020 Tracking Number Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: 000 Current Work RVU: **3.00** RUC Recommended RVU: **3.50**

CPT Descriptor: Placement of seton

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male with Crohn's disease undergoes placement of a seton to promote drainage and healing of an anal fistula that involves the anal sphincter(s).

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon will select and order the appropriate antibiotic(s) and confirm timing and administration and confirm any necessary pre-operative adjustments to other medications. The patient will be examined, with an interval update to the prior H&P. Pre-admission testing will be reviewed. The indications for the procedure, as well as the operative risks and benefits, are explained to the patient and/or family/caregiver, and informed consent is obtained. The length and type of anesthesia is reviewed with the anesthesiologist. The availability of all necessary instruments and equipment is confirmed. The patient is placed in the prone jackknife position making sure that the all pressure points are well padded and the chest rolls are properly positioned and a safety strap is placed over the legs. The buttocks are effaced with tape to allow better exposure of the anus, then prepped and draped in standard fashion. The surgeon scrubs and gowns. A surgical "time out" with the operating surgical team is performed. The surgeon injects local anesthesia around the anus and bilaterally into ischioanal fossa to block the pudendal nerves.

Description of Intra-Service Work: After induction of general anesthesia, a digital rectal exam is performed. Next, a lubricated operative anoscope is placed in the anal canal. The anoscope is rotated 180° and the obturator is removed. Visual inspection is performed. The internal and external openings of the fistula as well as its relationship to the anal sphincter are determined by a combination of digital rectal exam, anoscopy, and passage of fistula probes. Then the anoscope is replaced by the anal retractor to allow for better visualization. A biopsy of the fistula tract is performed as required. A blunt tipped fistula probe is then passed from external to internal opening. After assessment of the fistula, it is determined that a fistulotomy would result in either division of a significant amount of sphincter muscle or potential perianal deformity and therefore, a fistulotomy or division of muscle is not performed. The decision is made to place a seton drain in the fistula tract by securing the drain to a probe and pass both thru the tract. The seton is then secured to itself with 2-0 silk ties. The ends of the suture and seton are trimmed for patient comfort. Hemostasis is achieved with cautery. The wound is then infiltrated with bupivacaine, cleaned, and covered with a fluffed gauze dressing.

Description of Post-Service Work: The surgeon assists with repositioning the patient supine. A brief operative note is written. After emergence from anesthesia, the surgeon will discuss the procedure outcome and answer any patient/family questions. Home restrictions (eg, diet, activity, bathing) are discussed with patient and family members with an emphasis on management of the seton. Medications are reconciled, and orders for discharge medications (eg, pain, antibiotic, stool softener) are written. The procedure, including relevant anatomic findings and follow-up treatment plan are documented in the medical chart with copy to the referring provider. All appropriate medical records are completed, discharge summary, discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS					
Specialty Society(ies):	ASCRS, ACS					
CPT Code:	46020					
Sample Size:	1500	**Resp N:**	110			
Description of Sample:	ASCRS: random selection from membership roster ACS: random selection from members self-designated as general surgery					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	9.00	**15.00**	20.00	150.00
Survey RVW:	1.50	2.75	**3.50**	4.52	7.10
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	46020	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
46607	000	2.20	**RUC Time**

CPT Descriptor Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
45380	000	3.56	**RUC Time**

CPT Descriptor Colonoscopy, flexible; with biopsy, single or multiple

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52287	000	3.20	**RUC Time**	44,471

CPT Descriptor 1 Cystourethroscopy, with injection(s) for chemodenervation of the bladder

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52441	000	4.00	**RUC Time**	19,974

CPT Descriptor 2 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant

Other Reference CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor (2021) New Pt, 60-74 min day of visit

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 **% of respondents:** 18.1 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 10.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 46020	Top Key Reference CPT Code: 46607	2nd Key Reference CPT Code: **45380**
Median Pre-Service Time	50.00	27.00	22.00
Median Intra-Service Time	30.00	25.00	28.00
Median Immediate Post-service Time	20.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**100.00**	**62.00**	**65.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	4%	0%	19%	54%	23%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	19%	77%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	35%	65%
Physical effort required	4%	54%	42%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	23%	73%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	18%	46%	36%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	18%	73%
Physical effort required	18%	55%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	9%	82%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The RUC identified code 46020 through a screen of 10-day global codes with utilization greater than 1,000 and recommended the code be surveyed. Code 46030 was added as a family code.

The ASCRS and ACS volunteered to survey these codes. Prior to survey, the societies requested a change from 10-day global to 0-day global.

Rationale for 0-day global: A seton is typically placed under anesthesia in an OR and is typically left in place for 8-12 weeks (or indefinitely in selected cases), with the purpose of providing controlled abscess drainage, thereby allowing all the inflammation to subside and form a solid tract of scar along a fistula tract. Followup care of the patient will be variable, based on the complexity of the fistula and comorbid conditions (eg, Crohn's). A 0-day global will allow reporting postoperative care as medically necessary.

Compelling Evidence

Evidence that incorrect assumptions were made in the previous valuation of the service; flawed survey instrument, flawed global assignment and flawed reference service list used in previous evaluation.

Flawed survey instrument

To help understand our position, we have provided several historical documents:

1. Review page 6 of file titled "Att A, 08-2000 RUC global code survey" where you will see that Question 2 requested time and visit information for BOTH the survey code and the key reference code that was chosen.
2. Review page 3 of the "Att B, 2001 Work SoR for code 46020" where you will see the time results of the survey that show the survey time for the key reference code 46230 is almost identical to the survey time for 46020.
3. Review the RUC rationale in the RUC database that states "The survey respondents indicated (46020) was similar in time and intensity to 46230. The RUC recommends the survey median of 2.90 for code 46020."
4. Review the time data in the RUC database for Harvard code 46230 which shows significantly less total time (74 min) than the time collected for 46230 in 2001 (120 min) when 46230 was a key reference code.
5. Review the excerpt in the file titled "Att C, 02-2001 RUC Research Subcommittee Report" related to collection of physician time data for reference codes which describes the subcommittee's concern with this process and the RUC approval to eliminate asking for reference code time on the survey instrument.

These five points support our belief that the original valuation for new code 46020 used a flawed methodology that resulted in undervaluation because the recommendation was based on comparison of time data for 46230 collected via survey as a reference code that was significantly greater than the actual Harvard time. The time and visit data differences were not appropriately compared, nor was the resulting IWPUT as shown in the table below. Even though the pre-, intra-, and post-work were clearly significantly greater (~70%), a value was assigned that was minimally greater (14%). This was clearly a flawed evaluation in 2001 of the new procedure code 46020.

Source	CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMM POST	99238	99212
Harvard Actual Data	**46230**	Excision of multiple external papillae or tags, anus	2.62	**0.050**	**74**	14	30	14		1
Data collected in 2000 Survey used for RUC recommendation	**46230**	Excision of multiple external papillae or tags, anus	2.62	**0.004**	**126**	20	35	15	0.5	2
2000 Survey	**46020**	Placement of seton	3.00	**0.014**	**126**	20	35	20	0.5	2

Flawed global assignment

Code 46020 was created in 2001 to describe placement of a seton as a stand-alone procedure, because the service could be performed as a separate procedure and not in conjunction with other major surgical procedures. Although, the

procedure is a major operation performed under general anesthesia, CMS assigned the code a 10-day global. This resulted in an incorrect comparison of the new code 46020 to other 10-day global minor surgical procedures

Flawed reference service list

In 2000, the standard RSL for all surveys included specialty codes with all of the different global periods, including 0-day, 10-day, 90-day, and XXX. Only 3 codes were included on the RSL for ASCRS that had a 10-day global period—all of these were Harvard codes—and the survey instructions were clear that the survey respondent should pay attention to the global period when selecting a reference code. In essence, the survey respondents were asked to choose 1 of the 3 Harvard codes with a 10-day global as a reference – and then as we stated earlier, the respondents were also asked to provide time and visits for the reference code, instead of using the Harvard time and visits.

In our opinion, there were so many irregularities – wrong global assignment, short list of Harvard comparator codes for selection, asking for time for the reference code – that the value for 46020 cannot be considered valid. We also note that the irregularities were changed since that time – there is now a recommendation for global period assignment and rationale required in a CPT code change application, the RUC survey RSLs almost always only include codes with the same global period and it is strongly discouraged to include Harvard valued codes on the RSL, and more than 3 codes are included on the RSL.

Recommendation - 46020

We recommend a work RVU of 3.50 for code 46020 which is the survey median.

Pre-time

Package 3 is selected with the following modifications:

Evaluation time: Subtract 3 minutes (total = 30 minutes) to be consistent with survey median time.

Positioning time: Add 7 minutes (total = 10 minutes) for positioning the patient prone jackknife with appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape.

Scrub, dress, wait time: Subtract 5 minutes (total time = 10 minutes) to be consistent with survey median.

Post-time

Package 9b is selected with the following modifications: subtract 13 minutes (total = 20 minutes) to be consistent with the survey median

Key Reference Code Comparison

Code 46607 includes a diagnostic anoscopy, topical chemical agent magnification and a biopsy. The typical patient is non-Medicare aged and the typical procedure is performed in an office setting under topical and local anesthesia and dorsal lithotomy positioning. This work is significantly less intense and complex compared to 46020, which requires preoperative time for evaluation related to the patient's disease status, reviewing imaging studies, positioning the patient prone for a procedure under general anesthesia, more intense intraoperative work, and more immediate postoperative work and time related to patient recovery from the procedure and anesthesia and facility discharge related work. The IWPUT for 46020 with an RVW of 3.50 is appropriately higher than 46607.

Code 45380 is typically performed under moderate sedation with the patient self-positioning an their left side. The greater preoperative time for 46020 is related to anesthesia, positioning, and evaluation of a patient with an active disease (Crohn's) prior to surgery. Similar to 46020, time is needed to traverse a "tract" (fistula versus colon). Postoperative time for 45380 may be less than 46020 due to the differences in anesthesia recovery.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	2.20	0.058	62	17	5	5	25	10
46020	**Placement of seton**	**3.50**	**0.069**	**100**	**30**	**10**	**10**	**30**	**20**
45380	Colonoscopy, flexible; with biopsy, single or multiple	3.56	0.100	65	14	3	5	28	15

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	3.20	0.120	58	7	5	10	21	15
46020	Placement of seton	3.50	0.069	100	30	10	10	30	20
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	4.00	0.116	80	25	5	10	25	15

Other Code Comparison – Referencing 2021 Office/Outpatient E/M Services

Code 46020 can also be compared to non-surgical E/M services by comparing time. We believe the intensity of 46020 is comparable to the intensity of a new patient office/outpatient E/M service. The survey physician total time of 100 minutes on the day of the procedure (0-day global) equates to reporting 99205 x 1 and 99XXX x 2 as shown in the CPT instructions table below. This equals a 2021 work RVU of 4.72 (3.50+0.61+0.61), which is significantly greater than the recommendation of 3.50 for 46020.

Total Duration of New Patient Office/Outpatient Services	**Code(s)**
75-89 minutes	99205 x 1 and 99XXX x 1
90-104 minutes	99205 x 1 and 99XXX x 2

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 46020

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty colorectal surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency is not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,261
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty colorectal surgery Frequency 700 Percentage 55.51 %

Specialty general surgery Frequency 550 Percentage 43.61 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 46020

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:46030 Tracking Number

Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
RUC Recommended RVU: **2.00**

Global Period: 000 Current Work RVU: **1.26**

CPT Descriptor: Removal of anal seton, other marker

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 40-year-old male with Crohn's disease who previously had a seton placed to promote drainage from an anal fistula undergoes removal of the seton.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon will confirm any necessary pre-operative adjustments to medications. The patient will be examined to be certain findings have not changed. The indications for the procedure, as well as the operative risks and benefits, are explained to the patient and/or family/caregiver, and informed consent is obtained. The availability of all necessary instruments and equipment is confirmed. The patient is placed in the prone jackknife position making sure that the all pressure points are well padded and the chest rolls are properly positioned and a safety strap is placed over the legs. The buttocks are effaced with tape to allow better exposure of the anus, then prepped and draped in standard fashion. The surgeon scrubs and gowns. The surgeon injects local anesthesia.

Description of Intra-Service Work: A digital rectal exam is performed. Next, a lubricated operative anoscope is placed in the anal canal. The anoscope is rotated 180° and the obturator is removed. Visual inspection is performed. Using the seton as well as its relationship to the anal sphincter, the internal and external openings of the fistula are determined by a combination of digital rectal exam and anoscopy. The seton is then removed by cutting the looped seton and removing it. The fistula tract debrided with a curette as appropriate. Hemostasis is achieved with cautery. The internal opening is closed with 2-0 Vicryl suture. The wound is cleaned and covered with a fluffed gauze dressing.

Description of Post-Service Work: The surgeon assists with repositioning the patient supine. The surgeon will discuss the procedure outcome and answer any patient/family questions. Home restrictions (eg, diet, activity, bathing) are discussed with patient and family members. Medications are reconciled, and orders for medications (eg, pain, antibiotic, stool softener) are written. The procedure, including relevant anatomic findings and follow-up treatment plan are documented in the medical chart with copy to the referring provider. All appropriate medical records and insurance forms are completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS					
Specialty Society(ies):	ASCRS, ACS					
CPT Code:	46030					
Sample Size:	1500	**Resp N:**	110			
Description of Sample:	ASCRS: random selection from membership roster ACS: random selection from members self-designated general surgery					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**8.00**	16.00	100.00	
Survey RVW:	0.55	1.50	**2.00**	2.20	5.50	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	5.00	10.00	**15.00**	20.00	45.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	46030	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
46600	000	0.55	**RUC Time**

CPT Descriptor Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
46607	000	2.20	**RUC Time**

CPT Descriptor Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54150	000	1.90	**RUC Time**	227

CPT Descriptor 1 Circumcision, using clamp or other device with regional dorsal penile or ring block

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
55700	000	2.50	**RUC Time**	148,981

CPT Descriptor 2 Biopsy, prostate; needle or punch, single or multiple, any approach

Other Reference CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor (2021) Estab Pt, 40-54 min day of visit

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 **% of respondents:** 27.2 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 15.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 46030	Top Key Reference CPT Code: 46600	2nd Key Reference CPT Code: **46607**
Median Pre-Service Time	37.00	7.00	27.00
Median Intra-Service Time	15.00	5.00	25.00
Median Immediate Post-service Time	15.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**67.00**	**22.00**	**62.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	11%	26%	26%	26%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	30%	30%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	41%	33%	26%
Physical effort required	33%	37%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	19%	59%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	12%	6%	47%	29%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	53%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	23%	71%	6%
Physical effort required	18%	76%	6%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	29%	53%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The RUC identified code 46020 through a screen of 10-day global codes with utilization greater than 1,000 and recommended the code be surveyed. Code 46030 was added as a family code.

The ASCRS and ACS volunteered to survey these codes. Prior to survey, the societies requested a change from 10-day global to 0-day global.

46030 Removal of anal seton, other marker

Rationale for 0-day global: Removal of a seton may not require an E/M followup related to the removal of the seton or may not require a followup within 10 days. A 0-day global will allow reporting postoperative care as medically necessary.

Compelling Evidence

Evidence that incorrect assumptions were made in the previous valuation of the service; flawed global, flawed Harvard study estimation of work, surveyed only general surgeons.

Code 46030 is a legacy CPT code (pre-1990) that required the Harvard study to survey several general surgery panels to increase the number of responses; ultimately reaching only 17 responses and only for intraoperative work. The pre- and post-operative work were computed by algorithm. In addition, only general surgeons reviewed the code.

Recommendation - 46030

We recommend a work RVU of 2.00 for code 46030 which is the survey median.

Place of Service

Although the Medicare-age patient may typically undergo this procedure in a facility setting, the typical patient is not Medicare-aged and the societies' expert panel agree the typical place of service for the national patient will be the office setting. In addition, an E/M service will not typically be reported on the same date. This procedure will be scheduled.

Pre-time

Package 6 is selected with the following modifications:

Evaluation time: Package time of 17 minutes which is less than the survey median.

Positioning time: Add 9 minutes (total = 10 minutes) for positioning the patient prone jackknife with appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape.

Scrub, dress, wait time: Add 5 minutes (total time = 10 minutes). Package 6 includes 5 minutes to administer anesthesia, but does not allow any time to dress and scrub for the procedure. Five minutes for this activity, which is consistent with facility procedures without anesthesia, is recommended.

Post-time

The survey median time is recommended.

Key Reference Code Comparison

Code 46600 is a diagnostic anoscopy; a procedure that is not invasive or sterile. Positioning is typically lateral decubitus. The digital rectal exam and scope-in to scope-out work is brief. In contrast, 46030 will include anoscopy, the patient to be positioned prone jackknife, and the procedure instrumentation is sterile. The intraoperative work to track the seton from internal to external sites and dissect it free is more complex than an anoscopy. Although many respondents chose 46600 as a reference, the survey instructions state: *Based on your review of all previous questions, please provide your estimated work RVU for each survey code (to two decimal places). For example, if the survey code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the survey code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the survey service "relative" to the work RVU of the reference services*. Using magnitude estimation that incorporates both time and complexity, it is reasonable that 46030 would be "multiples" of 46600.

Code 46607 requires more intra-time for Lugol staining and visualization of lesions, but overall total time is slight less. In addition, the intra-time complexity is less because the lesions are surface lesions compared to a buried seton that needs to be dissected free.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.55	0.034	22	2	5	0	5	10
46030	Removal of anal seton, other marker	2.00	0.065	67	17	10	10	15	15
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	2.20	0.058	62	17	5	5	25	10

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	0.087	45	15	5	5	15	5
46030	Removal of anal seton, other marker	2.00	0.065	67	17	10	10	15	15
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.50	0.142	35	5	5	5	15	5

Other Code Comparison – Referencing 2021 Office/Outpatient E/M Services

Code 46030 can also be compared to non-surgical E/M services by comparing time. We believe the intensity of 46030 is comparable to the intensity of an established patient office/outpatient E/M service. The survey physician total time of 67 minutes on the day of the procedure (0-day global) equates to reporting 99215 x 1 and 99XXX x 1 as shown in the CPT instructions table below. This equals a 2021 work RVU of 2.53 (1.92+0.61), which is significantly greater than the recommendation of 2.00 for 46030.

Total Duration of Estab Patient Office/Outpatient Services	**Code(s)**
55-69 minutes	99215 x 1 and 99XXX x 1

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 46030

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty colorectal surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency is not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 328
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty colorectal surgery Frequency 220 Percentage 67.07 %

Specialty general surgery Frequency 110 Percentage 33.53 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 46030

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Placement/ Removal of Seton

TAB: 16

SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
REF1	46607	000	Anoscopy; with high-resolution magn	20	0.058	0.035			2.20			62	17	5	5			25			10												
REF2	45380	000	Colonoscopy, flexible; with biopsy, si	11	0.100	0.055			3.56			65	14	3	5			28			15												
CURRENT	46020	010	Placement of seton		0.014	0.024			3.00			126	20	0	0			35			20	0.5					2					
SVY	46020	000	Placement of seton	110	0.069	0.035	1.50	2.75	3.50	4.52	7.10	100	30	10	10	10	20	30	30	60	20								0	9	15	20	150
REC	46020	000	Placement of seton		0.069	0.035			3.50			100	30	10	10			30			20												
REF1	46600	000	Anoscopy; diagnostic, including colle	30	0.034	0.025			0.55			22	2	5	0			5			10												
REF1	46607	000	Anoscopy; with high-resolution magn	17	0.058	0.035			2.20			62	17	5	5			25			10												
HARVARD	46030	010	Removal of anal seton, other marker		0.031	0.027			1.26			47	11	0	0			18			10						0.5					
SVY	46030	000	Removal of anal seton, other marker	110	0.061	0.029	0.55	1.50	2.00	2.20	5.50	70	20	10	10	5	10	15	20	45	15								0	5	8	16	100
REC	46030	000	Removal of anal seton, other marker		0.065	0.030			2.00			67	17	10	10			15			15												

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 46020, 46030**
SPECIALTY SOCIETY(IES): ASCRS, ACS
PRESENTER(S): Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2020

CPT Code	Long Descriptor	Global Period
46020	Placement of seton	~~10~~ 0
46030	Removal of anal seton, other marker	~~10~~ 0

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
46020	A 40-year-old male with Crohn's disease undergoes placement of a seton to promote drainage and healing of an anal fistula that involves the anal sphincter(s).
46030	A 40-year-old male with Crohn's disease who previously had a seton placed to promote drainage from an anal fistula undergoes removal of the seton.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   46020: The ASCRS and ACS do not recommend non-facility pricing for 46020
   46030: The ASCRS and ACS advisors reviewed and updated the PE details for code 46030 to be consisted with current practice and RUC standards.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code details are used for reference

3. a. Is this code(s) typically reported with an E/M service?
   b. Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   a. No
   b. No

4. a. What specialty is the dominant provider in the nonfacility?
   b. What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   c. Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   46020: N/A
   46030:
   a. colorectal surgery
   b. 74%
   c. No

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A – all activities with standards are not exceeded

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

46020: The ASCRS and ACS do not recommend non-facility pricing for 46020
46030: This code was reviewed in January 2003 as part of a large family of 10-day global procedures prior to establishment of surgical packages/cleaning, scope setup/cleaning standards, additional positioning. This procedure requires local anesthesia, cautery, surgical instruments, and suction which were not considered in the initial review. All of these items are needed because a seton related to the typical patient will typically remain in place for many months resulting in adhesions that will need to be released using instruments and equipment that were not included in the initial review.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

This code was reviewed in January 2003 as part of a large family of 10-day global procedures that had 3 minutes applied across all the codes. It is current standard of practice to take at least 5 vitals: blood pressure, pulse, weight, temperature, respiration rate.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Extensive use of clinical staff is applied. These patients typically have an ongoing chronic disease that resulted in the placement of a seton to drain an abscess.

Complete pre-service diagnostic and referral forms	5 minutes: Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
Coordinate pre-surgery services (including test results)	3 minutes: Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information from other providers. Enter and record all clinical updates in EHR.
Provide pre-service education/obtain consent	7 minutes: Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
Complete pre-procedure phone calls and prescription	3 minutes: Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission family/caregiver questions. Enter and record in EHR.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

b. Service period (includes pre, intra and post):

See table below.

Row	Code	Pre-Service (of service period)	Current 46030	REC 46030	Notes
		Pre-Service (of service period)			
28	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	5	3	Decrease to 3 minute standard
29	CA010	Obtain vital signs	3	5	Increase to 5 minutes for 5 or more vitals (blood pressure, pulse, weight, temperature, respiration rate)
30	CA011	Provide education/obtain consent	3		Decrease to 0. Education provided prior to date of procedure.
31	CA013	Prepare room, equipment and supplies	2	2	Standard time. Set up instruments, suction supplies and equipment, cautery supplies and equipment, etc.
32	CA015	Setup scope (nonfacility setting only)		5	Standard time. Set up anoscope and lightsource. Ensure proper functioning
33	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2	2	Standard time. Set up injection supplies and assist physician with positioning.
34	CA040	Perform additional positioning of patient		8	Additional eight minutes to assist with prone jackknife positioning with padding and effacing of buttocks - add to CA016 to equal 10 minutes which is the same as the MD time for positioning.
35	CA017	Sedate/apply anesthesia	2	2	Standard time. Assist MD during injection of local anesthetic
		Intra-service (of service period)			
41	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	18	15	Assist MD 100%. Assist with suctioning/irrigation during procedure, hand off instruments and supplies. Obtain additional supplies as needed.
		Post-Service (of service period)			
45	CA022	Monitor patient following procedure/service, multitasking 1:4		2	Patient will typically be monitored for at least 10-15 minutes after being returned to supine from prone. Cleaning room for 3 minutes reduces time to 7-12 minutes. Assuming clinical staff can multitask and check on patient 1:4 for remainder of time, then 2-3 additional minutes applies. We are recommending 2 minutes.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Row	Code	Pre-Service (of service period)	Current 46030	REC 46030	Notes
46	CA023	Monitor patient following procedure/service, no multitasking	5		Delete. See response for CA022 above
47	CA024	Clean room/equipment by clinical staff	3	3	Standard time. Clean suction, cautery equipment and supplies. Safely dispose of all hazardous waste. Log and return injection vial to medication cart/room.
48	CA025	Clean scope		5	Standard time. Clean non-disposable anoscope and light channel.
49	CA026	Clean surgical instrument package		10	Standard time.
50	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	2		Delete. Although a biopsy may be taken, it will not occur >50%.
51	CA029	Check dressings, catheters, wounds		1	Prior to patient getting dressed, check that the fluffy gauze dressing is still secured by tape. Reapply tape as needed.
52	CA035	Review home care instructions, coordinate visits/prescriptions	3	2	Reinforce MD instructions about care of wound, activity, use of stool softener, diet.
		End: Patient leaves office/facility			

c. Post-service period:

Row	Code	Start: Patient leaves office/facility	Current 46030	REC 46030	Notes
59	CA037	Conduct patient communications		3	Clinical staff will communicate with patient / respond to patient regarding care of wound and dressings and bathroom activity.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Assist MD 100% with suctioning/irrigation during procedure, hand off instruments and supplies, obtain additional supplies as needed.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**2.1122**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).

b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Code	Desc		Current 46030	REC 46030	formula
EQ137	instrument pack, basic ($500-$1499)	Instrument Packs	51	44	+M28+M29+M30+M31+M32+M33+M35 +M41+M49
EQ235	suction machine (Gomco)	Default	51	38	+M28+M29+M30+M31+M32+M33+M35 +M41+M47+M51
EF015	mayo stand	Default		38	+M28+M29+M30+M31+M32+M33+M35 +M41+M47+M51
EF031	table, power	Default	63	38	+M28+M29+M30+M31+M32+M33+M35 +M41+M47+M51
EF014	light, surgical	Default	63	38	+M28+M29+M30+M31+M32+M33+M35 +M41+M47+M51
ES002	anoscope with light source	Scope Systems		31	+M31+M32+M33+M35+M41+M48
EQ110	electrocautery -hyfrecator, up to 45 watts	Default		38	+M28+M29+M30+M31+M32+M33+M35 +M41+M47+M51

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

See details of disposable supply recommendations below.

Row	Code	MEDICAL SUPPLIES	UNIT	Current 46030	REC 46030	Notes
77	SA048	pack, minimum multi-specialty visit	pack	2	1	adjusted down to 1 for day of procedure only – to reflect 0-day global
		paper, exam table 7 foot				
		gloves, non-sterile 2 pair				Worn by MD and staff to set up room and position and pad patient.
		gown, patient 1 item				
		pillow case 1 item				
		cover, thermometer probe 1 item				
78	SB001	cap, surgical	item	2	2	physician and staff

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Row	Code	MEDICAL SUPPLIES	UNIT	Current 46030	REC 46030	Notes
79	SB027	gown, staff, impervious	item	2	2	physician and staff
80	SB034	mask, surgical, with face shield	item	2	2	physician and staff
81	SB039	shoe covers, surgical	pair	2	2	physician and staff
82	SJ041	povidone soln (Betadine)	ml	10	10	prep
83	SB014	drape, sterile, three-quarter sheet	item		2	Add - Patient is prone jackknife wearing patient gown. One drape across back and one drape across legs.
84	SB020	drape-towel, sterile OR blue (2 pk uou)	item		1	Add -drape surgical area after prep
85	SJ032	lubricating jelly (K-Y) (5gm uou)	item	4	4	lubricate anoscope
86	SB022	gloves, non-sterile	pair		1	Add -Staff will change prior to procedure and/or change one or more times during procedure based on patient cleanliness "presentation"
87	SB024	gloves, sterile	pair		1	Add -MD will change from non-sterile to sterile prior to procedure.
88	SC028	needle, 18-26g 1.5-3.5in, spinal	item		1	Add -Long needle for internal injection of local.
89	SC029	needle, 18-27g	item		2	Add – one 18G needle to draw one 27G needle to for external injection of local
90	SC053	syringe 20ml	item		1	Add - one syringe (needles changed as appropriate).
91	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	ml		20	Add -for internal and external injection / block
92	SJ053	swab-pad, alcohol	item		1	Add -wipe top of local anesthesia multidose vial
93	SC056	syringe 50-60ml	item	1	1	irrigation syringe
94	SJ009	basin, irrigation	item		1	Add -for disposal of soiled supplies
95	SJ010	basin, emesis	item	1		delete – replace with SJ009
96	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	item		1	Add -for irrigation
97	SH068	sodium chloride 0.9% inj bacteriostatic (30ml uou)	item			delete – replace with SH069
98	SJ052	swab, procto 16in	item	3	3	to remove internal "debri" and blood
99	SD009	canister, suction	item	1	1	to remove internal "debri" and blood
100	SD132	tubing, suction, non-latex (6ft uou)	item	1	1	to remove internal "debri" and blood
101	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	item	1	1	to remove internal "debri" and blood

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Row	Code	MEDICAL SUPPLIES	UNIT	Current 46030	REC 46030	Notes
103	SF033	scalpel with blade, surgical (#10-20)	item		1	Add -to free seton adhesions
104	SF020	cautery, monopolar, pencil-handpiece	item		1	Add -to control bleeding
105	SB018	drape-sleeve, sterile, for handpiece	item		1	Add -to cover cautery handpiece
106	SF021	cautery, patient ground pad w-cord	item		1	Add -required for cautery system
107	SG053	gauze, sterile 2in x 2in	item		8	Add -used for intra-op wiping and "fluffy" dressing
108	SG055	gauze, sterile 4in x 4in	item		4	Add -used for intra-op wiping and "fluffy" dressing
109	SG077	tape, porous-hypoallergenic 2in (Scanpore)	inch		96	Add – 72 inches for effacing buttocks (36 in each side) attached from buttock to table 24 inches to secure postop fluffy dressing – 2x12 in strips across buttocks
110	SA042	pack, cleaning and disinfecting, endoscope	pack		1	Add -clean anoscope and light channel
111	SB012	drape, sterile, for Mayo stand	item		1	Add -drape stand that will hold supplies
112	SA043	pack, cleaning, surgical instruments	pack		1	Add -clean instruments (eg, probes, forceps, curettes scissors)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S): 46020, 46030**
SPECIALTY SOCIETY(IES): ASCRS, ACS
PRESENTER(S): Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2020

CPT Code	Long Descriptor	Global Period
46020	Placement of seton	~~10~~ 0
46030	Removal of anal seton, other marker	~~10~~ 0

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
46020	A 40-year-old male with Crohn's disease undergoes placement of a seton to promote drainage and healing of an anal fistula that involves the anal sphincter(s).
46030	A 40-year-old male with Crohn's disease who previously had a seton placed to promote drainage from an anal fistula undergoes removal of the seton.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
   The ASCRS and ACS advisors reviewed and updated the PE details based on current standard of care.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):
   Current codes 46020 and 46030 were used as references.

3. Is this code(s) typically reported with an E/M service?
   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   46020 and 46030 are major procedures that are typically performed under general anesthesia when performed in a facility.
   We are recommending 46020 not be priced in the office.
   Although 46030 can be performed in both the facility and non-facility setting, when a patient is required to undergo the procedure in a facility, it will be under general anesthesia and all the pre-service clinical staff activities associated with readying a patient for the OR are identical to 90-day global major procedures. The change to a 0-day global was requested to account for variable postoperative care and in no way changes the major procedure pre-service clinical staff work that is typical for major procedures in the facility setting. Therefore, we are recommending the 90-day global major surgery pre-service standard for the facility setting for both codes.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms	Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
Coordinate pre-surgery services (including test results)	Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission questions.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

CA037: Clinical staff will communicate with patient / respond to patient regarding care of wound, dressings and bathroom activity. CA038: Clinical staff will coordinate transfer of facility information to the surgeon's office medical record, including operative and discharge notes, medication list, other provider correspondence and imaging or lab results pending at discharge.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**46020 (RUC 2001)**		**46020**		**46030 (PEAC 2003)**		**46030**	
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 16 Specialty: ASCRS, ACS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Placement of seton		Placement of seton		Removal of anal seton, other marker		Removal of anal seton, other marker	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**10**	**10**	**0**	**0**	**10**	**10**	**0**	**0**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$85.95**	**$54.50**	**N/A**	**$24.42**	**$51.52**	**$16.10**	**$122.90**	**$13.32**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**177.0**	**120.0**	**0.0**	**66.0**	**70.5**	**38.5**	**86.0**	**36.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**35.0**	**60.0**	**0.0**	**60.0**	**9.0**	**19.0**	**18.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**88.0**	**6.0**	**0.0**	**0.0**	**48.0**	**6.0**	**65.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**54.0**	**54.0**	**0.0**	**6.0**	**13.5**	**13.5**	**3.0**	**6.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$65.49**	**$44.40**	**$ -**	**$24.42**	**$26.09**	**$14.25**	**$ 31.82**	**$13.32**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery/procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5	5		5	3	3	5	5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	10	20		20	3	5	3	10
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37	0	8		8	0	3	0	5
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	10	20		20	0	5	7	7
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	10	7		7	3	3	3	3
24		**End: When patient enters office/facility for surgery/procedure**											
25		**SERVICE PERIOD**											
26		**Start: When patient enters office/facility for surgery/procedure:**											
27		**Pre-Service (of service period)**											
28	CA009	Greet patient, provide gowning, ensure appropriate medical	L037D	RN/LPN/MTA	0.37	6				5		3	
29	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	2				3		5	
30	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37	5				3			
31	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	5				2		2	
32	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37							5	
33	CA016	Prepare, set-up and start IV, initial positioning and monitoring	L037D	RN/LPN/MTA	0.37	5				2		2	
34	CA040	Perform additional positioning of patient	L037D	RN/LPN/MTA	0.37							8	
35	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37	5				2		2	
40		**Intra-service (of service period)**											
41	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN/MTA	0.37	30				18		15	
44		**Post-Service (of service period)**											
45	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37							2	
46	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37	15				5			
47	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	10				3		3	
48	CA025	Clean scope	L037D	RN/LPN/MTA	0.37							5	
49	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37							10	
50	CA027	Complete post-procedure diagnostic forms, lab and x-ray	L037D	RN/LPN/MTA	0.37					2			
51	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	5						1	
52	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					3		2	
53	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**	**6**	**n/a**		**n/a**	**6**	**n/a**	
56		**End: Patient leaves office/facility**											
57		**POST-SERVICE PERIOD**											
58		**Start: Patient leaves office/facility**											
59	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37				3			3	3
60	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37				3				3
61		***Office visits: List Number and Level of Office Visits***	**MINUTE**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
62		99211 16 minutes	16										
63		99212 27 minutes	27			2	2			0.5	0.5		
64		99213 36 minutes	36										
65		99214 53 minutes	53										
66		99215 63 minutes	63										
67	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**54.0**	**54.0**	**0.0**	**0.0**	**13.5**	**13.5**	**0.0**	**0.0**
74		**End: with last office visit before end of global period**											

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**46020 (RUC 2001)**		**46020**		**46030 (PEAC 2003)**		**46030**	
4	**Clinical Activity Code**	**Meeting Date: 10/2020 Revision Date (if applicable): Tab: 16 Specialty: ASCRS, ACS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Placement of seton		Placement of seton		Removal of anal seton, other marker		Removal of anal seton, other marker	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**10**	**10**	**0**	**0**	**10**	**10**	**0**	**0**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$85.95**	**$54.50**	**N/A**	**$24.42**	**$51.52**	**$16.10**	**$122.90**	**$13.32**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**177.0**	**120.0**	**0.0**	**66.0**	**70.5**	**38.5**	**86.0**	**36.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**35.0**	**60.0**	**0.0**	**60.0**	**9.0**	**19.0**	**18.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**88.0**	**6.0**	**0.0**	**0.0**	**48.0**	**6.0**	**65.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**54.0**	**54.0**	**0.0**	**6.0**	**13.5**	**13.5**	**3.0**	**6.0**
75	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
76		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$13.62**	**$ 7.68**	**$ -**	**$ -**	**$23.80**	**$ 1.54**	**$ 88.11**	**$ -**
77	SA048	pack, minimum multi-specialty visit	3.0815	pack		3	2			2	1	1	
78	SB001	cap, surgical	0.6745	item						2		2	
79	SB027	gown, staff, impervious	1.186	item						2		2	
80	SB034	mask, surgical, with face shield	1.2395	item						2		2	
81	SB039	shoe covers, surgical	0.219	pair						2		2	
82	SJ041	povidone soln (Betadine)	0.137	ml						10		10	
83	SB014	drape, sterile, three-quarter sheet	3.645	item								2	
84	SB020	drape-towel, sterile OR blue (2 pk uou)	1.2435	item								1	
85	SJ032	lubricating jelly (K-Y) (5gm uou)	0.303	item		1	1			4		4	
86	SB022	gloves, non-sterile	0.192	pair								1	
87	SB024	gloves, sterile	0.875	pair								1	
88	SC028	needle, 18-26g 1.5-3.5in, spinal	6.637	item								1	
89	SC029	needle, 18-27g	0.0645	item		1						2	
90	SC053	syringe 20ml	0.694	item								1	
91	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	0.072	ml								20	
92	SJ053	swab-pad, alcohol	0.0265	item								1	
93	SC056	syringe 50-60ml	1.0055	item						1		1	
94	SJ009	basin, irrigation	1.771	item								1	
95	SJ010	basin, emesis	0.233	item						1			
96	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	2.707	item								1	
97	SH068	sodium chloride 0.9% inj bacteriostatic (30ml uou)	0.76	item		1							
98	SJ052	swab, procto 16in	0.1935	item						3		3	
99	SD009	canister, suction	4.109	item						1		1	
100	SD132	tubing, suction, non-latex (6ft uou)	1.2125	item						1		1	
101	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	2.8155	item						1		1	
102	SF031	loop, surgical (Surg-I-Loop)	2.0375	item		1							
103	SF033	scalpel with blade, surgical (#10-20)	0.867	item								1	
104	SF020	cautery, monopolar, pencil-handpiece	5.154	item								1	
105	SB018	drape-sleeve, sterile, for handpiece	0.1145	item								0	
106	SF021	cautery, patient ground pad w-cord	5.045	item								1	
107	SG053	gauze, sterile 2in x 2in	0.057	item								8	
108	SG055	gauze, sterile 4in x 4in	0.1745	item								4	
109	SG077	tape, porous-hypoallergenic 2in (Scanpore)	0.0235	inch								96	
110	SA042	pack, cleaning and disinfecting, endoscope	18.246	pack								1	
111	SB012	drape, sterile, for Mayo stand	1.379	item								1	
112	SA043	pack, cleaning, surgical instruments	8.9745	pack								1	
113	SD003	anoscope	1.2115	item		1	1						
116	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
117		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 6.84**	**$ 2.42**	**$ -**	**$ -**	**$ 1.63**	**$ 0.31**	**$ 2.98**	**$ -**
118	EQ137	instrument pack, basic ($500-$1499)	500	Instrument Packs	0.0023238					51	0	44	
119	EQ235	suction machine (Gomco)	767.478	Default	0.0020367					51	0	38	
120	EF015	mayo stand	526.782	Default	0.0011718							38	
121	EF031	table, power	6030.2	Default	0.0160025					63	14	38	
122	EF014	light, surgical	2872.9	Default	0.0063905					63	14	38	
123	ES002	anoscope with light source	10075.7	Scope Systems	0.0583770							31	
124	EQ110	electrocautery-hyfrecator, up to 45 watts	906.29	Default	0.002405							38	
125	EQ167	light source, xenon	9615.29		0.0380977	142	54						
126	EQ211	pulse oximeter w-printer	1641.54		0.0052983	88	0						
127	EF023	table, exam	3037.95		0.0067576	142	54						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Work Neutrality Review*

October 2020

Destruction by Neurolytic Agent – Tab 17

In September 2014, the Relativity Assessment Workgroup identified a work neutrality issue for CPT codes 64633-64636 related to incorrect coding relative to how the services were originally valued. Due to the nature of the possible incorrect coding of per nerve instead of per joint, the specialties were encouraged to immediately begin addressing this coding education and clarification. The RUC recommended that the specialty societies develop a CPT Assistant article to address this issue. The specialty societies submitted a CPT Assistant article stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as it did previously (publication date: February 2015). In January 2015, the Relativity Assessment Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. The RUC recommended that the specialty societies immediately submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint issue (for CPT 2016). The RUC requested that AMA staff compile data on how many times a service is reported for the same patient on the same day and 2014 preliminary Medicare utilization. The Workgroup reviewed the additional data in April 2015. The Workgroup agreed that the specialty societies took aggressive action to ensure correct reporting of these services. The Workgroup recommended to allow the multiple efforts to take effect and re-review the utilization data for these services in April 2017. In May 2015, the CPT Editorial Panel revised the parenthetical instructions for the four codes describing paravertebral facet join nerve destruction to clarify that these codes are reported per joint, not nerve. In April 2017, the specialty society indicated, and the Workgroup agreed that recent CPT changes did not take effect until 2016 and the Medicare utilization was not available when preparing for this meeting. The Workgroup recommended that more time was necessary to determine CPT changes were effective and that the Workgroup review these services in October 2019 when two years of Medicare utilization data are available. In October 2019, the Workgroup thoroughly discussed the history of this family, noting that although the specialty used best efforts to estimate utilization and distribution of reporting these services, the original recommendations were not work neutral and compelling evidence had not been approved. The Relativity Assessment Workgroup noted that the growth in these services is appropriate as the patient population requiring these services has grown. However, due to the extensive growth and original incorrect assumptions about distribution of reporting, the Workgroup determined that a new survey is required. A member questioned if the codes should be surveyed using a 000 global period, rather than the current 010-day global period. The specialty societies confirmed that 64633 and 64635 should be maintained as 010-day global periods. The RUC recommended that CPT codes 64633-64636 be surveyed.

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64633 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint***
The RUC reviewed the survey responses from 166 physicians and determined that a work RVU of 3.42 appropriately accounts for the physician work necessary to perform this service and matches the survey median of family code 64635. The RUC recommends the same survey median work RVU as 64635 for CPT code 64633 because the surveys indicate that these two services require the exact same physician time to perform and are performed on anatomically similar structures in the lumbar and cervical spine respectively. The RUC was concerned that the survey 25th percentile work RVU of 3.36 for CPT code 64633 is too low and would create a rank order anomaly with 64635. To prevent such an anomaly, the RUC recommends the same median value as 64635 as supported by the survey.

The RUC recommends 18 minutes pre-evaluation time, 5 minutes positioning time, 5 minutes scrub, dress and wait time, 20 minutes intra-service time, 10 minutes immediate post time, a half discharge day management and one 99213 office visit. The RUC confirmed that the half discharge day management is appropriate as this service is typically performed in the hospital or ambulatory surgery center setting.

The RUC compared CPT code 64633 with the top key reference service 64625 *Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)* (work RVU = 3.39, 30 minutes intra-service time and 98 minutes total time). CPT code 64633 is slightly more intense and complex than the reference code due to the anatomical differences in locations. While CPT code 64625 requires more injections, CPT code 64633 is in a much more clinically complex location, cervical or thoracic, requiring greater clinical expertise. CPT code 64633 also requires more total time than 64625 and the recommended higher work RVU maintains the proper rank order between these two services. For further support the RUC compared CPT code 64633 to MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 93 minutes total time), which requires the same physician work but slightly less total time. **The RUC recommends a work RVU of 3.42 for CPT code 64633.**

64634 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 164 physicians and recommends maintaining the current work RVU of 1.32 for CPT code 64634, which is lower than the survey 25th percentile of 1.50. The RUC recommends 20 minutes intra-service time for this add-on service. The RUC noted that 64634 requires more physician time and work than 64636 to account for the neurovascular structures in the cervical spine, making sure that the positioning is appropriate and safe. It requires more time to focus the correct targets on the cervical spine and the physician must correctly position the shoulder and visualize the correct anatomy.

The RUC compared CPT code 64634 to the top key reference service 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 25 minutes intra-service time). The RUC determined that 63634 requires less physician time to perform. Thus, is valued appropriately slightly less than key reference service 64645. The RUC also compared 64634 to the second key reference service 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet*

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(zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure) (work RVU = 1.16 and 15 minutes intra-service time). The RUC concurred that the physician time, technical skill, stress, and intensity of add-on code 64634 is greater than that of 64491.

For further support the RUC notes that CPT code 64634 is appropriately bracketed by MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 20 minutes intra-service time) and 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.32 for CPT code 64634.**

64635 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint***

The RUC reviewed the survey responses from 167 physicians and recommends the survey median work RVU of 3.42 for CPT code 64635. Due to the decrease in physician time the RUC determined that the decrease in work RVU was warranted. The RUC recommends 18 minutes pre-evaluation time, 5 minutes positioning time, 5 minutes scrub, dress and wait time, 20 minutes intra-service time, 10 minutes immediate post time, a half discharge day management and one 99213 office visit. The RUC confirmed that the half discharge day management is appropriate as this service is typically performed in the hospital or ambulatory surgery center setting. The RUC noted that CPT codes 64633 and 64635 require the exact same physician time and work to perform and therefore should be valued the same.

The RUC compared CPT code 64635 with the top key reference service 64625 *Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)* (work RVU = 3.39, 30 minutes intra-service time and 98 minutes total time). CPT code 64635 is slightly more intense and complex than the reference code due to the anatomical differences in locations. While CPT code 64625 requires more injections, CPT code 64635 is in a much more clinically complex location, lumbar or sacral, requiring greater clinical expertise. CPT code 64635 also requires more total time than 64625 and the recommended higher work RVU maintains the proper rank order between these two services. For further support the RUC compared CPT code 64635 to MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 93 minutes total time), which requires the same physician work but slightly less total time. **The RUC recommends a work RVU of 3.42 for CPT code 64635.**

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64636 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 166 physicians and recommends maintaining the current work RVU of 1.16 for CPT code 64636. The RUC recommends 15 minutes intra-service time for this add-on service.

The RUC compared CPT code 64636 to the top key reference service CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16 and 15 minutes intra-service time) noting that these services require the exact same physician work and intra-service time. The RUC also compared 64636 to the second top key reference service 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 25 minutes intra-service). The RUC determined that 63635 requires less physician time and work to perform. Thus, is valued appropriately less than key reference service 64645.

For further support the RUC references MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minute intra-service time) which requires the same physician time and similar physician work. **The RUC recommends a work RVU of 1.16 for CPT code 64636.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made minor modifications to the clinical staff time and to the supply items, noting that the SA041 *pack, basic injection* includes 10 ml povidone solution (Betadine) which may no longer be typical and could possibly be replaced by chlorhexidine in the future. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

RUC Database Flag
The RUC will flag CPT code 64633 as "do not use for comparison" in the RUC database since the work RVU recommendation was the survey median for CPT code 64635, which is currently under review with this service.

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CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010	3.42
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.32 (No Change)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010	3.42
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.16 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64633 Tracking Number Original Specialty Recommended RVU: **3.75**
Presented Recommended RVU: **3.42**
Global Period: 010 Current Work RVU: **3.84** RUC Recommended RVU: **3.42**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 19% , In the ASC 47%, In the office 34%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review records and any pertinent imaging studies. Confirm results of the diagnostic facet injections with patient. Communicate with other professionals, patient, and family, and obtain informed consent. Dress, scrub, and wait before the procedure. Prepare patient and needed equipment for the procedure. Position the patient on the X-ray table for appropri-ate fluoroscopic view. Drape injection site.

Description of Intra-Service Work: Monitor patient with continuous pulse oximetry, BP, and ECG. Rotate and adjust a C-arm fluoroscopic machine until the targeted facet joint and bony landmarks are optimally visualized. Anesthetize the skin and subcutaneous tissues with local anesthetic. Direct needles toward the lateral facet pillar and groove under intermittent fluoroscopic guidance. Take care to avoid vital neural structures or blood vessels. Stimulate patient with appropriate frequencies for sensory and motor stimulation to verify the needles are in the correct position.

Confirm appropriate position of the needle tips with multiple fluoroscopic views including AP and lateral projections. Inject anesthetic. Perform radiofrequency nerve ablation (RFN). After both nerves have been lesioned, apply a dressing.

Description of Post-Service Work: After the procedure, observe the patient for any new and unexpected neurological deficits. Review the procedure and results (including written and telephone reports and orders) with the patient and other professionals. Schedule an office visit within the ten-day global period to monitor for complications, assessment of pain and pain relief, and documentation of functional outcome are included in the medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD, MBA, FASE, FASA, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD					
Specialty Society(ies):	American Society of Anesthesiologists (ASA), American Academy of Physical Medicine and Rehabilitation (AAPM&R), North American Spine Society (NASS), The Spine Intervention Society (SIS), North American Neuromodulation Society (NANS), American Academy of Pain Medicine (AAPM)					
CPT Code:	64633					
Sample Size:	8123	**Resp N:**	166			
Description of Sample:	Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	20.00	**50.00**	90.00	1000.00	
Survey RVW:	1.16	3.36	**3.75**	4.10	8.00	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	1.00	15.00	**20.00**	30.00	60.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64633	**Recommended Physician Work RVU: 3.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64625	010	3.39	**RUC Time**

CPT Descriptor Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64624	010	2.50	**RUC Time**

CPT Descriptor Destruction by neurolyic agent, genicular nerve branches including imaging guidance, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11643	010	3.42	**RUC Time**	32,484

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49440	010	3.93	**RUC Time**	20,353

CPT Descriptor 2 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 104 **% of respondents:** 62.6 **%**

Number of respondents who choose 2nd Key Reference Code: 22 **% of respondents:** 13.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 64633	Top Key Reference CPT Code: 64625	2nd Key Reference CPT Code: **64624**
Median Pre-Service Time	28.00	19.00	23.00
Median Intra-Service Time	20.00	30.00	25.00
Median Immediate Post-service Time	10.00	7.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	0.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	23.0	23.00	16.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**100.00**	**98.00**	**74.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	13%	36%	48%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	26%	69%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	2%	17%	81%

Physical effort required	2%	31%	67%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	19%	77%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	18%	45%	37%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	14%	86%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	23%	77%
Physical effort required	5%	29%	66%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	14%	86%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Academy of Pain Medicine (AAPM), the American Society of Interventional Pain Physicians (ASIPP), the North American Neuromodulation Society (NANS), the North American Spine Society (NASS), and the

Spine Intervention Society (SIS) are submitting recommendations for CPT codes 64633-64636 for the October 2020 meeting. This code family describes destruction by a neurolytic agent with imaging guidance.

Code#	Descriptor	Global	2020 wRVU	Oct 2020 RUC Recommendation
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010	3.84	3.42
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.32	1.32
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010	3.78	3.42
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.16	1.16

Background

The following is a brief history of the code family.

- 2011: The code family was RUC surveyed.
- 2016: Parenthetical instructions for the code family were revised to clarify that these codes are reported per joint, not nerve.
- 2019: The Relativity Assessment Workgroup noted that the growth in this family was appropriate as the population has grown; however, the Workgroup recommended that the code family be surveyed.
- 2020: The code family was surveyed and presented at the October 2020 RUC meeting.

Recommendation

The specialties are recommending the survey median of 3.42 work RVUs, 0.5 - 99238 (discharge day management) and 1 – 99213 (office visit), which is a decrease from the current wRVU of 3.84.
For time the specialties are recommending:

- Pre-time: 18/5/5 minutes (Facility Pre-Service Package #2 Adjusted)
- Intra-time: 20 minutes (survey median)
- Post time: 10 minutes (survey median)

Survey Sample and Process

A total of 166 responses were received from a random sample of 8,123 clinicians (2.04 percent response rate). 94.58% of respondents agreed with the typical patient vignette. The median experience in the past 12 months was 50. The surveying societies convened an expert panel to review the survey data.

Summary of Survey Results

64633 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	3.36	3.75	4.10

Pre-Time	[redacted]	20/5/5	[redacted]
Intra-Time	15	20	30
Post Time	[redacted]	10	[redacted]
Top Ref Code	64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography))* • Selected by 104 out of 166 survey respondents		

Time Recommendation Rationale

The expert panel is recommending 102 minutes of total time: Pre-service: 28 minutes; intra-service: 20 minutes; immediate post-time: 10 minutes; discharge day management 19 minutes (0.5 – 99238); and office visit 23 minutes (1-99213).

Pre-time: The specialties are recommending an adjustment to the facility pre-service time package time package 2, *(Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)*.

	Evaluation	Positioning	Scrub, Dress, Wait
Facility Pre-Service Package #2	18	1	6
Adjustments	0	+4	-1
Recommendation	**18**	**5**	**5**

The expert panel concluded that the recommended adjustments, which are consistent with the survey median values, reflect the time that is needed during the pre-service period for a typical patient. The additional 4 minutes of time is needed for proper prone positioning which is important for this procedure, similar to other facet joint injection procedure positioning.

Intra-Time: The expert panel is recommending the survey median of 20 minutes for intra-service time.

Post Time and Post-Op Visits: The expert panel is recommending survey median time of 10 minutes for the immediate post-time. They are also recommending 0.5-99238 post discharge visit, as recommended by the RUC in October 2010 for a same day discharge and 1-99213 office visit based on survey data.

Work RVU Recommendation Rationale

The specialties are recommending the survey median of 3.42 work RVUs. This is less than the current work RVU value of 3.84. With the recommended time this results in an IWPUT of 0.066.

The expert panel's recommendation is based on: survey data, rank order within the family, comparison to key reference codes, and comparison to similar codes.

Survey Data: The expert panel is recommending 3.42 work RVUs. The survey was viewed as robust with 166 responses and the median experience in the last 12 months was 50.

Rank Order Within the Family: The expert panel also considered rank order within the family. They agreed it was appropriate for 64633 to be valued higher than 64635. The anatomical location of the injection site for 64633 made it more complex and intense procedure.

Comparison to Key Reference Code: The expert panel also concluded that the recommendation aligned well with the top reference code. 104 of the 166 respondents chose 64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography))* which has pre-time of 19 minutes (13/1/5), intra-service time of 30 minutes, immediate post-service time of 7 minutes, discharge day management 19 minutes (0.5 – 99238); and office visit time of 23 minutes (1-99213); and a work RVU of 3.39 which results in an IWPUT of 0.0423.

The expert panel believes that it is appropriate to value code 64633 higher than 64625 to reflect the survey respondents complexity/intensity ranking which aligns with the anatomical differences in locations, with the greater complexity for 64633 compared to 64625.

- Those that selected 64625 as the top reference code in the survey, 85% indicated the survey code, 64633, had somewhat or much more overall intensity and complexity.
- While 64625 has a greater number of injections, 64633 is located in a much more clinically complex location, requiring greater clinical expertise.
- As code 64633 has both a greater total time and IWPUT, recommending an equal or lower wRVU than 64625 could create a rank order anomaly between the codes.

Comparison to Similar Services

The expert panel also compared 64633 to other RUC surveyed codes and concluded that the recommendation maintained appropriate rank order and aligned well with other similar codes.

CPT	DESCRIPTOR	IWPUT	wRVU	TOTAL TIME	PRE	INTRA	POST	99238	99213	99213
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)	0.1169	3.00	66	7	10	10		1	1
46505	Chemodenervation of internal anal sphincter	0.0422	3.18	102	35	15	10	0.5	1	
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	0.0294	3.59	129	35	25	27	0.5	1	
64633	**Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint**	**0.052**	**3.42**	**102**	**28**	**20**	**10**	**0.5**	**1**	
38500	Biopsy or excision of lymph node(s); open, superficial	0.0517	3.79	115	35	30	15	0.5		1

In summary, for CPT code 64633 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint) ***ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS recommend 3.42 wRVUs and 28/20/10, 0.5-99238, and 1-99213 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64633

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 258039
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Pain Management Frequency 75863 Percentage 29.39 %

Specialty Interventional Pain Management Frequency 67039 Percentage 25.98 %

Specialty Anesthesiology Frequency 62394 Percentage 24.18 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 86,013 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Pain Management Frequency 25288 Percentage 29.40 %

Specialty Interventional Pain Management Frequency 22346 Percentage 25.97 %

Specialty Anesthesiology Frequency 20798 Percentage 24.18 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64633

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64634 Tracking Number Original Specialty Recommended RVU: **1.32**
Presented Recommended RVU: **1.32**
Global Period: ZZZ Current Work RVU: **1.32** RUC Recommended RVU: **1.32**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with constant neck pain due to degenerative disc disease and cervical spondylosis. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). She has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The treatment is repeated on an additional unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Monitor patient with continuous pulse oximetry, BP, and ECG. Rotate and adjust a C-arm fluoroscopic machine until the targeted facet joint and bony landmarks are optimally visualized. Anesthetize the skin and subcutaneous tissues with local anesthetic. Direct a needle toward the lateral facet pillar and groove under intermittent fluoroscopic guidance. Take care to avoid vital neural structures or blood vessels. Stimulate patient with appropriate frequencies for sensory and motor stimulation to verify the needle is in the correct position.

Confirm appropriate positioning of the needle tips with multiple fluoroscopic views including AP and lateral projections. Inject anesthetic. Perform RFN. Reposition the probe to complete additional lesion(s) along the nerve. Repeat the entire procedure for the second medial branch nerve. After both nerves are lesioned, apply a dressing.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD, MBA, FASE, FASA, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MD, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD					
Specialty Society(ies):	American Society of Anesthesiologists (ASA), American Academy of Physical Medicine and Rehabilitation (AAPM&R), North American Spine Society (NASS), The Spine Intervention Society (SIS), North American Neuromodulation Society (NANS), American Academy of Pain Medicine (AAPM)					
CPT Code:	64634					
Sample Size:	8123	**Resp N:**	164			
Description of Sample:	Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	20.00	**40.00**	100.00	1000.00	
Survey RVW:	0.70	1.50	**2.00**	3.46	8.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	3.00	12.00	**20.00**	29.00	120.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	64634	**Recommended Physician Work RVU: 1.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64645	ZZZ	1.39	**RUC Time**

CPT Descriptor Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64491	ZZZ	1.16	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 60 **% of respondents:** 36.5 **%**

Number of respondents who choose 2nd Key Reference Code: 58 **% of respondents:** 35.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 64634	Top Key Reference CPT Code: 64645	2nd Key Reference CPT Code: 64491
Median Pre-Service Time	0.00	1.00	0.00
Median Intra-Service Time	20.00	25.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**26.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	13%	42%	45%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	18%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	15%	83%
Physical effort required	2%	37%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	18%	79%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	23%	42%	35%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	31%	66%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	26%	74%
Physical effort required	0%	37%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	26%	74%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Academy of Pain Medicine (AAPM), the American Society of Interventional Pain Physicians (ASIPP), the North American Neuromodulation Society (NANS), the North American Spine Society (NASS), and the Spine Intervention Society (SIS) are submitting recommendations for CPT codes 64633-64636 for the October 2020 meeting. This code family describes destruction by a neurolytic agent with imaging guidance.

Code#	Descriptor	Global	2020 wRVU	Oct 2020 RUC Recommendation
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010	3.84	3.42
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.32	1.32
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010	3.78	3.42
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.16	1.16

Background

The following is a brief history of the code family.

- 2011: The code family was RUC surveyed.
- 2016: Parenthetical instructions for the code family were revised to clarify that these codes are reported per joint, not nerve.
- 2019: The Relativity Assessment Workgroup noted that the growth in this family was appropriate as the population has grown; however, the Workgroup recommended that the code family be surveyed.
- 2020: The code family was surveyed and presented at the October 2020 RUC meeting.

October 2020 RUC Meeting Recommendation Rationale

A total of 164 responses were received from a random sample of 8,123 clinicians (2.02% response rate). 95.73% of respondents agreed with the typical patient vignette. The median experience in the past 12 months was 40. The surveying societies convened an Expert Panel to review the survey data. ***The societies are recommending 1.32 wRVUs (current value) and an intra-time of 20 minutes (survey median and current value).***

Vignette

The vignette described a typical patient for code 64634 as a 65-year-old female presenting with constant neck pain due to degenerative disc disease and cervical spondylosis. She underwent revious trials of cervical medial branch nerve blocks proved beneficial (separately reported). She has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The treatment is repeated on an additional unilateral symptomatic facet joint.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64634
Highlights from Survey Data

	25th Percentile	Median	75th Percentile
Work	1.50	2.00	3.46
Intra	12	20	29

After a robust discussion, the Expert Panel agreed to recommend:

- wRVU
  - 1.32 wRVUs (current value)
- Time
  - Intra-time: 20 minutes (survey median and current value)

The panel noted that the median and 25th percentile wRVU values are higher than the current wRVU value.

Comparison to Key Reference Services

60 of the 164 respondents chose 64645 *(Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure))* which has a wRVU of 1.39 and an intra service time of 25 minutes, with one minute of positioning time, for a total of 26 minutes.

The Expert Panel conclude the recommendation aligned well with the top reference code. The Panel noted that the reference code has more intra-time, so the higher value for the reference code is appropriate.

Comparison to Key Reference Services

The Panel also concluded that the recommendation maintained appropriate rank order among other ZZZ codes.

CPT Code	Descriptor	Work RVU	Intra-Time
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	1.16	15
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level	1.20	15
64643	Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)	1.22	20
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	1.32	20
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)	1.39	25

In summary, for CPT code 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)) ***ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS recommend 1.32 wRVUs and 20 minutes for intra-time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64634

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 406767
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Pain Management Frequency 119671 Percentage 29.42 %

Specialty Interventional Pain Management Frequency 110844 Percentage 27.24 %

Specialty Anesthesiology Frequency 98275 Percentage 24.16 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 135,589 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Pain Management Frequency 39890 Percentage 29.41 %

Specialty Interventional Pain Management Frequency 36948 Percentage 27.24 %

Specialty Anesthesiology Frequency 32758 Percentage 24.15 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64634

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64635 Tracking Number Original Specialty Recommended RVU: **3.42**
Presented Recommended RVU: **3.42**
Global Period: 010 Current Work RVU: **3.78** RUC Recommended RVU: **3.42**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 19% , In the ASC 46%, In the office 35%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review records and any pertinent imaging studies. Confirm results of the diagnostic facet injections with patient. Com-municate with other professionals, patient, and family, and obtain informed consent. Dress, scrub, and wait before the procedure. Prepare patient and needed equipment for the procedure. Position the patient prone on the X-ray table for appropriate fluoroscopic view. Prepare the skind and drape the injection site.

Description of Intra-Service Work: Monitor patient with continuous pulse oximetry, BP, and ECG. Rotate and adjust a C-arm fluoroscopic machine until the targeted facet joint and bony landmarks are optimally visualized. Anesthetize the skin and subcutaneous tissues with local anesthetic. Direct the needle to the point at which the superior articular process and the transverse process meet under intermittent fluoroscopic guidance. Take care to avoid vital neural structures or blood vessels. Stimulate patient with appropriate frequencies for sensory and motor stimulation to verify the needles are in the correct position.

Confirm appropriate positioning of the needle tip with multiple fluoroscopic views, including AP and lateral projections. Inject anesthetic. Perform radiofrequency ablation of the nerve. Reposition the probe to complete additional lesion(s) along the nerve. Repeat the entire procedure for the second medial branch nerve. After both nerves are lesioned, apply a dressing.

Description of Post-Service Work: After the procedure, observe the patient for any new and unexpected neurological deficits. Review the procedure and results (including written and telephone reports and orders) with the patient and other professionals. Schedule an office visit within the ten-day global period to monitor for complications, assessment of pain and pain relief, and documentation of functional outcome are included in the medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD, MBA, FASE, FASA, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MD, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD					
Specialty Society(ies):	American Society of Anesthesiologists (ASA), American Academy of Physical Medicine and Rehabilitation (AAPM&R), North American Spine Society (NASS), The Spine Intervention Society (SIS), North American Neuromodulation Society (NANS), American Academy of Pain Medicine (AAPM)					
CPT Code:	64635					
Sample Size:	8123	**Resp N:**	167			
Description of Sample:	Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	40.00	**80.00**	150.00	1000.00	
Survey RVW:	1.15	3.00	**3.42**	3.90	8.00	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	1.00	14.00	**20.00**	28.00	50.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64635	**Recommended Physician Work RVU: 3.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64625	010	3.39	**RUC Time**

CPT Descriptor Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64624	010	2.50	**RUC Time**

CPT Descriptor Destruction by neurolyic agent, genicular nerve branches including imaging guidance, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11643	010	3.42	**RUC Time**	32,484

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49440	010	3.93	**RUC Time**	20,353

CPT Descriptor 2 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 107 **% of respondents:** 64.0 **%**

Number of respondents who choose 2nd Key Reference Code: 31 **% of respondents:** 18.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 64635	Top Key Reference CPT Code: 64625	2nd Key Reference CPT Code: **64624**
Median Pre-Service Time	28.00	19.00	23.00
Median Intra-Service Time	20.00	30.00	25.00
Median Immediate Post-service Time	10.00	7.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	0.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	23.0	23.00	16.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**100.00**	**98.00**	**74.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	1%	3%	30%	47%	19%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	43%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	2%	34%	67%

Physical effort required	9%	51%	41%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	34%	65%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	27%	53%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	48%	49%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	37%	60%
Physical effort required	10%	53%	37%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	23%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Academy of Pain Medicine (AAPM), the American Society of Interventional Pain Physicians (ASIPP), the North American Neuromodulation Society (NANS), the North American Spine Society (NASS), and the

Spine Intervention Society (SIS) are submitting recommendations for CPT codes 64633-64636 for the October 2020 meeting. This code family describes destruction by a neurolytic agent with imaging guidance.

Code#	Descriptor	Global	2020 wRVU	Oct 2020 RUC Recommendation
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010	3.84	3.42
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.32	1.32
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010	3.78	3.42
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.16	1.16

Background

The following is a brief history of the code family.

- 2011: The code family was RUC surveyed.
- 2016: Parenthetical instructions for the code family were revised to clarify that these codes are reported per joint, not nerve.
- 2019: The Relativity Assessment Workgroup noted that the growth in this family was appropriate as the population has grown; however, the Workgroup recommended that the code family be surveyed.
- 2020: The code family was surveyed and presented at the October 2020 RUC meeting.

Recommendation

The specialties are recommending the survey median of 3.42 work RVUs, which is a significant decrease from the current wRVU of 3.75. For time and visits the specialties are recommending:

- Pre-time: 18/5/5 minutes (Facility Pre-Service Package #2 Adjusted)
- Intra-time: 20 minutes (survey median)
- Post time: 10 minutes (survey median)
- Discharge Day Management: 0.50 – 99238
- Office Visit: 1-99213

Survey Sample and Process

A total of 167 responses were received from a random sample of 8,123 clinicians (2.06 percent response rate). 95.81% of respondents agreed with the typical patient vignette. The median experience in the past 12 months was 80. The surveying societies convened an expert panel to review the survey data.

Summary of Survey Results

64635 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile

Work	3.00	3.42	3.90
Pre	[redacted]	20/5/5	[redacted]
Intra	14	20	28
Post	[redacted]	10	[redacted]
Top Ref Code	64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography))* • Selected by 107 out of 167 survey respondents		

Time Recommendation Rationale

The expert panel is recommending 102 minutes of total time: Pre-service: 28 minutes; intra-service: 20 minutes; immediate post-time: 10 minutes; discharge day management 19 minutes (0.5 – 99238); and office visit 23 minutes (1-99213).

Pre-time: The specialties are recommending an adjustment to the facility pre-service time package time package 2, *(Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)*.

	Evaluation	Positioning	Scrub, Dress, Wait
Facility Pre-Service Package #2	18	1	6
Adjustments	0	+4	-1
Recommendation	**18**	**5**	**5**

The expert panel concluded that the recommended adjustments, which are consistent with the survey median values, reflect the time that is needed during the pre-service period for a typical patient. The additional 4 minutes of time is needed for proper prone positioning which is important for this procedure, similar to other facet joint injection procedure positioning.

Intra-Time: The expert panel is recommending the survey median of 20 minutes for intra-service time.

Post Time and Post-Op Visits: The expert panel is recommending survey median time of 10 minutes for the immediate post-time. They are also recommending 0.5-99238 post discharge visit, as recommended by the RUC in October 2010 for a same day discharge and 1-99213 office visit based on survey data.

Work RVU Recommendation Rationale

The specialties are recommending the survey median of 3.42 work RVUs. This is less than the current work RVU value of 3.78. With the recommended time this results in an IWPUT of 0.052.

The expert panel's recommendation is based on: survey data, rank order within the family, comparison to key reference codes, and comparison to similar codes.

Survey data: The expert panel is recommending the survey median of 3.42 work RVUs. The survey was viewed as robust with 167 responses and the median experience in the last 12 months was 80.

Rank Order Within the Family: The expert panel also considered rank order within the family. They agreed it was appropriate for 64633 to be valued higher than 64635 even though they had the same intra and total time. The anatomical location of the injection site for 64633 made it more complex and intense procedure so it was appropriate for it to be valued above 64635.

Comparison to Key Reference Code: The expert panel also concluded that the recommendation aligned well with the top reference code. 107 of the 167 respondents chose 64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography))* which has pre-time of 19 minutes (13/1/5), intra-service time of 30 minutes, immediate post-service time of 7 minutes, discharge day management 19 minutes (0.5 – 99238); and office visit time of 23 minutes (1-99213); and a work RVU of 3.39 which results in an IWPUT of 0.0423.

The expert panel believes that it is appropriate to value code 64635 higher than 64625 to reflect the survey respondents complexity/intensity ranking which aligns with the anatomical differences in locations, with the greater complexity for 64635 compared to 64625.

- Those that selected 64625 as the top reference code in the survey, 66% stated the survey code, 64635, has somewhat or much more overall intensity and complexity than the reference code.
- While 64625 has a greater number of injections, 64635 is located in a much more clinically complex location, requiring greater clinical expertise.
- As code 64635 has both a greater total time and IWPUT, recommending an equal or lower wRVU than 64625 could create a rank order anomaly between the codes.

Comparison to Similar Services

The expert panel also compared 64635 to other RUC surveyed codes and concluded that the recommendation maintained appropriate rank order and aligned well with other similar codes.

CPT	DESCRIPTOR	IWPUT	wRVU	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)	0.1169	3.00	66	7	10	10		1	1
46505	Chemodenervation of internal anal sphincter	0.0422	3.18	102	35	15	10	0.5	1	
64635	**Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint**	**0.052**	**3.42**	**102**	**30**	**20**	**10**	**0.5**	**1**	
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	0.0294	3.59	129	35	25	27	0.5	1	
38500	Biopsy or excision of lymph node(s); open, superficial	0.0517	3.79	115	35	30	15	0.5		1

In summary, for CPT code 64635 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint) ***ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS recommend 3.42 wRVUs and 28/20/10, 0.5-99238, and 1-99213 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64635

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1075250
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative Medicare utilization

Specialty Pain Management Frequency 301421 Percentage 28.03 %

Specialty Anesthesiology Frequency 263461 Percentage 24.50 %

Specialty Interventional Pain Management Frequency 255288 Percentage 23.74 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 358,450 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Pain Management Frequency 100474 Percentage 28.03 %

Specialty Anesthesiology Frequency 87820 Percentage 24.49 %

Specialty Interventional Pain Management Frequency 85096 Percentage 23.73 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64635

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64636 Tracking Number Original Specialty Recommended RVU: **1.16**
Presented Recommended RVU: **1.16**
Global Period: ZZZ Current Work RVU: **1.16** RUC Recommended RVU: **1.16**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents with constant low back pain due to degenerative disc disease and facet arthropathy. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The same treatment is performed on additional unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Monitor patient with continuous pulse oximetry, BP, and ECG. Rotate and adjust a C-arm fluoroscopic machine until the targeted facet joint and bony landmarks are optimally visualized. Anesthetize the skin and subcutaneous tissues with local anesthetic. Direct the needle to the point at which the superior articular process and the transverse process meet under intermittent fluoroscopic guidance Take care to avoid vital neural structures or blood vessels. Stimulate patient with appropriate frequencies for sensory and motor stimulation to verify the needles are in the correct position.

Confirm appropriate positioning of the needle tip with multiple fluoroscopic views including AP and lateral projections. Inject anesthetic. Perform radiofrequency ablation of the nerve. After both nerves are lesioned, apply a dressing.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Neal Cohen, MD, Richard Rosenquist, MD, Gordon Morewood, MD, MBA, FASE, FASA, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MD, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD					
Specialty Society(ies):	American Society of Anesthesiologists (ASA), American Academy of Physical Medicine and Rehabilitation (AAPM&R), North American Spine Society (NASS), The Spine Intervention Society (SIS), North American Neuromodulation Society (NANS), American Academy of Pain Medicine (AAPM)					
CPT Code:	64636					
Sample Size:	8123	**Resp N:**	166			
Description of Sample:	Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	39.00	**83.00**	173.00	1000.00	
Survey RVW:	0.30	1.30	**1.87**	3.00	8.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	3.00	10.00	**15.00**	25.00	120.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	64636	**Recommended Physician Work RVU: 1.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64491	ZZZ	1.16	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64645	ZZZ	1.39	**RUC Time**

CPT Descriptor Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 56 **% of respondents:** 33.7 **%**

Number of respondents who choose 2nd Key Reference Code: 46 **% of respondents:** 27.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 64636	Top Key Reference CPT Code: 64491	2nd Key Reference CPT Code: **64645**
Median Pre-Service Time	0.00	0.00	1.00
Median Intra-Service Time	15.00	15.00	25.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**26.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	33%	42%	18%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	27%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	38%	57%
Physical effort required	50%	38%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	20%	80%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	22%	41%	37%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	20%	76%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	26%	70%
Physical effort required	4%	26%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	20%	76%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Academy of Pain Medicine (AAPM), the American Society of Interventional Pain Physicians (ASIPP), the North American Neuromodulation Society (NANS), the North American Spine Society (NASS), and the Spine Intervention Society (SIS) are submitting recommendations for CPT codes 64633-64636 for the October 2020 meeting. This code family describes destruction by a neurolytic agent with imaging guidance.

Code#	Descriptor	Global	2020 wRVU	Oct 2020 RUC Recommendation
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010	3.84	3.42
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.32	1.32
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010	3.78	3.42
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	ZZZ	1.16	1.16

Background

The following is a brief history of the code family.

- 2011: The code family was RUC surveyed.
- 2016: Parenthetical instructions for the code family were revised to clarify that these codes are reported per joint, not nerve.
- 2019: The Relativity Assessment Workgroup noted that the growth in this family was appropriate as the population has grown; however, the Workgroup recommended that the code family be surveyed.
- 2020: The code family was surveyed and presented at the October 2020 RUC meeting.

October 2020 RUC Meeting Recommendation Rationale

A total of 166 responses were received from a random sample of 8,123 clinicians (2.04% response rate). 95.18% of respondents agreed with the typical patient vignette. The median experience in the past 12 months was 83. The surveying societies convened an Expert Panel to review the survey data. ***The societies are recommending 1.16 wRVUs (current value) and an intra-time of 15 minutes (survey median and current value).***

Vignette

The vignette described a typical patient for code 64636 as a 65-year-old male presenting with constant low back pain due to degenerative disc disease and facet arthropathy. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The same treatment is performed on additional unilateral symptomatic facet joint.

The Expert Panel reviewed the survey data.

64636

Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.30	1.87	3.00
Intra	10	15	25

After a robust discussion, the Expert Panel agreed to recommend:

- wRVU
  - 1.16 wRVUs (current value)
- Time
  - Intra-time: 15 minutes (survey median and current value)

The panel noted that the median and 25th percentile wRVU values are higher than the current wRVU value.

Comparison to Key Reference Services
56 of the 166 respondents chose 64491 (*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure))* which has a wRVU of 1.16 and an intra service time of 15 minutes.
The Expert Panel conclude the recommendation aligned well with the top reference code. The Panel noted that the reference code has identical intra-time.

Comparison to Key Reference Services
The Panel also concluded that the recommendation maintained appropriate rank order among other ZZZ codes.

CPT Code	Descriptor	Work RVU	Intra-Time
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	1.16	15
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	1.16	15
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level	1.20	15
64643	Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)	1.22	20
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)	1.39	25

In summary, for CPT code 64636 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)) ***ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS recommend 1.16 wRVUs and 15 minutes for intra-time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64636

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1617120
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Pain Management Frequency 454734 Percentage 28.11 %

Specialty Interventional Pain Management Frequency 405411 Percentage 25.06 %

Specialty Anesthesiology Frequency 400884 Percentage 24.78 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 539,040 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Pain Management Frequency 151578 Percentage 28.11 %

Specialty Interventional Pain Management Frequency 135137 Percentage 25.06 %

Specialty Anesthesiology Frequency 133628 Percentage 24.78 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64636

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Destruction by Neurolytic Agent

TAB: 17

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-inpt/same day 38	39	Office 15	14	13	12	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	64625	010	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image		0.042			3.39			98	13	1	5			30			7						0.5		1								
2nd REF	64624	010	Destruction by neurolytic agent, genicular nerve branches including imaging		0.054			2.50			74	17	1	5			25			10											1				
CURRENT	64633	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.044			3.84			116	18	5	6			30			15						0.5		1								
SVY	64633	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with	166	0.098	1.16	3.36	3.75	4.10	8.00	83	20	5	5	1	15	20	30	60	10								1				0	20	50	90	1000
REC	64633	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.052			3.42			100	18	5	5			20			10						0.5		1								

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-inpt/same day 38	39	Office 15	14	13	12	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	64645	ZZZ	Chemodenervation of one extremity; each additional extremity, 5 or more muscles	60	0.055			1.39			26		1				25																		
2nd REF	64491	ZZZ	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal)	58	0.077			1.16			15						15																		
CURRENT	64634	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.066			1.32			20						20																		
SVY	64634	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with	164	0.100	0.70	1.50	2.00	3.46	8.00	20				3	12	20	29	120													0	20	40	100	1000
REC	64634	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.066			1.32			20						20																		

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-inpt/same day 38	39	Office 15	14	13	12	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	64625	010	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image		0.042			3.39			98	13	1	5			30			7						0.5		1								
2nd REF	64624	010	Destruction by neurolytic agent, genicular nerve branches including imaging		0.054			2.50			74	17	1	5			25			10											1				
CURRENT	64635	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.045			3.78			114	18	5	6			28			15						0.5		1								
SVY	64635	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with	167	0.081	1.15	3.00	3.42	3.90	8.00	83	20	5	5	1	14	20	28	50	10								1				0	40	80	150	1000
REC	64635	010	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.052			3.42			100	18	5	5			20			10						0.5		1								

Source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-inpt/same day 38	39	Office 15	14	13	12	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	64491	ZZZ	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal)	56	0.077			1.16			15						15																		
2nd REF	64645	ZZZ	Chemodenervation of one extremity; each additional extremity, 5 or more muscles	46	0.055			1.39			26		1				25																		
CURRENT	64636	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.077			1.16			15						15																		
SVY	64636	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with	166	0.124	0.30	1.30	1.86	3.00	8.00	15				3	10	15	25	120													0	39	83	173	1000
REC	64636	ZZZ	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with		0.077			1.16			15						15																		

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-36**
SPECIALTY SOCIETY(IES):_AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS __
PRESENTER(S):_ Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64633	A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for code 64633

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are

typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Clinical staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

N/A

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)



NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-36**

SPECIALTY SOCIETY(IES):_AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS

PRESENTER(S):_ Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64633	A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for 64633

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No, it is reported with an E/M service 4% of the time. In the nonfacility, it is reported with an E/M service 7% of the time.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Interventional Pain Management is the dominant provider in the nonfacility setting, providing the service 31% of the time. The global dominant provider is Pain Management, which provides the service 29% of the time globally.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

5 minutes was allocated to CA010 in the existing data for this code. We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: BP, RR, Pulse, Temp, O2 sat.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Staff briefly reviews procedure with patient via phone. Staff coordinates any necessary prescriptions for the patient.

   b. Service period (includes pre, intra and post):

Staff greets the patient and prepares them for the procedure including providing in-person education, obtaining consent and obtaining vital signs. Staff prepares the room, equipment and supplies. Staff assists the physician with the procedure. Following the procedure, staff monitors the patient for any adverse events, checks dressings and helps with discharging the patient.

   c. Post-service period:

Staff assists the physician during the level 3 office visit in the period following the procedure.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

L037D RN/LPN/MTA Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure. L041B Radiologic Technologist Staff is present and assisting the physician during the entire procedure. Staff assists with patient positioning and ensures fluoroscopic guidance is appropriately capturing the patient's anatomy while the procedure is occurring to ensure proper placement.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

SA041 pack, basic injection – unit price 11.36
Applicator, sponge-tipped, 3 items
Bandage, strip 0.75in x 3in, 1 item
Cap, surgical, 1 item
Drape, sterile barrier 16in x 29in, 1 item
Drape, sterile, for Mayo stand, 1 item
Gauze, sterile 4in x 4in, 2 items
Gloves, sterile, 2 pair
Gown, staff, impervious, 1 item
Gown, surgical, sterile, 1 item
Lidocaine 1%-2% inj (xylocaine), 5ml
Mask, surgical 1 item
Needle, 18-27g, 2 item
Povidone soln (betadine), 10ml
Syringe 3ml, 1 item
Underpad 2ftx3ft (chux), 1 item

SA048 pack, minimum multi-specialty visit – unit price 2.1122
Paper, exam table, 7 feet
Gloves, non-sterile, 2 pair
Gown, patient, 1 item
Pillow case, 1 item
Cover, thermometer probe, 1 item

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031 – Table, power – Default
EL018 – Room, mobile c-ARM – Highly Technical
EQ214 – Radiofrequency generator (NEURO) – Default
EQ354 – Radiofrequency kit for destruction by neurolytic agent – Default
EQ211 – Pulse oximeter w-printer – Default

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ED050 – Technologist PACS workstation – PACS
EF015 – Mayo stand – Default
EQ168 – Light, exam - Default

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Regarding our supply inputs, our experts recognize that the basic injection pack and minimum multi-specialty pack include many of the items needed to perform this procedure, but in insufficient numbers. A number of the inputs in our spreadsheet are duplicates of the contents in the packs. Our experts felt this was the most fiscally appropriate method of detailing the necessary supplies for this procedure. Having both an RN/LPN/MTA and a radiologic technologist present for the procedure increases the needs for protective gowns, masks, etc. Further, additional draping, syringes and bandages are needed for this service.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

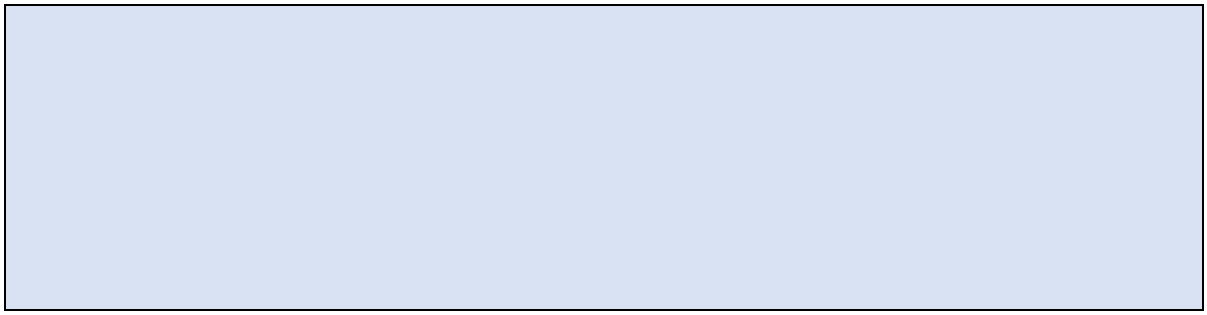
22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)



NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-36**

SPECIALTY SOCIETY(IES):_ AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS

PRESENTER(S): Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64634	A 65-year-old female presents with constant neck pain due to degenerative disc disease and cervical spondylosis. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). She has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The treatment is repeated on an additional unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for 64634.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No, it is reported with an E/M service 4% of the time. In the nonfacility, it is reported with an E/M service 7% of the time.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Interventional Pain Management is the dominant provider in the nonfacility setting, providing the service 32% of the time. The global dominant provider is Pain Management, which provides the service 29% of the time globally.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

No time allocated to obtain vital signs because this is an add on code.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

Staff assists the physician with the procedure

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

L037D RN/LPN/MTA Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes,

gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
L041B Radiologic Technologist Staff is present and assisting the physician during the entire procedure. Staff assists with patient positioning and ensures fluoroscopic guidance is appropriately capturing the patient's anatomy while the procedure is occurring to ensure proper placement.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031 – Table, power – Default EL018 – Room, mobile c-ARM – Highly Technical EQ214 – Radiofrequency generator (NEURO) – Default EQ354 – Radiofrequency kit for destruction by neurolytic agent – Default EQ211 – Pulse oximeter w-printer – Default ED050 – Technologist PACS workstation – PACS EF015 – Mayo stand – Default EQ168 – Light, exam - Default

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise

the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-64636**

SPECIALTY SOCIETY(IES):____ AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS

PRESENTER(S): Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64635	A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for 64635

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Clinical staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

N/A

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list

of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-36**

SPECIALTY SOCIETY(IES):_ AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS _

PRESENTER(S): Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64635	A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for 64635.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No, it is reported with an E/M service 4% of the time. In the nonfacility, it is reported with an E/M service 7% of the time.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Interventional Pain Management is the dominant provider in the nonfacility setting, providing the service 29% of the time. The global dominant provider is Pain Management, which provides the service 28% of the time globally.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

5 minutes was allocated to CA010 in the existing data for this code. We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: BP, RR, Pulse, Temp, O2 sat.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Staff briefly reviews procedure with patient via phone. Staff coordinates any necessary prescriptions for the patient.

   b. Service period (includes pre, intra and post):

Staff greets the patient and prepares them for the procedure including providing in-person education, obtaining consent and obtaining vital signs. Staff prepares the room, equipment and supplies. Staff assists the physician with the procedure. Following the procedure, staff monitors the patient for any adverse events, checks dressings and helps with discharging the patient.

   c. Post-service period:

Staff assists the physician during the level 3 office visit in the period following the procedure.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

related to physician work time or *Perform procedure/service---NOT directly related to physician work time:*

L037D RN/LPN/MTA Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
L041B Radiologic Technologist Staff is present and assisting the physician during the entire procedure. Staff assists with patient positioning and ensures fluoroscopic guidance is appropriately capturing the patient's anatomy while the procedure is occurring to ensure proper placement.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

SA041 pack, basic injection – unit price 11.36
Applicator, sponge-tipped, 3 items
Bandage, strip 0.75in x 3in, 1 item

Cap, surgical, 1 item
Drape, sterile barrier 16in x 29in, 1 item
Drape, sterile, for Mayo stand, 1 item
Gauze, sterile 4in x 4in, 2 items
Gloves, sterile, 2 pair
Gown, staff, impervious, 1 item
Gown, surgical, sterile, 1 item
Lidocaine 1%-2% inj (xylocaine), 5ml
Mask, surgical 1 item
Needle, 18-27g, 2 item
Povidone soln (betadine), 10ml
Syringe 3ml, 1 item
Underpad 2ftx3ft (chux), 1 item

SA048 pack, minimum multi-specialty visit – unit price 2.1122
Paper, exam table, 7 feet
Gloves, non-sterile, 2 pair
Gown, patient, 1 item
Pillow case, 1 item
Cover, thermometer probe, 1 item

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031 – Table, power – Default
EL018 – Room, mobile c-ARM – Highly Technical
EQ214 – Radiofrequency generator (NEURO) – Default
EQ354 – Radiofrequency kit for destruction by neurolytic agent – Default
EQ211 – Pulse oximeter w-printer – Default
ED050 – Technologist PACS workstation – PACS
EF015 – Mayo stand – Default
EQ168 – Light, exam - Default

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Regarding our supply inputs, our experts recognize that the basic injection pack and minimum multi-specialty pack include many of the items needed to perform this procedure, but in insufficient numbers. A number of the inputs in our spreadsheet are duplicates of the contents in the packs. Our experts felt this was the most fiscally appropriate method of detailing the necessary supplies for this procedure. Having both an RN/LPN/MTA and a radiologic technologist present for the procedure increases the needs for protective gowns, masks, etc. Further, additional draping, syringes and bandages are needed for this service.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64633-36**

SPECIALTY SOCIETY(IES):_ AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS _

PRESENTER(S): Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):64633-36**

SPECIALTY SOCIETY(IES):_ AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS

PRESENTER(S): Neal Cohen, MD, Gordon Morewood, MD, MBA, FASE, FASA, Richard Rosenquist, MD, Carlo Milani, MD, David Reece, DO, Kano Mayer, MD, Karin Swartz, MS, Wesley Ibazebo, MD, Damean Freas, MD, Gregory Polston, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 8-10, 2020

CPT Code	Long Descriptor	Global Period
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64636	A 65-year-old male presents with constant low back pain due to degenerative disc disease and facet arthropathy. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He has undergone radiofrequency neurotomy of two medial branch nerves innervating one symptomatic facet joint (separately reported). The same treatment is performed on additional unilateral symptomatic facet joint.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense recommendations for codes 64633-36 were determined through conference call and email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs for the four codes. They also considered Practice Expense Subcommittee feedback and approved inputs for more recently reviewed codes that are similar to the facet joint destruction codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing inputs for 64636.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No, it is reported with an E/M service 4% of the time. In the nonfacility, it is reported with an E/M service 7% of the time.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Interventional Pain Management is the dominant provider in the nonfacility setting, providing the service 31% of the time. The global dominant provider is Pain Management, which provides the service 28% of the time globally.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed there is no duplication in these added inputs. Further, in using the appropriate formulas to calculate equipment times, the times are higher than current equipment time inputs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

No time allocated to obtain vital signs because this is an add on code.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

Staff assists the physician with the procedure.

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

L037D RN/LPN/MTA Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment

or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure. L041B Radiologic Technologist Staff is present and assisting the physician during the entire procedure. Staff assists with patient positioning and ensures fluoroscopic guidance is appropriately capturing the patient's anatomy while the procedure is occurring to ensure proper placement.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?

a. If yes, please explain how the computer is used for this service(s).
b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031 – Table, power – Default EL018 – Room, mobile c-ARM – Highly Technical EQ214 – Radiofrequency generator (NEURO) – Default EQ354 – Radiofrequency kit for destruction by neurolytic agent – Default EQ211 – Pulse oximeter w-printer – Default ED050 – Technologist PACS workstation – PACS EF015 – Mayo stand – Default EQ168 – Light, exam - Default

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

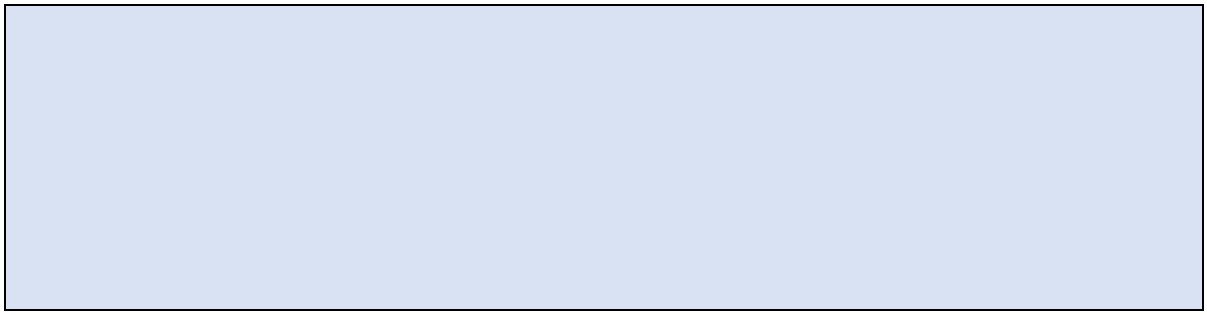
22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).



	A	B	D	E	F	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2						CPT Code 64633		CPT Code 64633		CPT Code 64634		CPT Code 64634		CPT Code 64635		CPT Code 64635		CPT Code 64636		CPT Code 64636	
3		*RUC Collaboration Website*				Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, single		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each	
4	Clinical Activity Code	Meeting Date: October 8-10, 2020 Revision Date (if applicable): Tab: 17 Destruction by Neurolytic Agent Specialty: AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute																
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ	010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 174.51	$ 21.47	$ 223.09	$ 17.39	$ 97.19	$ -	$ 158.37	$ -	$ 171.37	$ 21.47	$ 223.09	$ 17.39	$ 89.29	$ -	$ 150.48	$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	138.0	57.0	109.5	47.0	40.0	0.0	40.0	0.0	134.0	57.0	109.5	47.0	30.0	0.0	30.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	14.0	21.0	3.0	11.0	0.0	0.0	0.0	0.0	14.0	21.0	3.0	11.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	88.0	0.0	70.5	0.0	40.0	0.0	40.0	0.0	84.0	0.0	70.5	0.0	30.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ 52.46	$ 21.09	$ 41.52	$ 17.39	$ 15.60	$ -	$ 15.60	$ -	$ 50.90	$ 21.09	$ 41.52	$ 17.39	$ 11.70	$ -	$ 11.70	$ -
13		PRE-SERVICE PERIOD																			
14		Start: Following visit when decision for surgery/procedure made																			
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	3	3							3	3						
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		5		3						5		3				
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		5		3						5		3				
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	5	5		2					5	5		2				
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	3	3					3	3	3	3				
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37																
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37																
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37																
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L041B	Radiologic	0.41	3								3							
26		*Other activity: please include short clinical description here and type new in*	L037D	RN/LPN/MTA	0.37																
29		End: When patient enters office/facility for surgery/procedure																			
30		SERVICE PERIOD																			
31		Start: When patient enters office/facility for surgery/procedure:																			
32		Pre-Service (of service period)																			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37	3		3						3		3					
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5						5		5					
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			2								2					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37																
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2						2		2					
38	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41			2								2					
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37			0								0					
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37																
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	3		2						3		2					
42	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L041B	Radiologic	0.41	2		1						2		1					
43	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37																
44			L037D	RN/LPN/MTA	0.37																
47		*Other activity: please include short clinical description here and type new in*	L037D	RN/LPN/MTA	0.37																
50		Intra-service (of service period)																			
51	CA018	Assist physician or other qualified healthcare professional---directly related to	L037D	RN/LPN/MTA	0.37	30		20		20		20		28		20		15		15	
52	CA018	Assist physician or other qualified healthcare professional---directly related to	L041B	Radiologic	0.41	30		20		20		20		28		20		15		15	
53	CA019	Assist physician or other qualified healthcare professional---directly related to	L037D	RN/LPN/MTA	0.37																
54	CA020	Assist physician or other qualified healthcare professional---directly related to	L037D	RN/LPN/MTA	0.37																
55	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37																
58			L037D	RN/LPN/MTA	0.37																
59		*Other activity: please include short clinical description here and type new in*	L037D	RN/LPN/MTA	0.37																
62		Post-Service (of service period)																			
63	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37	10		2.5						10		2.5					
64	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37																
65	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3						3		3					
66	CA025	Clean scope	L037D	RN/LPN/MTA	0.37																
67	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37																
68	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37																
69	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37																
70	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37			1								1					
71	CA030	Technologist QC's images in PACS, checking for all images, reformats, and	L041B		0.41			2								2					
72	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37			2								2					
73	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate	L037D	RN/LPN/MTA	0.37			1								1					
74	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37																
75	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG	L037D	RN/LPN/MTA	0.37																
76	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			2								2					
77	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
78			L037D	RN/LPN/MTA	0.37																
81		*Other activity: please include short clinical description here and type new in*	L037D	RN/LPN/MTA	0.37																
84		End: Patient leaves office/facility																			
85		POST-SERVICE PERIOD																			
86		Start: Patient leaves office/facility																			
87	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37																
88	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37																
89		*Office visits: List Number and Level of Office Visits*	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
90		99211 16 minutes	16																		
91		99212 27 minutes	27																		
92		99213 36 minutes	36			1	1	1	1					1	1	1	1				
93		99214 53 minutes	53																		
94		99215 63 minutes	63																		
95	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0
96			L037D	RN/LPN/MTA	0.37																
99		*Other activity: please include short clinical description here and type new in*	L037D	RN/LPN/MTA	0.37																
102		End: with last office visit before end of global period																			

	A	B	D	E	F	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2						CPT Code 64633		CPT Code 64633		CPT Code 64634		CPT Code 64634		CPT Code 64635		CPT Code 64635		CPT Code 64636		CPT Code 64636	
3		*RUC Collaboration Website*				Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, single		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, each		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or throacic, each additional facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each	
4	Clinical Activity Code	Meeting Date: October 8-10, 2020 Revision Date (if applicable): Tab: 17 Destruction by Neurolytic Agent Specialty: AAPM, AAPM&R, ASA, ASIPP, NANS, NASS, SIS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute																
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ	010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 174.51	$ 21.47	$ 223.09	$ 17.39	$ 97.19	$ -	$ 158.37	$ -	$ 171.37	$ 21.47	$ 223.09	$ 17.39	$ 89.29	$ -	$ 150.48	$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	138.0	57.0	109.5	47.0	40.0	0.0	40.0	0.0	134.0	57.0	109.5	47.0	30.0	0.0	30.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	14.0	21.0	3.0	11.0	0.0	0.0	0.0	0.0	14.0	21.0	3.0	11.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	88.0	0.0	70.5	0.0	40.0	0.0	40.0	0.0	84.0	0.0	70.5	0.0	30.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0	36.0	36.0	36.0	36.0	0.0	0.0	0.0	0.0
103	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT																	
104		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ 90.57	$ -	$ 157.46	$ -	$ 65.61	$ -	$ 126.81	$ -	$ 90.57	$ -	$ 157.46	$ -	$ 65.61	$ -	$ 126.81	$ -
105	SA041	pack, basic injection	11.06	pack		1		1						1		1					
106	SA048	pack, minimum multi-specialty visit	3.0815	pack		2		1						2		1					
107	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.2265	item				1				2				1				2	
108	SB028	gown, surgical, sterile	4.9005	item				1								1					
109	SB033	mask, surgical	0.153	item				2								2					
110	SB008	drape, sterile, c-arm, fluoro	4.942	item		1		1						1		1					
111	SC051	syringe 10-12ml	0.197	item		1		1						1		1					
112	SC055	syringe 3ml	0.173	item		1								1							
113	SH022	bupivacaine 0.5% inj (Marcaine)	0.12	ml		3				3				3				3			
114	SD011	cannula (radiofrequency denervation) (SMK-C10)	24.615	item		2		2		2		2		2		2		2		2	
115	SD087	guide, needle, for localization	16.02	item		1		2		1		2		1		2		1		2	
116	SD269	Grounding pad	2.425	item		1		1						1		1					
117	SK075	skin marking pen, sterile (Skin Skribe)	1.334	item				1								1					
118	SJ081	swab, patient prep, 1.5 ml (chloraprep)	1.065	item				0								0					
119	SB019	drape-towel, sterile 18in x 26in	0.376	item				1								1					
120	SH021	bupivacaine 0.25% inj (Marcaine)	0.377	ml				1								1					
121	SD050	electrode needle, injectable (Myoject)	22.545	item				2				2				2				2	
122	SC057	syringe 5-6ml	0.14	item				1								1					
123	SJ001	alcohol isopropyl 70%	0.016	ml				1								1					
124	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.999	item				1								1					
125	SL259	Bleach cleaning wipe	0.715	item				1								1					
126		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*																			
128	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute																
129		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ 31.48	$ 0.38	$ 24.12	$ -	$ 15.98	$ -	$ 15.96	$ -	$ 29.90	$ 0.38	$ 24.12	$ -	$ 11.98	$ -	$ 11.97	$ -
130	EF018	stretcher	5005.0105		0.013281929	59				20				59				15			
131	EF031	table, power	6030.195	Default	0.016002488			38				20				38				15	
132	EL018	room, mobile c-ARM	151200	Highly Technical	0.572899695	38		27		20		20		36		27		15		15	
133	EQ214	radiofrequency generator (NEURO)	35136.5	Default	0.136158406	38		38		20		20		36		38		15		15	
134	EQ354	radiofrequency kit for destruction by neurolytic agent	2695	Default	0.040425			38				20				38				15	
135	EQ211	pulse oximeter w-printer	1641.54	Default	0.005298287	38		38		20		20		36		38		15		15	
136	ED050	Technologist PACS workstation	5557	PACS	0.022017924	59		43		20		20		57		43		15		15	
137	ED031	printer, dye sublimation (photo, color)	12398.3365		0.049124642	38				20				36				15			
138	EF015	mayo stand	526.782	Default	0.001171771			38				20				38				15	
139	EF023	table, exam	3037.9485	Office Visits	0.006757594	36	36							36	36						
140	EQ168	light, exam	1431.5035	Default	0.003798819	36	36	38				20		36	36	38				15	
141																					
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*																			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
ZZZ Global Period Services with Office Visits

October 2020

Strabismus Surgery – Tab 18

After the RUC reviewed the Evaluation and Management (E/M) office visits in April 2019, it also recommended that the increases for physician work and time, if accepted, should be incorporated into the surgical global periods for each CPT code with a global of 010-day, 090-day and MMM (maternity) codes. When AMA staff compiled the list of 010-day, 090-day and MMM services in which these changes should be applied, they noticed that several low volume codes that were converted to ZZZ global periods in 1999 still included office visits (CPT codes 67320, 67331, 67332, 67334, 67340). It appeared that these office visits may not be appropriate for these services. Additionally, these services received the increase in 2007, when the E/M increases were applied to the surgical global periods. The RUC noted that these services 1999 work RVUs were calculated and the methodology used would not be a valid methodology today and the physician times are based on Harvard data. The RUC recommended that add-on codes 67320, 67331, 67332, 67334, 67335, and 67340 be surveyed for April 2020 along with the base codes in which these services are typically reported (CPT codes 67311, 67312 67314, 67316 and 67318). This issue was deferred until October 2020.

In May 2020, the specialties reported an incident with a communication during the survey period containing the current publicly available work RVUs for the 11 codes. The RUC discussed extensively and determined that only the pre-disclosure data obtained from the period prior to the communication would be used for valuation, thus maintaining the integrity of the survey data.

Compelling Evidence
The family of five 090-day global base codes and six ZZZ add-on codes comprises the entirety of strabismus eye muscle surgery procedures in the CPT code set. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was identified because five of the add-on codes carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes were presented to the RUC for valuation. Although it was not needed overall for the family, the specialty societies presented compelling evidence as there are two codes proposed to increase in value, CPT codes 67318 and 67335. The RUC noted that the recommendations for the family of strabismus codes will result in an overall work savings to be redistributed back to the Medicare conversion factor. The RUC reviewed and accepted compelling evidence based on flawed methodology as outlined below.

The current times for these services are over 25 years old from the Harvard study and not valid for comparison. During the initial Harvard study, only overall post-operative time was surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC reviewed the hospital and office visits for these services and the first time survey data was

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collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times highly inappropriate for major surgical procedures.

There is compelling evidence that the add-on codes in this family were valued using improper methodology during a value correction in 1998, resulting in anomalous value relationships among all the codes under review. CPT add-on codes 67320, 67331, 67332, 67334 and 67340 each have 4 postoperative visits listed in the database as well as pre- and post-time. They were last evaluated by the RUC in May 1998. These codes were changed from stand-alone codes with a global period of 090 days to add-on ZZZ codes. The rationale to adjust their value at the May 1998 RUC meeting reads:

> The family of add-on codes in the Strabismus Surgery section of CPT were reevaluated as they are currently identified as stand-alone codes with a global period of 90 days. Previously, the descriptors for CPT codes 67320, 67331, 67332, 67334 and 67340 included not only the intra-service work described by the code, but also a number of unstated, but implied, services that are associated with pre-service and post service work. These codes will now be identified as add-on codes with a global period of ZZZ and the work rvus should be reduced accordingly.
>
> The RUC recommends the following work values: 4.33 (67320); 4.06(67331); 4.49 (67332); 3.98 (66334); 4.93 (67340). The specialty society used an arithmetic adjustment to the work values of these procedural codes. These proposed values were established by reducing the current work values by 50% using rules for multiple surgical procedures performed on the same day. Also, the Harvard data indicates that 59% of the codes were for intra-work, further justifying these proposed work values.

The RUC database confirms those reductions were implemented in the RUC recommendations and accepted by CMS for 1999:

1998 CPT	1999 RVU	2018 RVU	Claims
+67320	8.26	4.33	369
+67331	8.12	4.06	866
+67332	8.99	4.49	1,682
+67334	7.96	3.98	128
+67335	2.49	2.49	1,756
+67340	9.85	4.93	68

When the ZZZ-global codes were revalued in 1998 to address the inaccurate inclusion of postoperative visits by the Harvard surveyors, they were valued by applying 50% multiple procedure payment reductions (MPPR) to the initial Harvard valuations. This is no longer an accepted

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methodology. The use of this methodology created anomalous relationships within the family and distorted relativity with the remainder of the RUC database.

All the base codes in the family and add-on code 67335 were excluded in the group of codes revalued in 1998. CPT code 67335 was initially Harvard valued as a ZZZ code with no pre- or post-time or postoperative visits. Excluding this code and all the 090-day global base codes within the family from the 1998 revaluation process was also flawed methodology which allowed the rank order anomalies to continue.

There is also the argument that Harvard-based times and work values are no longer consistent with RUC methodology that has been in place for the last two decades and which has generated the values for those frequently performed procedures in the database that make up the bulk of Medicare claims volume. Whether outdated Harvard methodology is sufficient compelling evidence in and of itself, the use of an MPPR calculation to value only some of the add-on procedures in the family and the exclusion of the base codes from the valuation process in 1998 is certainly inconsistent with today's accepted RUC methodology. The RUC accepted compelling evidence based on flawed methodology and believes that the arguments presented help to build the case for the proposed RVU recommendations given the decreases in time reflected in the survey.

Intensity
The strabismus procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and suturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures.

While it may seem that the intensity of work for each of the base codes might be similar, there are marked differences between single-muscle and two-muscle procedures and surgery on the superior oblique muscle. Single-muscle procedures are typically recessions, where the muscle insertion is detached and reattached further posteriorly on the globe, in effect "lengthening" the muscle. Two-muscle procedures typically involve a recession of one muscle and a resection of the second muscle; thus, it is not simply performing the same procedure twice. The resection component of the procedure requires detachment of the muscle from its insertion, resection of a specific length of the muscle, and reattaching it, in effect "shortening" the muscle. Muscle resections are markedly more intense and complex than recessions. This makes 2-muscle procedures significantly more intense and complex than 1-muscle procedures, independent of the increased time required to operate on 2 muscles. Surgery on the superior oblique muscle, because of its insertion location, reflected tendon, posterior location, small size and difficulty in isolating the muscle, is more difficult than surgery on horizontal or vertical rectus muscles. It is similar in intensity and complexity to that of the 2-muscle procedures.

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Based on the relative intensity and complexity of the base codes and to avoid rank-order anomalies, the RUC noted that the single-muscle procedures (CPT codes 67311 and 67314) should have lower intensity than the two-muscle procedures (CPT codes 67312 and 67316) or the superior oblique procedure (CPT code 67318). The two-muscle procedures and the superior oblique procedure should have similar intensity.

Base Codes

67311 ***Strabismus surgery, recession or resection procedure; 1 horizontal muscle***

CPT code 67311 is a procedure on a single horizontal muscle, typically a medial rectus recession to correct esotropia in a child. The RUC reviewed the survey results from 62 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) accurately reflects the physician work necessary for this service and falls below both the survey 25th percentile and the survey low response.

The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 25 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The 2-99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The RUC compared CPT code 67311 to the top key reference service and MPC code 67904, *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is almost double that of the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67311 is considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 26765 *Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each* (work RVU = 5.86, 45 minutes intra-service time and 217 minutes total time) and 25071 *Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater* (work RVU = 5.91, 45 minutes intra-service time and 178 minutes total

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time) and noted the similar amount of physician work but longer times for the comparison codes. The RUC reiterated that the survey code current times are Harvard-source and not valid for comparison.

The RUC concluded that CPT code 67311 should be valued based on a direct work RVU crosswalk to CPT code 53854 with times as supported by the survey. **The RUC recommends a work RVU of 5.93 for CPT code 67311.**

67312 ***Strabismus surgery, recession or resection procedure; 2 horizontal muscles***
CPT code 67312 is a procedure on 2 horizontal muscles of the same eye, typically a recession of the medial rectus and a resection of the lateral rectus to correct esotropia in a child with a larger deviation than can be corrected with single-muscle surgery (CPT code 67311). The muscle resection makes it significantly more intense and complex than that of a recession alone, so a recess-resect combination on two muscles is more than twice the intra-service physician work than a single muscle recession.

The RUC reviewed the survey results from 57 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 9.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 40 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intensity associated with this value (0.153) is higher than that of the single-muscle codes, CPT codes 67311 and 67314. This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical component of this two-muscle procedure. It is, appropriately, almost identical to the intensity for CPT code 67316, two vertical muscles, which is 0.154 at the recommended value.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva, coverage of the operative site, and assess ocular alignment.

The RUC compared CPT code 67312 to the top key reference service and MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is 5 minutes less for the survey code and intensity is more justifying the higher value. CPT code 67312 is considered more intense, with

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nearly 2/3 of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared CPT code 67312 with the second key reference code 67966 *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (work RVU = 8.97, 60 minutes intra-service time and 200 minutes total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67312 is clearly considered more intense, with 80% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, 60 minutes intra-service time and 183 minutes total time) and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and 207 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67312 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 9.50 for CPT code 67312.**

67314 ***Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)***
CPT code 67314 is a procedure on a single vertical muscle other than the superior oblique, which is a lengthier procedure. It is typically a superior rectus recession performed to correct hypertropia in a child. The RUC reviewed the survey results from 54 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) would accurately reflect the physician work necessary for this service and falls well below the survey 25th percentile.

The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 26 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intra-service time is within 1 minute of that of CPT code 67311, the single horizontal muscle procedure.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3

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minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

The RUC compared CPT code 67314 to the top key reference service and MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67314 is considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 26765 *Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each* (work RVU = 5.86, 45 minutes intra-service time and 217 minutes total time) and 25071 *Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater* (work RVU = 5.91, 45 minutes intra-service time and 178 minutes total time) and noted the similar amount of physician work but longer times for the comparison codes. The RUC reiterated that the survey code current times are Harvard-source and not valid for comparison.

The RUC concluded that CPT code 67314 should be valued based on a direct work RVU crosswalk to CPT code 53854 with times as supported by the survey. **The RUC recommends a work RVU of 5.93 for CPT code 67314.**

67316 ***Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)***
CPT code 67316 is a procedure performed on two vertical muscles, typically a recession of the superior rectus and a resection of the inferior rectus to correct hypertropia in a child with a vertical deviation that is too large to be corrected with single-muscle surgery (CPT code 67314). The resection portion of the procedure makes it significantly more intense and complex than that of a recession alone, so a recess-resect combination on two muscles is more than twice the intra-service physician work than a single muscle recession.

The RUC reviewed the survey results from 50 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 10.31 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intensity associated with the recommended value (0.154) is significantly higher than that of the single-muscle codes, CPT codes 67311 and 67314. This is consistent with the

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increased intensity and complexity of performing a muscle resection which is a typical component of this service. It is, appropriately, almost identical to the intensity for CPT code 67312, two horizontal muscles, which is 0.153 at the recommended value.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

The RUC compared CPT code 67316 to the top key reference service and MPC code 67036 *Vitrectomy, mechanical, pars plana approach;* (work RVU = 12.13, 50 minutes intra-service time and 250 minutes total time) and noted that the intra-service time is 5 minutes less for the survey code and intensity is more but the reference code has five 99213 postoperative visits resulting in much higher total time. CPT code 67316 is considered more intense, with nearly 2/3 of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared CPT code 67316 with the second key reference code 67966 *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (work RVU = 8.97, 60 minutes intra-service time and 200 minutes total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67316 is clearly considered more intense, with nearly 90% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible* (work RVU= 10.03, 90 minutes intra-service time and 283 minutes total time) and 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service time and 141 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

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The RUC concluded that CPT code 67316 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 10.31 for CPT code 67316.**

67318 ***Strabismus surgery, any procedure, superior oblique muscle***
CPT code 67318 is a procedure on the superior oblique muscle, typically a resection or plication of the muscle, in effect shortening it to correct a superior oblique palsy and resulting hypertropia in a child. Some or all of the tendon is included. Superior oblique muscle surgery has its own code to distinguish it from surgery on a single vertical muscle because operating on the superior oblique typically takes longer and is more intense and complex than surgery on a single vertical muscle. The greater intensity is due to the smaller size, the posterior location of the tendon, more difficult to identify insertion of the superior oblique muscle, and the greater difficulty of a resection or plication in comparison with the recession typically performed on a single vertical or horizontal muscle.

The RUC reviewed the survey results from 50 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 9.80 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 40 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 2-99213 office visits and 1-99212 office visit. The proposed value is slightly higher than the code's current value of 9.12, as supported by compelling evidence and the robust survey data. The intensity associated with this value (0.149) is significantly higher than that of the other single-muscle codes, CPT codes 67311 and 67314. This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical for this service. The intensity is, appropriately, very close to the intensity for the two-muscle procedures, CPT codes 67312 and 67316, which also include a muscle resection. The recommended work value is slightly higher than that of CPT code 67312 despite identical intra-service times of 40 minutes. This is partially attributable to the additional 99213 postoperative visit and partially attributable to the slightly greater intensity of operating on a superior oblique muscle compared to horizontal muscles. The recommended value therefore maintains an appropriate rank order within the family.

The first 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The second visit, a 99212, is necessary to confirm healing of the conjunctiva and assess ocular alignment (horizontal, vertical, and torsional). The third visit, another 99213, confirms that vertical alignment is maintained after further healing and requires a dilated fundus exam to assess the fundus for degree of correction of ocular torsion. Because the superior oblique muscle intorts the eye in addition to depressing it, and symptoms or torsional misalignment are not typically expressed accurately by patients, the dilated fundus check for rotational alignment is necessary for current and future treatment. The requirement for two 99213 postoperative visits distinguishes this code from the other 090-day global codes in the family, which need only one 99213 postoperative visit.

The RUC compared CPT code 67318 to the top key reference service and MPC code 66170 *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (work RVU = 13.94, 45 minutes intra-service time and 278 minutes total time) and noted that the intra-

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service time is 5 minutes less for the survey code and intensity is more but the reference code has nine postoperative visits resulting in much higher total time. CPT code 67318 is considered more intense, with most survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and 207 minutes total time) and 21015 *Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm* (work RVU = 9.89, 75 minutes intra-service time and 277 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67318 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 9.80 for CPT code 67318.**

Add-On Codes

The six add-on codes (CPT codes 67320, 67331, 67332, 67334, 67335 and 67340) are all performed with one or more of the base codes (CPT codes 67311, 67312 67314, 67316 and 67318). Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create new combined codes. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT codes 67320 (transposition), 67331 (prior eye surgery) and 67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT code 67332, a re-operation with scarring of the extraocular muscles, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT codes 67335 (adjustable suture) and 67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

Note: This family of codes was recommended for survey because five of the add-on codes (67320, 67331, 67332, 67334 and 67340) carried postoperative visits in the RUC database. These procedures were changed from 090-day global to ZZZ codes and work values were correspondingly reduced in 1999. However, the pre- and post-service times and the 4 postoperative visits were not removed from the RUC database. Therefore, the pre- and post-service times and postoperative visits and the intensity based on those times must be disregarded when comparing current values with the recommended times and work RVUs. On the Summary Spreadsheet, the erroneous times and postoperative

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visits have been removed from the "Current" row to provide a correct relativity comparison and a row has been added showing the pre-reduction data from 1998.

67320 ***Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)***
CPT code 67320 is an add-on procedure typically performed for patients with a paretic lateral rectus muscle. It entails detaching the inferior and superior rectus muscles, repositioning them on the globe in an unusual location, and reattaching them in addition to the base procedure on the horizontal muscle(s). The need to relocate both muscles in an unusual location makes this procedure more intense than the single-muscle base procedures. It is not as intense as the two-muscle base procedures because it does not require a muscle resection.

The RUC reviewed the survey results from 51 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 36907 *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service and total time) accurately reflects the physician work necessary for this service and falls below the survey 25th percentile. The RUC recommends 23 minutes intra-service time for this add-on code.

The RUC discussed that there are only two 23-minute ZZZ codes in the database: CPT codes 33517 *Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)* (work RVU = 3.61, 23 minutes intra-service time and 53.5 minutes total time) and 88350 *Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)* (work RVU = 0.59, 23 minutes intra-service and total time) and noted that neither are acceptable crosswalks. There are only two 24-minute ZZZ codes in the database, and both are Harvard valued. The RUC therefore chose CPT code 36907, a 25-minute ZZZ code, as an appropriate crosswalk. It yields an intensity of 0.130, which places the survey code appropriately between the single- and two-muscle base codes and is almost identical to the intensity of similarly intense add-on codes 67331 and 67334.

To support the value, the RUC compared the survey code to CPT codes 32506 *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* and 32667 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* both of which have work RVUs = 3.00 and 25 minutes intra-service and total time.

The RUC also compared CPT code 67320 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67320 is

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considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced MPC codes 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65, 30 minutes intra-service and total time) and 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67320 should be valued based on a direct work RVU crosswalk to CPT code 36907 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 3.00 for CPT code 67320.**

67331 ***Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)***
CPT code 67331 is an add-on procedure typically performed for patients with scarring from previous eye surgery not directly affecting the extraocular muscles, typically from prior glaucoma filtering surgery. The scar tissue must be dissected without disturbing the delicate balance of flow through the filtering bleb. This makes the procedure more intense than that of the single-muscle base codes, but not as intense as the two-muscle base codes including a muscle resection.

The RUC reviewed the survey results from 51 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 2.00 accurately reflects the physician work necessary to perform this service. The RUC recommends 15 minutes intra-service time for this add-on code. The intensity associated with this value (0.133) is appropriately intermediate between the single- and two-muscle base codes. It is almost identical to the intensity of CPT codes 67320 and 67334 at the recommended values. These three procedures are all similar in intensity and complexity.

The RUC compared CPT code 67331 to the top key reference code 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67331 is clearly considered more intense, with 100% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

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For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67331 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.00 for CPT code 67331.**

67332 *Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)*
CPT code 67332 is an add-on procedure typically performed for patients with scarring of the extraocular muscles from previous surgery, trauma, or thyroid ophthalmopathy, typically from prior eye muscle surgery. The scar tissue must be identified and dissected, and the muscle isolated prior to proceeding with the base recession or resection procedure. In addition, the muscle is often inelastic and moved from its normal anatomic position. This is the most intense and complex of the add-on procedures in this family, similar in difficulty to a muscle resection and superior oblique surgery. The dissection is more difficult than that required for scarring that does not involve the extraocular muscles, CPT code 67331, and has a more profound effect on the outcome because it directly alters the muscle insertion anatomy and its effect on ocular motility.

The RUC reviewed the survey results from 53 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 3.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 24 minutes intra-service time for this add-on code. The intensity associated with this value (0.146), is higher than that of any of the other add-on codes, maintaining an appropriate rank order within the ZZZ family. It is slightly less than that of the 2-muscle base codes (recession and resection), and almost identical to that of the superior oblique code, CPT code 67318. This places it in appropriate rank order amongst all the codes in the family.

The RUC compared CPT code 67332 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67332 is clearly considered more intense, with 85% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared the survey code to CPT code 36907 *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition*

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to code for primary procedure) (work RVU = 3.00, 25 minutes intra-service and total time) and noted that this comparator code is being recommended for the less difficult transposition procedure, CPT code 67320. CPT code 67332 is more work and should be valued higher than CPT code 67320 and its crosswalk code.

For additional support, the RUC referenced key MPC codes 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67332 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.50 for CPT code 67332.**

67334 ***Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)***
CPT code 67334 is an add-on procedure typically performed to alter the effect of a muscle recession by fixing the muscle to the sclera with an additional suture posterior to the muscle insertion, thereby avoiding the need for resection of a second muscle. This procedure is separate and additional to the base surgery. The typical patient is a child with esotropia. The location of the suture placement far posteriorly on the globe makes the procedure much more difficult, with increased risk of globe perforation, than that of the single-muscle base codes, but not as difficult as the two-muscle base codes requiring a resection.

The RUC reviewed the survey results from 46 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 2.06 accurately reflects the physician work necessary to perform this service. The RUC recommends 15 minutes intra-service time for this add-on code. The intensity associated with this value (0.137) is appropriately intermediate between the single- and two-muscle base codes. It is almost identical to the intensity of CPT codes 67320 and 67331 at the recommended values. These three procedures are all similar in intensity and complexity.

The RUC compared CPT code 67334 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67334 is clearly considered more intense, with 88% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

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The RUC also compared the survey code to CPT code 36907 *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service and total time) and noted that this comparator code is being recommended for the less difficult transposition procedure, CPT code 67320. CPT code 67332 is more work and should be valued higher than CPT code 67320 and its crosswalk code.

For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67334 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.06 for CPT code 67334.**

67335 ***Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)***

CPT code 67335 is performed as an add-on procedure to titrate the effect of the base code recession or resection procedure more precisely by allowing adjustment after completion of the base code procedure. An adjustable suture is placed intra-operatively. The adjustment is typically performed on the same day as the base procedure. It is typically done in the post-anesthesia care unit after sedation and local anesthesia have worn off, allowing assessment of alignment while the patient is awake and fixating. Although performed in the PACU, the adjustment procedure and final tying of the suture is an essential part of the intra-service work. There is no post-service work for this add-on code.

Unlike the other add-on codes in this family, CPT code 67335 was originally Harvard valued as a ZZZ and was not converted from a 090-day global, thus avoiding the clerical error that occurred in 1998. The changes at that time resulted in an anomalous relationship between this code and the other add-on procedures in the family. The anomalous relationship continued when the other add-on codes were converted from 090-day to ZZZ global and re-valued in 1998 using an MPPR calculation, while the value of CPT code 67335 was left unchanged. The MPPR methodology used to revalue the family in 1998 was flawed and is not considered acceptable today, as outlined in the compelling evidence argument.

The RUC reviewed the survey results from 35 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 3.23 accurately reflects the physician work necessary to perform this service. This is an increase from the current value of the code, as supported by compelling evidence and the robust survey results.

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The RUC recommends 30 minutes intra-service time for CPT code 67335. This procedure requires more time than CPT codes 67320, 67331, 67332 or 67334, but is less intense. It does not require unusual muscle placement or dissection of scar tissue like those codes. However, it does take longer to place the suture and then adjust those sutures when the patient awakens. The intensity associated with this value (0.108) is lower than that of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. CPT code 67335 is of similar intensity to that of the one-muscle base codes and the other lengthy add-on code for a detached muscle, CPT code 67340.

The RUC compared CPT code 67335 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is 10 minutes more than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67335 is considered more intense, with most survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65, 30 minutes intra-service and total time) and 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67335 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.23 for CPT code 67335.**

67340 ***Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)***

CPT code 67340 is an add-on procedure typically performed for patients with a detached extraocular muscle. These are uncommon procedures, typically in young patients after prior ocular surgery or trauma. The muscle is typically retracted into the posterior orbit and must be found via a lengthy exploration prior to reattachment.

The RUC reviewed the survey results from 33 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 5.00 accurately reflects the physician work necessary to perform this service. The RUC recommends 45 minutes intra-service time for CPT code 67340. This procedure requires more time than CPT codes 67320, 67331, 67332 or 67334 but is less intense. It does not require

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unusual muscle placement or dissection of scar tissue like those codes. However, the exploration to locate the retracted muscle is lengthy. The intensity associated with this value (0.111) is lower than that of most of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. CPT code 67340 is appropriately like that of the single-muscle base codes and the other lengthy add-on code for an adjustable suture, CPT code 67335.

The RUC compared CPT code 67340 to the top key reference code 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67340 is clearly considered more intense, with nearly100% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared the survey code to CPT code 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time) and noted that the codes have identical intra-service time and similar amount of physician work. The comparator code, however, yields an intensity closer to that of some of the more difficult codes in the family.

The RUC concluded that CPT code 67340 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 5.00 for CPT code 67340.**

Practice Expense
The Practice Expense Subcommittee accepted the spreadsheet for CPT codes 67311, 67312 67314, 67316 and 67318 without modification. No direct practice expense inputs are recommended for the ZZZ codes 67320, 67331, 67332, 67334, 67335 and 67340 as the practice expense for the add-on codes is already included in the base codes. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

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CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
67311 (f)	Strabismus surgery, recession or resection procedure; 1 horizontal muscle	090	5.93
67312 (f)	Strabismus surgery, recession or resection procedure; 2 horizontal muscles	090	9.50
67314 (f)	Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)	090	5.93
67316 (f)	Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)	090	10.31
67318 (f)	Strabismus surgery, any procedure, superior oblique muscle	090	9.80
67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)	ZZZ	3.00
67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)	ZZZ	2.00
67332	Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)	ZZZ	3.50

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67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	ZZZ	2.06
67335 (f)	Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)	ZZZ	3.23
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	ZZZ	5.00

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67311 Tracking Number Original Specialty Recommended RVU: **7.44**
Presented Recommended RVU: **5.93**
Global Period: 090 Current Work RVU: **7.77** RUC Recommended RVU: **5.93**

CPT Descriptor: Strabismus surgery, recession or resection procedure; 1 horizontal muscle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A three-year-old girl with partially accommodative esotropia will have a medial rectus muscle recession performed in the right eye.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 56% , In the ASC 44%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing, including prior surgical reports. Measurements of the ocular deviation at distance in primary, right, and left gaze and at near are performed and compared to pre-operative measurements. The surgical plan is reviewed and either confirmed or revised based on the measurements performed in the pre-operative area, taking into consideration patient age and size of the globe and risk of amblyopia. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform an initial surgical time-out with the care team. Administer topical anesthetic and mydriatic eye drops. Reposition the patient. Prepare and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Perform a final surgical time out. The conjunctiva is examined. The limbus is grasped inferonasally and the eye rotated up and out. Conjunctiva in the inferonasal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the medial rectus muscle. A larger hook is then passed under the rectus muscle and the tendon width evaluated for completeness. Conjunctiva is pulled superiorly with a small hook. The superior Tenon's capsule is incised at the tip of the hook taking care to avoid injuring the rectus muscle, then two small hooks are passed through the incision to perform a pole test. Anterior Tenon's capsule is dissected as well as intermuscular membrane and check ligaments. A double armed 6-O absorbable suture is passed through partial thickness muscle both superiorly and inferiorly and locked at both muscle poles. The muscle is disinserted with scissors and the insertion site cauterized. The medical rectus muscle is then reattached to the sclera 4.5 mm posterior to the original insertion site using the spatula needles through partial thickness sclera. The sutures are secured, and the muscle examined for any posterior sag, which is pulled forward when needed. The conjunctiva is closed with 7-O chromic sutures. The speculum is removed and antibiotic-steroid and proparacaine eye drops are instilled in the eye.

Description of Post-Service Work: Write postoperative orders and prescriptions for postoperative medications. Complete a brief operative note and the complete operative report. Discuss the surgical procedure and postoperative instructions with the patient and family. Review necessary follow-up testing and examinations, as well as medications, activity, and restrictions. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67311					
Sample Size:	1093	**Resp N:**	62			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	50.00	**75.00**	147.50	330.00
Survey RVW:	6.05	8.22	**9.18**	10.63	18.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	5.00	20.00	**25.00**	30.00	60.00

Immediate Post Service-Time:	**14.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	67311	**Recommended Physician Work RVU: 5.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**33.00**	**-23.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**33.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67904	090	7.97	**RUC Time**

CPT Descriptor Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67966	090	8.97	**RUC Time**

CPT Descriptor Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26765	090	5.86	**RUC Time**	1,365

CPT Descriptor 1 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
25071	090	5.91	**RUC Time**	1,689

CPT Descriptor 2 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater

Other Reference CPT Code	Global	Work RVU	Time Source
53854	090	5.93	**RUC Time**

CPT Descriptor Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 24 **% of respondents:** 38.7 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 67311	Top Key Reference CPT Code: 67904	2nd Key Reference CPT Code: **67966**
Median Pre-Service Time	30.00	35.00	35.00
Median Intra-Service Time	25.00	45.00	60.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	55.0	71.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**144.00**	**185.00**	**200.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	21%	67%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	38%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	83%	13%
Physical effort required	13%	71%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	38%	58%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	91%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	64%	36%
Physical effort required	0%	82%	18%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	18%	82%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67311, *Strabismus surgery, recession or resection procedure; 1 horizontal muscle* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes carried postoperative visits in the database. While

this was a clerical error as the work value associated with the visits had been removed in 1999 (to be discussed in the ZZZ SORs), all eleven codes are being presented to the RUC for valuation.

COMPELLING EVIDENCE
There is compelling evidence that the add-on codes in this family were valued using improper methodology during a value correction in 1998, resulting in anomalous value relationships among all of the codes under review.

CPT +67320, +67331, +67332, +67334, and+ 67340 each have 4 postoperative visits listed in the database as well as pre- and post-time. They were last evaluated by the RUC in May 1998. These codes were changed from stand-alone codes with a global period of 90 days to add-on ZZZ codes. The rationale to adjust their value at the May 1998 RUC meeting reads:

"The family of add-on codes in the Strabismus Surgery section of CPT were reevaluated as they are currently identified as stand alone codes with a global period of 90 days. Previously, the descriptors for CPT codes 67320, 67331, 67332, 67334 and 67340 included not only the intraservice work described by the code, but also a number of unstated, but implied, services that are associated with pre-service and post service work. These codes will now be identified as add-on codes with a global period of ZZZ and the work rvus should be reduced accordingly.

The RUC recommends the following work values: 4.33 (67320); 4.06(67331); 4.49 (67332); 3.98 (66334); 4.93 (67340). The specialty society used an arithmetic adjustment to the work values of these procedural codes. These proposed values were established by reducing the current work values by 50% using rules for multiple surgical procedures performed on the same day. Also, the Harvard data indicates that 59% of the codes were for intra-work, further justifying these proposed work values."

The RUC database confirms those reductions were implemented in the RUC recommendations and accepted by CMS for 1999:

1998 CPT	1999 WRVU	2018 WRVU	Claims
+67320	8.26	4.33	369
+67331	8.12	4.06	866
+67332	8.99	4.49	1,682
+67334	7.96	3.98	128
+67335	2.49	2.49	1,756
+67340	9.85	4.93	68

When the ZZZ-global codes were revalued in 1998 to address the inaccurate inclusion of postoperative visits by the Harvard surveyors, they were valued by applying 50% multiple procedure payment reductions to the initial Harvard valuations. This is no longer an accepted methodology. The use of this methodology created anomalous relationships within the family and distorted relativity with the remainder of the RUC database.

CPT +67335 and none of the 090-global base codes (CPT 67311-67318) in the family were included in the group of codes revalued in 1998. CPT +67335 was initially Harvard valued as a ZZZ code with no pre- or post-time or postoperative visits. Excluding this code and all of the 090-day global base codes within the family from the 1998 revaluation process was also flawed methodology which allowed the rank order anomalies to continue.

There is also the argument that Harvard-based times and work values are no longer consistent with RUC methodology that has been in place for the last two decades and which has generated the values for those frequently performed procedures in the database that make up the bulk of Medicare claims volume.

Whether outdated Harvard methodology is sufficient compelling evidence in and of itself, the use of an MPPR calculation to value only some of the add-on procedures in the family and the exclusion of the base codes from the valuation process in 1998 is certainly inconsistent with today's accepted RUC methodology.

SOR RATIONALE

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and resuturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures. In adults, realignment may be done to eliminate diplopia or correct eye misalignment from disease or trauma.

On April 17, a survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. On April 22, the AAO became aware that a member of AAPOS emailed a list of the publicly available current WRVUs for the surveyed codes to the AAPOS list-serve address. The survey was halted on April 22 while an investigation was carried out. The results of the investigation revealed that the list of current WRVUs was emailed by a member to the list-serve on April 19 at 6:26 AM PDT/9:26 AM EDT. Thirty-seven AAPOS members immediately received an email containing the WRVU list. The remaining 1,913 AAPOS members did not receive the WRVU list until it was distributed at 5:00 PM PDT/8:00 PM EDT on April 19 as part of a daily digest.

Following early closure of the survey, many AAPOS and AAP/O members raised concerns about being unable to participate, noting that the survey was initially intended to be open until May 1, almost two weeks later. We met with the leadership of these sub-specialty societies. We agreed to resume the surveys on April 26 with a new end date of May 4, knowing that the disclosed WRVUs are publicly available from CMS and other sources and that we would be able to analyze the data as a whole and in subsets: prior to and after disclosure of the current WRVUs.

None of those who submitted surveys on April 17 or 18 would have seen the WRVU list that was distributed on April 19. They were included in the pre-disclosure data set. All those who submitted surveys on or after April 20 would have had an opportunity to see the WRVU list and were included in the post-disclosure data set.

We considered excluding all of those who submitted surveys on April 19, the day that the WRVU list was distributed, from the pre-disclosure group. However, that would have left fewer than the 30 responses necessary for all of the surveys to be valid. Therefore, the only April 19 responses that we moved from the pre-disclosure group to the post-disclosure group were from those who were sent the WRVU list that morning and submitted their survey on April 19. There were from 2-5 survey respondents for each code in this situation.

We presented this information to the AMA RUC staff and to the Research Committee, asking for guidance on whether the entire data set or only the pre-disclosure subset should be used to develop work recommendations. The Research Committee recommended that all 3 data sets (pre-disclosure, post-disclosure, full data set) be presented, that the societies should decide which data set to use to develop work recommendations, and that the RUC would decide which approach was appropriate after reviewing all of the data. Therefore, we have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison.

The survey times and WRVUs in the pre-disclosure data were lower for most of the surveyed codes than those in the post-disclosure and full data sets, though in most cases the differences were not statistically significant.

We initially considered WRVU recommendations based on the entire data set to include all of those who took the time to complete the surveys, nearly all of whom never saw the emailed publicly available WRVU data, and many ophthalmologists who expressed concern about exclusion when the survey was initially halted. However, after careful consideration of comments made during Research Committee and Pre-Facilitation meeting discussions, we chose to base our recommendations for the entire family of codes on the pre-disclosure data set. We made this choice in order to eliminate any perception of potential for bias introduced by the disclosure of current WRVUs. For clarity, we have included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

The survey results provided additional challenges across the entire family of codes as the key reference services chosen had consistently longer times than the surveyed times. This was the case for both the 090-day base codes and particularly for the ZZZ add-on codes. Further, use of the 25th percentile magnitude estimation of work values for all of the codes resulted in several rank-order anomalies. Similarly, a purely crosswalk methodology based on median survey times for all of the codes also resulted in rank-order anomalies. The panel prepared values based on and considered both of these approaches. We also considered valuing some of the codes based on a time and intensity calculation. Although done in the past, this method is no longer a RUC-approved procedure and was therefore abandoned. Ultimately, the expert panel has chosen a hybrid methodology that preserved a proper rank-order of intensity and complexity: We valued some of the procedures based on crosswalks to survey median times and valued others based on 25th percentile magnitude estimation of work. In all cases we have used the pre-disclosure data.

While it may seem on its face that the intensity of work for each of the base codes might be similar, there are marked differences between single-muscle and two-muscle procedures and surgery on the superior oblique muscle.

Single-muscle procedures are typically recessions, where the muscle insertion is detached and reattached further posteriorly on the globe, in effect “lengthening” the muscle.

Two-muscle procedures typically involve a recession of one muscle and a resection of the second muscle; thus, it is not simply performing the same procedure twice. The resection component of the procedure requires detachment of the muscle from its insertion, resection of a specific length of the muscle, and reattaching it, in effect “shortening” the muscle. Muscle resections are markedly more intense and complex than recessions. This makes 2-muscle procedures significantly more intense and complex than 1-muscle procedures, independent of the increased time required to operate on 2 muscles.

Surgery on the superior oblique muscle, because of its insertion location, reflected tendon, posterior location, small size and difficulty in isolating the muscle, is more difficult than surgery on horizontal or vertical rectus muscles. It is similar in intensity and complexity to that of the 2-muscle procedures.

Based on the relative intensity and complexity of the base codes and to avoid rank-order anomalies, the single-muscle procedures (67311 and 67314) should have lower IWPUTs than the two-muscle procedures (67312, 67316) or the superior oblique procedure (67318). The two-muscle procedures and the superior oblique procedure should have similar IWPUTs.

CPT 67311 is a procedure on a single horizontal muscle, typically a medial rectus recession to correct esotropia in a child.

For 67311 there were 62 respondents (full: 225), 76% (full: 82%) of whom found the vignette to be typical. The median WRVU was 9.18 (full: 9.60). The 25th percentile was 8.22 (full: 8.50). The code’s current value is 7.77 WRVU. The median IST was 25 minutes (full: 30). The survey showed one discharge day management service and three level 3 postop visits (full: same).

The top key reference service, chosen by 39% (full: 32%) of respondents, was CPT 67904, *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (RUC 2005), with a WRVU of

7.97, an IST of 45 minutes, and one level 3 and three level 2 postoperative visits. The second reference service, chosen by 18% (full: 13%) of respondents, was CPT 67966, *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (RUC 2005), with a WRVU of 8.97, an IST of 60 minutes, and one level 3 and three level 2 postoperative visits. As noted above, the survey times were significantly shorter than the KRS times. The majority of respondents ranked the surveyed code higher than both key references services on overall intensity and complexity and the mental effort and psychological stress submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 25 minutes (full: 30) and three postoperative visits. We reduced the level of two of the postoperative visits to level 2 and retained one level 3 visit. The level 3 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two level 2 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 10 (full:15) minutes. We maintained the survey positioning time of 5 (full: 5) minutes, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time, 15 (full: 15) minutes matches that of the package and is necessary due to use of general anesthesia in the typical child. We used the survey post-service time median of 14.5 (full: 20) minutes, which is less than the 33 minutes of post-service time package 9B (general anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 143.5 (full: 159) minutes, with an IST of 25 (full: 30) minutes.

A crosswalk-derived work value of 5.93 WRVU for CPT 67311, identical to our recommended value for CPT 67314 (single vertical rectus muscle), is below the survey 25th percentile and significantly lower than the code's current value of 7.77 WRVU. The recommended value produces an IWPUT of 0.103. This is consistent with the intensity/complexity metrics compared to the reference services. It is also very close to the IWPUT of the other single-muscle procedure within the family, CPT 67314 (0.099), thus preserving an appropriate rank order within the family and within other ophthalmic procedures.

The crosswalk chosen was CPT 53854, *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (RUC 2018). The crosswalk code has an identical IST and a total time of 137 minutes with three postoperative visits. The IWPUT of the surveyed code (0.103) is higher than that of the crosswalk (0.085) due to the difference in discharge management and level of one postoperative visit. The complexity of a procedure on a child with risk of amblyopia in the typical patient and diplopia for others, and placement of sutures within 0.5 mm of the retina support a higher IWPUT.

We recommend a work value of 5.93 WRVU for CPT 67311, with times of 30/25/14.5 and a total time of 143.5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	67331	36	57	17	202	5.13	ZZZ	18.13%
5.	67332	37	71	18	218	5.56	ZZZ	21.88%
6.	67335	N/A	52	N/A	52	2.49	ZZZ	20.63%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 60000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,955
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 4955 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67311

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67312 Tracking Number Original Specialty Recommended RVU: **10.00**
Presented Recommended RVU: **9.50**
Global Period: 090 Current Work RVU: **9.66** RUC Recommended RVU: **9.50**

CPT Descriptor: Strabismus surgery, recession or resection procedure; 2 horizontal muscles

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A two-year-old boy with left eye early onset non-accommodative esotropia with amblyopia requires a medial rectus muscle recession and lateral rectus muscle resection in the same eye.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 54% , In the ASC 46%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing, including prior surgical reports. Measurements of the ocular deviation at distance in primary, right, and left gaze and at near are performed and compared to pre-operative measurements. The surgical plan is reviewed and either confirmed or revised based on the measurements performed in the pre-operative area, taking into consideration patient age and size of the globe and risk of amblyopia. Discuss the planned procedure with the patient/ family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform an initial surgical time-out with the care team. Administer topical anesthetic and mydriatic eye drops. Reposition the patient. Prepare and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Perform a final surgical time out. The conjunctiva is examined. The limbus is grasped inferonasally with forceps and the eye rotated up and out. Conjunctiva in the inferonasal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the medial rectus muscle. A larger hook is then passed under the rectus muscle and pass is evaluated for completeness. Conjunctiva is pulled superiorly over the tip of the large hook with a small hook. The superior Tenon's capsule is incised at the tip of the large hook and two small hooks passed through the incision to visual the superior pole of the muscle to ensure full capture of the muscle. Anterior Tenon's capsule is dissected as well as intermuscular membrane and check ligaments. A double armed 6-O absorbable suture is passed through partial thickness muscle both superiorly and inferiorly and locked at both muscle poles. The muscle is disinserted with scissors and the insertion site cauterized. The medical rectus muscle is then reattached to the sclera 4.5 mm posterior to the original insertion site using calipers. The spatula needles are passed through partial thickness sclera. The sutures are secured to the sclera and the muscle examined for any posterior sag, which is pulled forward when needed. The conjunctiva is closed with 7-O chromic sutures.

The limbus is grasped inferotemporally with forceps and the eye rotated up and in. Conjunctiva in the inferotemporal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the lateral rectus muscle. A larger hook is then passed under the rectus muscle and the pass is evaluated for completeness. Conjunctiva is pulled superiorly over the tip of the large hook with a small hook. The superior Tenon's capsule is incised at the tip of the large hook and two small hooks passed through the incision to visual the superior pole of the muscle to ensure full capture of the muscle. Anterior Tenon's capsule is dissected as well as intermuscular membrane and check ligaments posteriorly beyond the planned muscle resection. The inferior oblique is

visualized and separated from the lateral rectus muscle. Calipers are used to measure the amount of muscle to be removed. This is marked with cautery. A double armed 6-O absorbable suture is passed through partial thickness muscle both superiorly and inferiorly and locked at both muscle poles behind the row of cautery. The muscle is clamped anterior to the sutures. The muscle is divided with scissors, the anterior muscle and tendon are disinserted from the insertion and the insertion cauterized. The lateral rectus muscle is then reattached to the sclera at the original insertion site using the spatula needles passed through partial thickness sclera. The sutures are secured and the muscle is examined for any posterior sag, which is pulled forward when needed.

The conjunctiva is closed with 7-O chromic sutures. Antibiotic-steroid and proparacaine eye drops are placed on the eye.

Description of Post-Service Work: Write postoperative orders and prescriptions for postoperative medications. Complete brief immediate post-operative note and operative report. Discuss the surgical procedure and postoperative instructions with the recovery room staff, patient and family or guardian. Review necessary follow-up testing and examinations, as well as medications, activity, and restrictions. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67312					
Sample Size:	1093	**Resp N:**	57			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	25.00	**40.00**	75.00	215.00
Survey RVW:	7.00	9.50	**10.75**	12.50	25.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	32.00	**40.00**	50.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	67312	**Recommended Physician Work RVU: 9.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**33.00**	**-23.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**33.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67904	090	7.97	**RUC Time**

CPT Descriptor Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67966	090	8.97	**RUC Time**

CPT Descriptor Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
14060	090	9.23	**RUC Time**	90,113

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
50590	090	9.77	**RUC Time**	54,658

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source
52400	090	8.69	**RUC Time**

CPT Descriptor Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 19.2 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 67312	Top Key Reference CPT Code: 67904	2nd Key Reference CPT Code: **67966**
Median Pre-Service Time	30.00	35.00	35.00
Median Intra-Service Time	40.00	45.00	60.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	55.0	71.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**159.00**	**185.00**	**200.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	55%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	55%	46%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	73%	27%
Physical effort required	9%	64%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	46%	46%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	70%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	20%	70%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	70%	30%
Physical effort required	0%	70%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67312, *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes carried postoperative visits in the database. While

this was a clerical error as the work value associated with the visits had been removed in 1999 (to be discussed in the ZZZ SORs), all eleven codes are being presented to the RUC for valuation.

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and resuturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures. In adults, realignment may be done to eliminate diplopia or correct eye misalignment from disease or trauma.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT 67312 is a procedure on 2 horizontal muscles of the same eye, typically a recession of the medial rectus and a resection of the lateral rectus to correct esotropia in a child with a larger deviation than can be corrected with single-muscle surgery (CPT 67311). As discussed in the SOR for CPT 67311, the muscle resection makes it significantly more intense and complex than that of a recession alone, so a recess-resect combination on two muscles is more than twice the intraservice physician work than a single muscle recession.

For 67312 there were 57 respondents (full: 215), 93% (full: 95%) of whom found the vignette to be typical. The median WRVU was 10.75 (full: 11.25). The 25th percentile was 9.50 (full: 10.00). The code's current value is 9.66 WRVU. The median IST was 40 minutes (full: 50). The survey showed one discharge day management service and three level 3 postop visits (full: same).

The top key reference service, chosen by 19% (full: 24%) of respondents, was CPT 67904, *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (RUC 2005), with a WRVU of 7.97, an IST of 45 minutes, and one level 3 and three level 2 postoperative visits. The second reference service, chosen by 18% (full: 20%) of respondents, was CPT 67966, *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (RUC 2005), with a WRVU of 8.97, an IST of 60 minutes, and one level 3 and three level 2 postoperative visits. The survey times were significantly shorter than the KRS times. The majority of respondents ranked the surveyed code higher than the top key reference service on overall intensity and complexity and identical on the individual submeasures (full: same). The majority of respondents ranked the surveyed code higher than the second key reference service on overall intensity and complexity and the mental effort submeasure, and identical on the other submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 40 minutes (full: 50) and three postoperative visits. We reduced the level of two of the postoperative visits to level 2 and retained one level 3 visit. The level 3 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two level 2 visits are necessary to confirm healing of the conjunctiva, coverage of the operative site, and assess ocular alignment.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical

plan reviewed. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 10 (full:15) minutes. We maintained the survey positioning time of 5 (full: 5) minutes, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time, 15 (full: 15) minutes matches that of the package and is necessary due to use of general anesthesia in the typical child. We used the survey post-service time median of 15 (full: 20) minutes, which is less than the 33 minutes of post-service time package 9B (general anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 159 (full: 179) minutes, with an IST of 40 (full: 50) minutes.

As discussed in the SOR for CPT 67311, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others. There are no codes in the database that meet the criteria for an acceptable crosswalk to support a value for this code that preserves an appropriate rank order. **We therefore propose to value CPT 67312 based on the 25th percentile magnitude estimation of work at 9.50 WRVU.** This is below the code's current value of 9.66. The IWPUT associated with this value, 0.153, is higher than that of the single-muscle codes (CPT 67311, 67314). This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical component of this two-muscle procedure. It is, appropriately, almost identical to the IWPUT for CPT 67316 (two vertical muscles), which is 0.154 at our recommended value.

We recommend a work value based on the survey 25th percentile of 9.50 WRVU for CPT 67312, with times of 30/40/15 and a total time of 159 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	67332	37	71	18	218	5.56	ZZZ	18.92%
5.	67335	N/A	52	N/A	52	2.49	ZZZ	29.73%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 20000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,514
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 1514 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67312

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67314 Tracking Number Original Specialty Recommended RVU: **7.27**
Presented Recommended RVU: **5.93**
Global Period: 090 Current Work RVU: **8.79** RUC Recommended RVU: **5.93**

CPT Descriptor: Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old male with a history of left hypertropia from primary inferior oblique muscle overaction will have a left inferior oblique muscle recession performed.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 54% , In the ASC 46%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing, including prior surgical reports. Measurements of the ocular deviations at distance in primary, up, and down gaze and at near are performed and compared to pre-operative measurements. The surgical plan is reviewed and either confirmed or revised based on the measurements performed in the pre-operative area, considering the patient's age, size of the globe, and risk of amblyopia. Discuss the planned procedure with the patient/ family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform an initial surgical time-out with the care team. Administer topical anesthetic and mydriatic eye drops. Reposition the patient. Prepare and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Perform a final surgical time out. The conjunctiva is examined. The limbus is grasped with forceps nasally and an exaggerated oblique traction test is performed. Then the limbus is grabbed inferotemporally with forceps and the eye rotated up and in. Conjunctiva in the inferotemporal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the lateral rectus muscle. A larger hook is then passed under the lateral rectus muscle. A Gass hook is then passed under the lateral rectus muscle which is used to place a silk traction suture under the muscle. The traction suture pulls the eye up and in, which is clamped in place. A Conway retractor is used to open the sub-Tenon's space, within in which the inferior oblique muscle is identified, hooked, and elevated. A second hook is placed beneath the muscle. Tenon's capsule is incised at the tips of the hooks. The inferior oblique muscle is dissected nears the insertion. The muscle is clamped with a small hemostat. The muscle is disinserted with scissors and rotated out of the wound. The muscle stump is cauterized. A double armed 7-O absorbable suture is passed through partial thickness muscle to both sides and locked at both muscle poles. The inferior rectus muscle is then hooked on a small followed by a large muscle hook. The inferior oblique muscle is then reattached to the sclera 3 mm posterior and 2 mm lateral to the lateral edge of the inferior rectus muscle insertion site using the spatula needles through partial thickness sclera. The sutures are secured and the muscle examined for any posterior sag, which is pulled forward when needed. The conjunctiva is closed with 7-O chromic sutures. The speculum is removed and antibiotic-steroid and proparacaine eye drops are instilled in the eye.

Description of Post-Service Work: Write postoperative orders and prescriptions for postoperative medications. Complete a brief operative note and the complete operative report. Discuss the surgical procedure and postoperative instructions with the patient/family. Review necessary follow-up testing and examinations, as well as medications, activity, and restrictions. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67314					
Sample Size:	1093	**Resp N:**	54			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	6.00	16.50	**30.00**	50.00	150.00
Survey RVW:	4.50	9.00	**10.00**	12.00	20.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	10.00	20.00	**26.00**	30.00	57.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	67314	**Recommended Physician Work RVU: 5.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**33.00**	**-23.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**26.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**33.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67904	090	7.97	**RUC Time**

CPT Descriptor Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67966	090	8.97	**RUC Time**

CPT Descriptor Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26765	090	5.86	**RUC Time**	1,365

CPT Descriptor 1 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
25071	090	5.91	**RUC Time**	1,689

CPT Descriptor 2 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater

Other Reference CPT Code	Global	Work RVU	Time Source
53854	090	5.93	**RUC Time**

CPT Descriptor Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 27.7 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 20.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 67314	Top Key Reference CPT Code: 67904	2nd Key Reference CPT Code: **67966**
Median Pre-Service Time	30.00	35.00	35.00
Median Intra-Service Time	26.00	45.00	60.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	55.0	71.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**145.00**	**185.00**	**200.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	20%	67%	7%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	20%	73%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	7%	27%	67%
Physical effort required	7%	73%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	33%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	27%	64%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	55%	46%
Physical effort required	9%	55%	36%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	27%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67314, *Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits

had been removed in 1999 (to be discussed in the ZZZ SORs), all eleven codes are being presented to the RUC for valuation.

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and resuturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures. In adults, realignment may be done to eliminate diplopia or correct eye misalignment from disease or trauma.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT 67314 is a procedure on a single vertical muscle other than the superior oblique, which is a lengthier procedure. It is typically a superior rectus recession performed to correct hypertropia in a child.

For 67314 there were 54 respondents (full: 205), 78% (full: 83%) of whom found the vignette to be typical. The median WRVU was 10.00 (full: 10.25). The 25th percentile was 9.00 (full: 9.15). The code's current value is 8.79 WRVU. The median IST was 26 minutes (full: 30). The survey showed one discharge day management service and three level 3 postop visits (full: same).

The top key reference service, chosen by 28% (full: 27%) of respondents, was CPT 67904, *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (RUC 2005), with a WRVU of 7.97, an IST of 45 minutes, and one level 3 and three level 2 postoperative visits. The second reference service, chosen by 20% (full: 22%) of respondents, was CPT 67966, *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (RUC 2005), with a WRVU of 8.97, an IST of 60 minutes, and one level 3 and three level 2 postoperative visits. The survey times were significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than the top key reference service on overall intensity and complexity and the mental effort, technical skill, and psychological stress submeasures, and identical on the physical effort submeasure (full: same). The majority of respondents ranked the surveyed code higher than the second key reference service on overall intensity and complexity and the mental effort and psychological stress submeasures, and identical on the other submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 26 minutes (full:30) and three postoperative visits. We reduced the level of two of the postoperative visits to level 2 and retained one level 3 visit. The level 3 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two level 2 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 10 (full:15) minutes. We maintained the survey positioning time of 5 (full: 5) minutes, longer than the

package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time, 15 (full: 15) minutes matches that of the package and is necessary due to use of general anesthesia in the typical child. We used the survey post-service time median of 15 (full: 20) minutes, which is less than the 33 minutes of post-service time package 9B (general anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 145 (full: 159) minutes, with an IST of 26 (full: 30) minutes. The IST is within 1 minute of that of CPT 67311, the single horizontal muscle procedure. The panel agreed that the work of the two procedures is not significantly different.

A crosswalk-derived work value of 5.93 WRVU for CPT 67314, identical to our recommended value for CPT 67311, is below the survey 25th percentile and well below the code's current value of 8.79. The recommended value produces an IWPUT of 0.099. This is consistent with the intensity/complexity metrics compared to the reference services. It is also almost identical to the IWPUT of the other single-muscle procedure, CPT 67311 (0.103), thus preserving an appropriate rank order within the family and within other ophthalmic procedures.

The crosswalk chosen was CPT 53854, *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (RUC 2018). The crosswalk code has an identical IST and a total time of 137 minutes with three postoperative visits. The IWPUT of the surveyed code (0.099) is higher than that of the crosswalk (0.085) due to the difference in discharge management and level of one postoperative visit. The complexity of a procedure on a child with risk of amblyopia in the typical patient and diplopia for others, and placement of sutures within 0.5 mm of the retina support the higher IWPUT.

We recommend a work value of 5.93 WRVU for CPT 67314, with times of 30/25/14.5 and a total time of 143.5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	67331	36	57	17	202	5.13	ZZZ	12.73%
5.	67332	37	71	18	218	5.56	ZZZ	30.91%
6.	67335	N/A	52	N/A	52	2.49	ZZZ	23.64%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance

Specialty Ophthalmology Frequency 19000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,533
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 2533 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67314

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67316 Tracking Number Original Specialty Recommended RVU: **10.95**
Presented Recommended RVU: **10.31**
Global Period: 090 Current Work RVU: **10.93** RUC Recommended RVU: **10.31**

CPT Descriptor: Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 5-year-old girl with a large right hypertropia with no evidence of paresis requires a right superior rectus muscle recession and right inferior rectus muscle resection in the same eye.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 50% , In the ASC 50%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing, including prior surgical reports. Measurements of the ocular deviations at distance in primary, up, and down gaze and at near are performed and compared to pre-operative measurements. The surgical plan is reviewed and either confirmed or revised based on the measurements performed in the pre-operative area, considering the patient's age, size of the globe, and risk of amblyopia. Discuss the planned procedure with the patient/ family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform an initial surgical time-out with the care team. Administer topical anesthetic and mydriatic eye drops. Reposition the patient. Prepare and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Perform a final surgical time out. The conjunctiva is examined. The limbus is grasped superotemporally with forceps and the eye rotated down and in. Conjunctiva in the superotemporal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the superior rectus muscle. A larger hook is then passed under the rectus muscle and pass is evaluated for completeness. Conjunctiva is pulled nasally over the tip of the large hook with a small hook. Tenon's capsule is incised at the tip of the large hook and two small hooks passed through the incision to visual the medial pole of the muscle to ensure full capture of the superior rectus muscle. Anterior Tenon's capsule is dissected as well as intermuscular membrane and check ligaments. The superior oblique tendon is identified. A double armed 6-O absorbable suture is passed through partial thickness muscle both temporally and medially and locked at both muscle poles. The muscle is disinserted with scissors and the insertion site cauterized. The superior rectus muscle is reattached to the sclera 4.0 mm posterior to the original insertion site using calipers to mark the desired location. The spatula needles are passed for about 3 mm through partial thickness sclera. The sutures are secured, and the muscle examined for any posterior sag, which is pulled forward when needed. The conjunctiva is closed with one or more 7-O chromic sutures.

The limbus is grasped inferotemporally with forceps and the eye rotated up and in. Conjunctiva in the inferotemporal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the inferior rectus muscle. A larger hook is then passed under the inferior rectus muscle and the pass is evaluated for completeness. Conjunctiva is pulled medially over the tip of the large hook with a small hook. The Tenon's capsule is incised at the tip of the large hook and two small hooks passed through the incision to visual the

superior pole of the muscle to ensure full capture of the muscle. Anterior Tenon's capsule is dissected as well as intermuscular membrane and check ligaments posteriorly beyond the planned muscle resection. Calipers are used to measure the amount of muscle to be removed from the insertion. This is marked with cautery. A double armed 6-O absorbable suture is passed through partial thickness muscle both medially and temporally and locked at both muscle poles behind the row of cautery. The muscle is clamped anterior to the sutures with a muscle clamp. The muscle is divided with scissors anterior to the sutures, the anterior muscle and tendon are disinserted from the scleral insertion and the insertion cauterized. The inferior rectus muscle is then reattached to the sclera at the original insertion site using the spatula needles passed through partial thickness sclera. The sutures are secured, and the muscle examined for any posterior sag, which is pulled forward when needed.

The conjunctiva is closed with 7-O chromic sutures. Place antibiotic-steroid and proparacaine eye drops in the eye.

Description of Post-Service Work: Write postoperative orders and prescriptions for postoperative medications. Complete brief immediate post-operative note and operative report. Discuss the surgical procedure and postoperative instructions with the recovery room staff, patient and family or guardian. Review necessary follow-up testing and examinations, as well as medications, activity, and restrictions. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67316					
Sample Size:	1093	**Resp N:**	50			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	23.75	50.00
Survey RVW:	7.97	10.31	**11.50**	14.00	28.61
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	40.00	**45.00**	60.00	240.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	67316	**Recommended Physician Work RVU: 10.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**33.00**	**-23.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**33.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67036	090	12.13	**RUC Time**

CPT Descriptor Vitrectomy, mechanical, pars plana approach;

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67966	090	8.97	**RUC Time**

CPT Descriptor Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
21025	090	10.03	**RUC Time**	3,614

CPT Descriptor 1 Excision of bone (eg, for osteomyelitis or bone abscess); mandible

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36906	090	10.42	**RUC Time**	14,028

CPT Descriptor 2 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

Other Reference CPT Code	Global	Work RVU	Time Source
52400	090	8.69	**RUC Time**

CPT Descriptor Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 20.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 18.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 67316	Top Key Reference CPT Code: 67036	2nd Key Reference CPT Code: 67966
Median Pre-Service Time	30.00	51.00	35.00
Median Intra-Service Time	45.00	50.00	60.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	55.0	115.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**164.00**	**250.00**	**200.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	20%	20%	30%	30%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	10%	80%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	30%	40%	30%

Physical effort required	0%	50%	50%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	30%	60%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	11%	67%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	22%	78%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	33%	67%
Physical effort required	0%	44%	56%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67316, *Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes carried

postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999 (to be discussed in the ZZZ SORs), all eleven codes are being presented to the RUC for valuation.

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and resuturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures. In adults, realignment may be done to eliminate diplopia or correct eye misalignment from disease or trauma.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT 67316 is a procedure performed on 2 vertical muscles, typically a recession of the superior rectus and a resection of the inferior rectus to correct hypertropia in a child with a vertical deviation that is too large to be corrected with single-muscle surgery (CPT 67314). As discussed in the SOR for CPT 67311, the resection portion of the procedure makes it significantly more intense and complex than that of a recession alone.

For 67316 there were 50 respondents (full: 186), 86% (full: 87%) of whom found the vignette to be typical. The median WRVU was 11.50 (full: 12.17). The 25th percentile was 10.31 (full: 10.95). The code's current value is 10.93 WRVU. The median IST was 45 (full: 60) minutes. The survey showed one discharge day management service and three level 3 postop visits (full: same).

The top key reference service, chosen by 20% (full: 22%) of respondents, was CPT 67036, *Vitrectomy, mechanical, pars plana approach* (RUC 2013), with a WRVU of 12.13, an IST of 50 minutes, and five level 3 postoperative visits. The second reference service, chosen by 18% (full: 20%) of respondents, was CPT 67966, *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (RUC 2005), with a WRVU of 8.97, an IST of 60 minutes, and one level 3 and three level 2 postoperative visits. The survey times were significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than the top key reference service on overall intensity and complexity and the mental effort and psychological stress submeasures (full: same). The majority ranked the surveyed code higher than the second key reference on overall intensity and complexity and all submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 45 minutes (full: 60) and three postoperative visits. We reduced the level of two of the postoperative visits to level 2 and retained one level 3 visit. The level 3 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two level 2 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. We reduced the package pre-service evaluation time from 33 minutes to match the survey time

of 10 (full:15) minutes. We maintained the survey positioning time of 5 (full: 5) minutes, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time, 15 (full: 15) minutes matches that of the package and is necessary due to use of general anesthesia in the typical child. We used the survey post-service time median of 15 (full: 20) minutes, which is less than the 33 minutes of post-service time package 9B (general anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 164 (full: 189) minutes, with an IST of 45 (full: 60) minutes.

As discussed in the SOR for CPT 67311, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others. There are no codes in the database that meet the criteria for an acceptable crosswalk to support a value for this code that preserves an appropriate rank order.

We chose to value CPT 67316 based on the 25th percentile magnitude estimation of work at 10.31 WRVU. This is less than the code's current value of 10.93 WRVU. The IWPUT associated with the recommended value, 0.154, is significantly higher than that of the single-muscle codes (CPT 67311, 67314). This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical component of this service. It is, appropriately, almost identical to the IWPUT for CPT 67312 (two horizontal muscles), which is 0.153 at our recommended value.

We recommend a work value based on the survey 25th percentile of 10.31 WRVU for CPT 67316, with times of 30/45/15 and a total time of 164 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) The 90-day procedures are the primary/base procedures for strabismus surgery. There is a set of ZZZ-codes (add-ons) that can be performed in conjunction with the base codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 1200 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 168
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 168 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67316

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67318 Tracking Number Original Specialty Recommended RVU: **10.10**
Presented Recommended RVU: **9.80**
Global Period: 090 Current Work RVU: **9.12** RUC Recommended RVU: **9.80**

CPT Descriptor: Strabismus surgery, any procedure, superior oblique muscle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 7-year-old female with congenital superior oblique palsy on the right is to have a right superior oblique tuck performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 50% , In the ASC 50%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing, including prior surgical reports. Measurements of the ocular deviation at distance in the six cardinal gaze positions and at near are performed and compared to pre-operative measurements. The surgical plan is reviewed and either confirmed or revised based on the measurements performed in the pre-operative area, considering patient age, size of the globe, and risk of amblyopia. Discuss the planned procedure with the patient/ family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform an initial surgical time-out with the care team. Administer topical anesthetic and mydriatic eye drops. Reposition the patient. Prepare and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Perform a final surgical time out. The conjunctiva is examined. The limbus is grasped superotemporally with forceps and the eye rotated down and in. Conjunctiva in the superotemporal fornix is lifted with forceps and a conjunctival incision is made with Westcott scissors. Tenon's capsule is then lifted with forceps and incised. Scissors are used to bluntly open the sub-Tenon's space. A small muscle hook is passed through the incision and used to hook the superior rectus muscle. A larger hook is then passed under the rectus muscle and the tendon width evaluated for completeness. Conjunctiva is pulled nasally with a small hook. The Tenon's capsule is incised at the tip of the hook taking care to avoid injuring the rectus muscle, then two small hooks are passed through the incision to perform a pole test. Anterior Tenon's capsule is opened in the superonasal quadrant and a Conway retractor introduced for visualization. A small muscle hook is passes along the medial aspect of the superior rectus muscle identifying and then hooking the tendon of the superior oblique muscle. Its covering tissue is opened, and a tendon tucker is engaged. The tucked tendon is sutured with a double armed non absorbable 6-O suture passing through the tucked tendon twice. Tenons' capsule is closed with 7-O chromic sutures. The conjunctiva is closed with 7-O chromic sutures. The speculum is removed and antibiotic-steroid and proparacaine eye drops are instilled in the eye.

Description of Post-Service Work: Write postoperative orders and prescriptions for postoperative medications. Complete a brief operative note and the complete operative report. Discuss the surgical procedure and postoperative instructions with the patient/family. Review necessary follow-up testing and examinations, as well as medications, activity, and restrictions. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67318					
Sample Size:	1093	**Resp N:**	50			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**5.00**	12.00	60.00
Survey RVW:	7.97	9.80	**11.55**	13.50	22.46
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**40.00**	48.75	70.00

Immediate Post Service-Time:	**14.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	67318	**Recommended Physician Work RVU: 9.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**33.00**	**-23.00**
Pre-Service Positioning Time:		**5.00**	**3.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**33.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66170	090	13.94	**RUC Time**

CPT Descriptor Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66184	090	9.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
50590	090	9.77	**RUC Time**	54,658

CPT Descriptor 1 Lithotripsy, extracorporeal shock wave

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
21015	090	9.89	**RUC Time**	506

CPT Descriptor 2 Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm

Other Reference CPT Code	Global	Work RVU	Time Source
52400	090	8.69	**RUC Time**

CPT Descriptor Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 22.0 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 67318	Top Key Reference CPT Code: 66170	2nd Key Reference CPT Code: **66184**
Median Pre-Service Time	30.00	25.00	25.00
Median Intra-Service Time	40.00	45.00	60.00
Median Immediate Post-service Time	15.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	62.0	179.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**165.50**	**278.00**	**254.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	36%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	36%	64%
Physical effort required	0%	55%	46%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	27%	64%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	80%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	20%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	20%	80%
Physical effort required	10%	60%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	30%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 67318, *Strabismus surgery, any procedure, superior oblique muscle* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes carried postoperative visits in the database. While this

was a clerical error as the work value associated with the visits had been removed in 1999 (to be discussed in the ZZZ SORs), all eleven codes are being presented to the RUC for valuation.

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and resuturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocularity from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures. In adults, realignment may be done to eliminate diplopia or correct eye misalignment from disease or trauma.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT 67318 is a procedure on the superior oblique muscle, typically a resection or plication of the muscle, in effect shortening it to correct a superior oblique palsy and resulting hypertropia in a child. Some or all of the tendon is included. Superior oblique muscle surgery has its own code to distinguish it from surgery on a single vertical muscle because operating on the superior oblique typically takes longer and is more intense and complex than surgery on a single vertical muscle. The greater intensity is due to the smaller size, the posterior location of the tendon, more difficult to identify insertion of the superior oblique muscle, and the greater difficulty of a resection or plication in comparison with the recession typically performed on a single vertical or horizontal muscle.

For 67318 there were 50 respondents (full: 174), 90% (full: 93%) of whom found the vignette to be typical. The median WRVU was 11.55 (full: 12.00). The 25th percentile was 9.80 (full: 10.10). The code's current value is 9.12 WRVU. The median IST was 40 minutes (full: 42). The survey showed one discharge day management service and three level 3 postop visits (full: same).

The top key reference service, chosen by 22% (full: 23%) of respondents, was CPT 66170, *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (RUC 2015), with a WRVU of 13.94, an IST of 45 minutes, and five level 3 and four level 2 postoperative visits. The second reference service, chosen by 20% (full: 18%) of respondents, was CPT 66184, *Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft* (RUC 2014), with a WRVU of 9.58, an IST of 60 minutes, and four level 3 and three level 2 postoperative visits. The survey times were shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than both key references services on overall intensity and complexity and the mental effort, technical skill, and psychological stress submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 40 minutes (full: 42) and three postoperative visits. We reduced the level of one of the postoperative visits to level 2 and retained two level 3 visits. The first level 3 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The second visit, a level 2, is necessary to confirm healing of the conjunctiva and assess ocular alignment (horizontal, vertical, and torsional). The third visit, another level 3, confirms that vertical alignment is maintained after further healing and also requires a dilated fundus exam to assess the fundus for degree of correction of ocular torsion. Because the superior oblique muscle intorts the eye in addition to depressing it, and symptoms or torsional misalignment are not typically expressed accurately by patients, the dilated fundus check for rotational alignment is necessary for current and future treatment. The requirement for two level-3

postoperative visits distinguishes this code from the other 090-day global codes in the family, which need only one level-3 postoperative visit.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 10 (full:15) minutes. We maintained the survey positioning time of 5 (full: 5) minutes, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time, 15 (full: 15) minutes matches that of the package and is necessary due to use of general anesthesia in the typical child. We used the survey post-service time median of 14.5 (full: 20) minutes, which is less than the 33 minutes of post-service time package 9B (general anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 165.5 (full: 178) minutes, with an IST of 40 (full: 42) minutes.

As discussed in the SOR for CPT 67311, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others. There are no codes in the database that meet the criteria for an acceptable crosswalk to support a value for CPT 67318 that preserves the appropriate rank order.

We chose to value CPT 67318 based on the 25th percentile magnitude estimation of work at 9.80 WRVU. This is greater than the code's current value of 9.12 WRVU, as supported by compelling evidence and the robust survey data. The IWPUT associated with this value, 0.149, is significantly higher than that of the other single-muscle codes (CPT 67311, 67314). This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical of this service. The IWPUT is, appropriately, very close to the IWPUT for the two-muscle procedures (CPT 67312, 67316) which also include a muscle resection. The recommended work value is slightly higher than that of CPT 67312 despite identical ISTs of 40 minutes. This is partially attributable to the additional level 3 postoperative visit and partially attributable to the slightly greater intensity of operating on a superior oblique muscle compared to horizontal muscles. The recommended value therefore maintains an appropriate rank order within the family.

We recommend a work value based on the survey 25th percentile of 9.80 WRVU for CPT 67318, with times of 30/40/14.5 and a total time of 165.5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) The 90-day procedures are the primary/base procedures for strabismus surgery. There is a set of ZZZ-codes (add-ons) that can be performed in conjunction with the base codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 2000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 205
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 205 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67318

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67320 Tracking Number Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **3.00**
Global Period: ZZZ Current Work RVU: **5.40** RUC Recommended RVU: **3.00**

CPT Descriptor: Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a right abducens nerve palsy and a complete abduction deficit. A full tendon transposition of the superior and inferior rectus muscles with a Foster suture is required in the same eye (67316 is reported separately). (This is an add-on code and describes only that work done in addition to the primary eye muscle procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: (Initial surgery is the parent procedure.)

The limbus is grasped inferotemporally with forceps and the eye rotated up and in. Conjunctiva in the inferotemporal fornix is lifted with a small hook. A small muscle hook is passed through the incision and used to hook the lateral rectus muscle. A larger hook is then passed under the rectus muscle and pass is evaluated for completeness. The sclera along the inferior border of the lateral rectus muscle is examined and the attachment site marked. The inferior rectus muscle is reattached to the sclera with the temporal site at the lower pole of the inferior rectus muscle (as part of the parent procedure). A 6-0 absorbable suture is used for the Foster augmentation suture, securing the inferior rectus muscle to partial thickness sclera 5 mm posteriorly.

The limbus is grasped superotemporally with forceps and the eye rotated down and in. Conjunctiva in the superotemporal fornix is lifted with a small hook onto the tip of a previously placed large hook. The sclera along the superior border of the lateral rectus muscle is examined and the attachment site marked. The superior rectus muscle is reattached to the sclera with the temporal site at the lower pole of the inferior rectus muscle (as part of the parent procedure). A 6-0 absorbable suture is used for the Foster augmentation suture, securing the superior rectus muscle to partial thickness sclera 5 mm posteriorly.

(Surgery is completed as described in parent code.)

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67320					
Sample Size:	1093	**Resp N:**	51			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.50	**5.00**	15.00	175.00
Survey RVW:	1.80	3.73	**4.25**	5.88	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	17.50	**23.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67320	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**23.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36476	ZZZ	2.65	**RUC Time**	7,170

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	128,927

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36907	ZZZ	3.00	**RUC Time**

CPT Descriptor Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 21 **% of respondents:** 41.1 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 67320	Top Key Reference CPT Code: 14302	2nd Key Reference CPT Code: **11008**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	23.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**23.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	24%	48%	24%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	29%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	38%	57%
Physical effort required	14%	57%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	29%	71%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	6%	41%	53%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	12%	17%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	6%	88%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67320, *Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

COMPELLING EVIDENCE

There is compelling evidence that the codes in this family were valued using improper methodology. CPT +67320, +67331, +67332, +67334, and +67340 each have 4 postoperative visits listed in the database as well as pre- and post-time. They were last evaluated by the RUC in May 1998. These codes were changed from stand-alone codes with a global period of 90 days to add-on ZZZ codes. The rationale to adjust their value at the May 1998 RUC meeting reads:

"The family of add-on codes in the Strabismus Surgery section of CPT were reevaluated as they are currently identified as stand alone codes with a global period of 90 days. Previously, the descriptors for CPT codes 67320, 67331, 67332, 67334 and 67340 included not only the intraservice work described by the code, but also a number of unstated, but implied, services that are associated with pre-service and post service work. These codes will now be identified as add-on codes with a global period of ZZZ and the work rvus should be reduced accordingly.

The RUC recommends the following work values: 4.33 (67320); 4.06(67331); 4.49 (67332); 3.98 (66334); 4.93 (67340). The specialty society used an arithmetic adjustment to the work values of these procedural codes. These proposed values were established by reducing the current work values by 50% using rules for multiple surgical procedures performed on the same day. Also, the Harvard data indicates that 59% of the codes were for intra-work, further justifying these proposed work values."

The RUC database confirms those reductions were implemented in the RUC recommendations and accepted by CMS for 1999:

1998 CPT	1999 WRVU	2018 WRVU	Claims
+67320	8.26	4.33	369
+67331	8.12	4.06	866
+67332	8.99	4.49	1,682
+67334	7.96	3.98	128
+67335	2.49	2.49	1,756
+67340	9.85	4.93	68

When the ZZZ-global codes were revalued in 1998 to address the inappropriate inclusion of postoperative visits, they were incorrectly valued by applying 50% multiple procedure payment reductions to the initial Harvard valuations. This is no longer an accepted methodology. The use of this methodology created anomalous relationships within the family and distorted relativity with the remainder of the RUC database.

CPT +67335 and none of the 090-global base codes (CPT 67311-67318) in the family were included in the group of codes revalued in 1998. CPT +67335 was initially Harvard valued as a ZZZ code with no pre- or post-time or postoperative visits. Excluding this code and all of the 090-day global base codes within the family from the 1998 revaluation process was also flawed as this methodology allowed the rank order anomalies to remain.

The RVU reductions associated with removal of the pre- and post-service work, including postoperative visits went into effect in January 1999 for CPT +67320, +67331, +67332, +67334, and +67340 . However, the pre- and post-service times and postoperative visits were not removed from the "Physician

Time" tab in the RUC database. Therefore, the pre- and post-service times and postoperative visits and the IWPUTs based on those incorrect times for these 5 codes must be disregarded when comparing current values to the recommended times and WRVUs. We have removed the incorrect times and postoperative visits from the "Current" row in the Summary Spreadsheets in order to provide a more accurate relativity comparison. We have also added a row showing the pre-reduction data from 1998.

There is also an argument that Harvard-based times and work values are no longer consistent with RUC methodology that has been in place for the last several decades and which has generated the values for those frequently performed procedures in the database that make up the bulk of the claims volume.

Whether outdated Harvard methodology is sufficient compelling evidence in and of itself, the use of an MPPR calculation to value only a portion of the add-on procedures in the family and the exclusion of the base codes from the valuation process in 1998 is clearly inconsistent with accepted RUC methodology.

SOR RATIONALE

The six add-on codes (CPT +67320, +67331, +67332, +67334, +67335, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

As with the base codes, the survey results in the family of add-on codes presented a challenge due to the key reference services chosen having significantly longer times than the surveyed times. Use of the 25th percentile estimates of work for all six of the ZZZ codes resulted in some rank order anomalies, as did use of crosswalks to median times for all six codes. We therefore used a mix of 25th percentile work estimates and crosswalks to the median times in order to preserve the proper order of intensity and complexity for the family of codes.

CPT +67320 is an add-on procedure typically performed for patients with a paretic lateral rectus muscle. It entails detaching the inferior and superior rectus muscles, repositioning them on the globe in an unusual location, and reattaching them in addition to the base procedure on the horizontal muscle(s). The need to relocate both muscles in an unusual location makes this procedure more intense than the single-muscle base

procedures. It is not as intense as the two-muscle base procedures because it does not require a muscle resection.

For CPT +67320 there were 51 respondents (full: 178), 98% (full: 96%) of whom found the vignette to be typical. The median WRVU was 4.25 (full: 5.57). The 25th percentile was 3.73 (full: 5.00). The current value of the code is 5.40 WRVU. The median IST was 23 minutes (full: 25).

The top key reference service, chosen by 41% (full: 43%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The second reference service, chosen by 33% (full: 34%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than the primary reference service on overall intensity and complexity and all of the individual submeasures except physical effort, where the majority ranked them equally (full: same). The majority ranked the surveyed code higher than the second key reference service on all intensity and complexity measures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 23 minutes (full: 25).

There are only two 23-minute ZZZ codes in the database. CPT 33517, *Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)* (RUC 2005) has 3.61 WRVU and 30.5 minutes of post-time. *CPT 88350, Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)* (RUC 2015) is an add-on immunofluorescent stain with 0.59 WRVU. Neither are acceptable crosswalks. There are only two 24-minute ZZZ codes in the database, and both are Harvard valued.

We therefore chose 25-minute ZZZ codes as eligible crosswalks, recognizing that a 2-minute time difference is not significant, particularly when the crosswalk codes were surveyed prior to the current survey instructions advising against rounding time estimates.

We chose a crosswalk to CPT 36907, *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (RUC 2016), with 3.00 WRVU and an IST of 25 minutes. This value is below the survey 25th percentile and is a significant reduction from the code's current value of 5.40 WRVU. It yields an IWPUT of 0.130, appropriately between the IWPUTs of the single- and two-muscle base codes, and almost identical to the IWPUTs of similarly intense add-on codes CPT +67331 and +67334.

The value is also supported by CPT 32506, *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* (RUC 2011) and CPT 32667, *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* (RUC 2011), both of which have ISTs of 25 minutes and 3.00 WRVU.

We recommend a crosswalked work value of 3.00 WRVU for CPT +67320, with an intraservice time of 23 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 5000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 362
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 362 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67320

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67331 Tracking Number Original Specialty Recommended RVU: **3.56**
Presented Recommended RVU: **2.00**
Global Period: ZZZ Current Work RVU: **5.13** RUC Recommended RVU: **2.00**

CPT Descriptor: Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male presents with a history of a trabeculectomy superiorly in the right eye with an exotropia who will have two-muscle horizontal strabismus surgery in the same and previously operated upon eye (67312 is reported separately). (This service is for the additional work related to scarring and not disrupting the filtering bleb. This is an add-on code and describes only that work done in addition to the primary eye muscle(s) procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: Identify conjunctival scars, anterior segment conditions and external reservoirs in the eye being operated upon. Release scar tissue and preserve conjunctiva and capsule around external reservoirs.

(Surgery is completed as described in parent code.)

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67331					
Sample Size:	1093	**Resp N:**	51			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.50	**9.00**	20.00	125.00
Survey RVW:	0.63	2.00	**4.00**	5.50	8.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	30.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67331	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	13,979

CPT Descriptor 2 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15136	ZZZ	1.50	**RUC Time**

CPT Descriptor Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 33.3 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 21.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 67331	Top Key Reference CPT Code: 11008	2nd Key Reference CPT Code: **14302**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	60.00	40.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**60.00**	**40.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	59%	41%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	6%	88%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	12%	88%
Physical effort required	0%	35%	65%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	12%	88%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	27%	46%	18%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	27%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	9%	73%
Physical effort required	18%	55%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	27%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67331, *Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

As described in the SOR for CPT +67320, this code has 4 postoperative visits as well as pre- and post-time listed incorrectly in the database. The procedure was changed from a 090-day global to a ZZZ code and work values were correspondingly reduced in 1999. However, the pre- and post-service times and postoperative visits were not removed from the "Physician Time" tab in the RUC database. Therefore, the pre- and post-service times and postoperative visits and the IWPUTs based on those incorrect times must be disregarded when comparing current values with the recommended times and WRVUs. We have removed the incorrect times and postoperative visits from the "Current" row in the Summary Spreadsheets in order to provide a correct relativity comparison. We have also added a row showing the pre-reduction data from 1998.

The six add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create any new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT +67331 is an add-on procedure typically performed for patients with scarring from previous eye surgery not directly affecting the extraocular muscles, typically from prior glaucoma filtering surgery. The scar tissue must be dissected without disturbing the delicate balance of flow through the filtering bleb. This makes the procedure more intense than that of the single-muscle base codes, but not as intense as the two-muscle base codes including a muscle resection.

For +67331 there were 51 respondents (full: 186), 96% (full: 97%) of whom found the vignette to be typical. The median WRVU was 4.00 (full: 5.22). The 25th percentile was 2.00 (full: 3.56). The current value of the code is 5.13 WRVU. The median IST was 15 minutes (full: 20).

The top key reference service, chosen by 33% (full: 42%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The second reference service, chosen by 22% (full: 24%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than the primary reference service on overall intensity and complexity and all of the individual submeasures (full: same). The same was true for the second key reference service with the exception of the physical effort submeasure, where the majority ranked them identical (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 15 minutes (full: 20).

As discussed in the SORs for CPT 67311 and CPT +67320, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others.

One option is a crosswalk to MPC code 36227, *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (RUC 2012), with 2.09 WRVU and an IST of 15 minutes, comes close. This value is minimally above the survey 25th percentile, however, and results in an IWPUT of 0.139.

Instead, we chose to value CPT +67331 based on the 25th percentile magnitude estimation of work at 2.00 WRVU. This is a significant reduction in the current value of the code of 5.13 WRVU. The IWPUT associated with this value, 0.133, is appropriately intermediate between the IWPUTs of the single- and two-muscle base codes. It is almost identical to the IWPUTs of CPT codes +67320 and +67334 at our recommended values. These three procedures are all similar in intensity and complexity.

We recommend a work value of 2.00 WRVU for CPT +67331, with an intraservice time of 15 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. CPT Code Pre- Intra- Post- Total Time Work RVU Global Period % Billed Together

4.	67311	40	35	18	173.5	7.77	090	18.13%
5.	67314	34	40	16	182	8.79	090	12.73%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 3000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 902
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 902 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67331

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67332 Tracking Number Original Specialty Recommended RVU: **4.20**
Presented Recommended RVU: **3.50**
Global Period: ZZZ Current Work RVU: **5.56** RUC Recommended RVU: **3.50**

CPT Descriptor: Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old female presents with a history of bilateral medial rectus recessions as an infant and requires an advancement of the right medial rectus muscle. She undergoes the rectus muscle advancement (67311 is reported separately). (This service is for the additional work related to scarred tissue. This is an add-on code and describes only that work done in addition to the primary eye muscle procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: Identify conjunctival scars, anterior segment conditions, external scleral buckles, bands and external reservoirs. Adjust standard incision placement and increase size… Use sharp and blunt dissection to open inferonasal quadrant. Insert a Conway retractor to visualize equatorial scarring of Tenon's capsule to sclera and to conjunctiva. Hook the medial rectus muscle 12 mm from the limbus (out of normal location. Sharply dissect and elevate conjunctiva over the muscle insertion…Clean scar tissue from over the original insertion. Pull muscle forward to original insertion…

(Surgery is completed as described in parent code.)

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67332					
Sample Size:	1093	**Resp N:**	53			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	15.00	**25.00**	40.00	265.00
Survey RVW:	1.50	3.50	**4.93**	6.50	15.24
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	15.00	**24.00**	30.00	75.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67332	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**24.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	128,927

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 2 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36907	ZZZ	3.00	**RUC Time**

CPT Descriptor Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 35.8 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 35.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 67332	Top Key Reference CPT Code: 14302	2nd Key Reference CPT Code: **11008**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	24.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**24.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	16%	53%	32%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	21%	79%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	21%	79%

Physical effort required	0%	53%	47%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	26%	74%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	47%	53%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	11%	90%
Physical effort required	0%	21%	79%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	5%	95%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67332, *Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five

base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

As described in the SOR for CPT +67320, this code has 4 postoperative visits as well as pre- and post-time listed incorrectly in the database. The procedure was changed from a 090-day global to a ZZZ code and work values were correspondingly reduced in 1999. However, the pre- and post-service times and postoperative visits were not removed from the "Physician Time" tab in the RUC database. Therefore, the pre- and post-service times and postoperative visits and the IWPUTs based on those incorrect times must be disregarded when comparing current values with the recommended times and WRVUs. We have removed the incorrect times and postoperative visits from the "Current" row in the Summary Spreadsheets in order to provide a correct relativity comparison. We have also added a row showing the pre-reduction data from 1998.

The six add-on codes (CPT +67320, +67331, +67332, +67334, +67335, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create any new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT +67332 is an add-on procedure typically performed for patients with scarring of the extraocular muscles from previous surgery, trauma, or thyroid ophthalmopathy, typically from prior eye muscle surgery. The scar tissue must be identified and dissected, and the muscle isolated prior to proceeding with the base recession or resection procedure. In addition, the muscle is often inelastic and moved from its normal anatomic position. This is the most intense and complex of the add-on procedures in this family, similar in difficulty to a muscle resection and superior oblique surgery. The dissection is more difficult than that required for scarring that does not involve the extraocular muscles (CPT +67331) and has a more profound effect on the outcome because it directly alters the muscle insertion anatomy and its effect on ocular motility.

For +67332 there were 53 respondents (full: 197), 92% (full: 91%) of whom found the vignette to be typical. The median WRVU was 4.93 (full: 6.00). The 25th percentile was 3.50 (full: 4.20). The current value of the code is 5.56 WRVU. The median IST was 24 minutes (full: 30).

The top key reference service, chosen by 36% (full: 38%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The second reference service, chosen by 36% (full: 32%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than the primary reference service on overall intensity and complexity and all of the individual submeasures except for physical effort, where the majority ranked them identically (full: same). The majority ranked the surveyed code higher than the second key reference service on overall intensity and complexity and all of the sub measures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 24 minutes (full: 30).

As discussed in the SORs for CPT 67311 and +67320, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others.

As discussed in the SOR for CPT +67320, there are no eligible 24-minute crosswalks in the database. We therefore used 25-minute ZZZ codes as eligible crosswalks, recognizing that a 1-minute time difference is not significant, particularly when the crosswalk codes were surveyed prior to the current survey instructions advising against rounding time estimates.

We considered a crosswalk to CPT 36907, *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (RUC 2016), with 3.00 WRVU and an IST of 25 minutes. This value is below the survey 25th percentile. However, this value is identical to the one we are recommending for the less difficult transposition procedure, CPT +67320. An identical value would create a rank order anomaly with a less intense and complex procedure and an IST within 1 minute. CPT +67332 is more work and should be valued higher than CPT +67320.

Therefore, we chose to value CPT +67332 based on the 25th percentile magnitude estimation of work at 3.50 WRVU. This is a significant reduction from the current value of the code at 5.56 WRVU. The IWPUT associated with this value, 0.146, is higher than that of any of the other add-on codes, maintaining an appropriate rank order within the ZZZ family. It is slightly less than that of the 2-muscle base codes (recession and resection), and almost identical to that of the superior oblique code (CPT 67318). This places it in appropriate rank order amongst all of the codes in the family.

We recommend a work value of 3.50 WRVU for CPT +67332, with an intraservice time of 24 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4.	67311	40	35	18	173.5	7.77	090	21.88%
5.	67312	34	54	22	190.5	9.66	090	18.92%
6.	67314	34	40	16	182	8.79	090	30.91%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 9000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 9000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,753
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 1753 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67332

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67334 Tracking Number Original Specialty Recommended RVU: **3.60**
Presented Recommended RVU: **2.06**
Global Period: ZZZ Current Work RVU: **5.05** RUC Recommended RVU: **2.06**

CPT Descriptor: Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old male with a large early onset esotropia has a left medial rectus muscle recession (67311 is reported separately). In addition there is placement of a posterior fixation suture to further reduce adduction. (This is an add-on code and describes only that work done in addition to the primary eye muscle procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: (Initial surgery is the parent procedure.)

The inferior border of the reattached medial rectus muscle is visualized. About 10 mm from the original insertion along the inferior border of the muscle a 6-0 absorbable suture is placed through the medial rectus muscle and then through partial thickness sclera, securing the muscle to the sclera at this posterior location.
The superior border of the reattached medial rectus muscle is visualized. About 14 mm from the original insertion along the superior border of the muscle a 6-0 non absorbable suture is placed through the medial rectus muscle and then through partial thickness sclera, securing the muscle to the sclera at this posterior location.

(Surgery is completed as described in parent code.)

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67334					
Sample Size:	1093	**Resp N:**	46			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.25	**5.00**	10.00	100.00
Survey RVW:	1.50	2.06	**3.87**	5.31	20.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	12.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67334	**Recommended Physician Work RVU: 2.06**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	13,979

CPT Descriptor 2 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15136	ZZZ	1.50	**RUC Time**

CPT Descriptor Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 34.7 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 23.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 67334	Top Key Reference CPT Code: 14302	2nd Key Reference CPT Code: **11008**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	13%	69%	19%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	13%	88%
Physical effort required	0%	44%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	13%	81%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	46%	55%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	18%	82%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67334, *Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

As described in the SOR for CPT +67320, this code has 4 postoperative visits as well as pre- and post-time listed incorrectly in the database. The procedure was changed from a 090-day global to a ZZZ code and work values were correspondingly reduced in 1999. However, the pre- and post-service times and postoperative visits were not removed from the "Physician Time" tab in the RUC database. Therefore, the pre- and post-service times and postoperative visits and the IWPUTs based on those incorrect times must be disregarded when comparing current values with the recommended times and WRVUs. We have removed the incorrect times and postoperative visits from the "Current" row in the Summary Spreadsheets in order to provide a correct relativity comparison. We have also added a row showing the pre-reduction data from 1998.

The six add-on codes (CPT +67320, +67331, +67332, +67334, +67335, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create any new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT +67334 is an add-on procedure typically performed to alter the effect of a muscle recession by fixing the muscle to the sclera with an additional suture posterior to the muscle insertion, thereby avoiding the need for resection of a second muscle. This procedure is separate and additional to the base surgery. The typical patient is a child with esotropia. The location of the suture placement far posteriorly on the globe makes the procedure much more difficult, with increased risk of globe perforation, than that of the single-muscle base codes, but not as difficult as the two-muscle base codes requiring a resection.

For +67334 there were 46 respondents (full: 146), 78% (full: 84%) of whom found the vignette to be typical. The median WRVU was 3.87 (full: 5.10). The 25th percentile was 2.06 (full: 3.60). The current value of the code is 5.05 WRVU. The median IST was 15 minutes (full: 20).

The top key reference service, chosen by 35% (full: 30%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The second reference service, chosen by 24% (full: 34%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than either reference service on overall intensity and complexity and on all of the individual submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 15 minutes (full: 20).

As discussed in the SORs for CPT 67311 and +67320, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others.

One option is a crosswalk to MPC code 36227, *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (RUC 2012), with 2.09 WRVU and an IST of 15 minutes, comes close. This value is minimally above the survey 25th percentile, however, and results in an IWPUT of 0.139.

Instead, we chose to value CPT +67334 based on the 25th percentile magnitude estimation of work at 2.06 WRVU. This is a significant reduction from the code's current value of 5.05 WRVU. The IWPUT associated with this value, 0.137, is appropriately intermediate between the IWPUTs of the single- and two-muscle base codes. It is almost identical to the IWPUTs of CPT codes +67320 and +67331 at our recommended values. These three procedures are all similar in intensity and complexity.

We recommend a work value of 2.06 WRVU for CPT +67334, with an intraservice time of 15 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 1200 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 128
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 128 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67334

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67335 Tracking Number Original Specialty Recommended RVU: **3.74**
Presented Recommended RVU: **3.23**
Global Period: ZZZ Current Work RVU: **2.49** RUC Recommended RVU: **3.23**

CPT Descriptor: Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male presents with a sensory exotropia has two-muscle one-eye surgery (67312 is reported separately). It requires adjustable sutures placement and adjustment on one of the muscles at the same session. (This is an add-on code and describes only that work done in addition to the primary eye muscle(s) procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: (Initial surgery is the parent procedure, 67312 with a recession of the lateral rectus muscle and a resection of the ipsilateral medial rectus muscle.)

Once the lateral rectus muscle pole sutures are place through partial thickness sclera, an absorbable slip-knot noose is placed around those sutures, allowing the muscle to sag posteriorly from the insertion. A caliper is used to adjust the recession to 7.0 mm. A traction suture of 6-0 non-absorbable material is passed through the superior border of the insertion. The sutures are placed out of the way for the remainder of surgery and taped to the eyelid skin at the conclusion of the surgery. The eye is patched.

(Surgery is completed as described in parent code. The patient is moved to the PACU.)

In the PACU when the patient awakens from sedation and the muscles recover from any anesthetic, the patch is removed, and topical anesthesia is administered. The patient sits up and views distance and near targets. The surgeon assesses the position of the eye with a cover-uncover test as well as questions about fusion and diplopia. The surgeon moves the noose suture to change the surgical dose and then reassesses the alignment. Typically, one move is necessary but can vary widely. The pole sutures are tied and trimmed. The slip-knot noose is trimmed, and the traction suture is removed. The conjunctiva is the pulled down to cover the knot.
An antibiotic-steroid eye drop is placed in the eye.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67335					
Sample Size:	1093	**Resp N:**	35			
Description of Sample:	Random sample of practicing members of AAO, AAP, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.50	**10.00**	50.00	355.00
Survey RVW:	1.50	3.23	**4.00**	5.13	115.94
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	21.00	**30.00**	42.50	360.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67335	**Recommended Physician Work RVU: 3.23**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36476	ZZZ	2.65	**RUC Time**	7,170

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	128,927

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
47543	ZZZ	3.00	**RUC Time**

CPT Descriptor Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 31.4 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 28.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 67335	Top Key Reference CPT Code: 14302	2nd Key Reference CPT Code: **11008**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	46%	18%	36%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	27%	73%
Physical effort required	18%	27%	55%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	18%	73%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	10%	30%	60%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	10%	90%
Physical effort required	0%	10%	90%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	10%	90%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67335, *Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

Unlike the other add-on codes in this family, CPT +67335 was originally Harvard valued as a ZZZ and was not converted from a 090 global, thus avoiding the clerical error that occurred in 1998. The changes at that time resulted in an anomalous relationship between this code and the other add-on procedures in the family. The anomalous relationship continued when the other add-on codes were converted from 090- to ZZZ-globals and re-valued in 1998 using an MPPR calculation, while the value of CPT +67335 was left unchanged. The MPPR methodology used to revalue the family in 1998 was flawed and is not considered acceptable today, as outlined in the compelling evidence argument presented in the SORs for the lead base and add-on codes in the family, CPT 67311 and +67320.

The six add-on codes (CPT +67320, +67331, +67332, +67334, +67335, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create any new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

CPT +67335 is performed as an add-on procedure to more precisely titrate the effect of the base code recession or resection procedure by allowing adjustment after completion of the base code procedure. An adjustable suture is placed intra-operatively. The adjustment is typically performed on the same day as the base procedure. It is typically done in the post-anesthesia care unit after sedation and local anesthesia have worn off, allowing assessment of alignment while the patient is awake and fixating. Although performed in the PACU, the adjustment procedure and final tying of the suture is an essential part of the intra-service work. There is no post-service work for this add-on code.

This procedure requires more time than CPT +67320, +67331, +67332, or +67334, but is less intense. It does not require unusual muscle placement or dissection of scar tissue like those codes. However, it does take longer to place the suture and then adjust those sutures when the patient awakens than those codes. CPT +67335 is of similar intensity to that of the one-muscle base codes and the other lengthy add-on code for a detached muscle, CPT +67340.

For +67335 there were 35 respondents (full: 138), 94% (full: 94%) of whom found the vignette to be typical. The median WRVU was 4.00 (full: 5.29). The 25th percentile was 3.23 (full: 3.74). The current value of the code is 2.49 WRVU. The median IST was 30 minutes (full: 38).

The top key reference service, chosen by 31% (full: 32%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The second reference service, chosen by 29% (full: 33%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code higher than either reference service on overall intensity and complexity and all of the individual submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 30 minutes (full: 38).

As discussed in the SORs for CPT 67311 and +67320, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others.

We chose to value CPT +67335 based on the survey 25th percentile magnitude estimation of work at 3.23 WRVU. This is an increase from the current value of the code, as supported by compelling evidence and the robust survey results. The IWPUT associated with this value, 0.108, is lower than that of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. It is appropriately similar to that of the single-muscle base codes and the detached muscle add-on procedure, CPT +67340.

We recommend a work value based on the survey 25th percentile of 3.23 WRVU for CPT +67335, with an intraservice time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6300
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 6300 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,681
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 1681 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67335

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67340 Tracking Number Original Specialty Recommended RVU: **5.61**
Presented Recommended RVU: **5.00**
Global Period: ZZZ Current Work RVU: **6.00** RUC Recommended RVU: **5.00**

CPT Descriptor: Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old male presents with a left eye consecutive exotropia due to a severed medial rectus muscle following pterygium excision. He undergoes reattachment of the medial rectus muscle (reported as 67311). (This service is for the additional work of the exploration. This is an add-on code and describes only that work done in addition to the primary eye muscle procedure.)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA – pre-service work is included in the global of the primary procedure.

Description of Intra-Service Work: Identify conjunctival scars, anterior segment conditions, external scleral buckles, bands and external reservoirs. Adjust standard incision placement to radial and increase size to the limbus. Extend the conjunctival incision superiorly along the limbus. Use sharp and blunt dissection to open inferonasal and superonasal quadrants. Insert a Conway retractor to visualize equatorial scarring of Tenon's capsule to sclera and to conjunctiva. Sharply dissect and elevate conjunctiva over the muscle insertion. Follow Tenon's capsule posteriorly hand over hand searching for evidence of medial rectus tendon or muscle fibers. (Secure muscle per parent code.) Dissect muscle free of Tenon's capsule for 7 mm along the muscle. Clean scar tissue from over the original insertion. Pull muscle forward to original insertion.

(Surgery is completed as described in parent code.)

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Michael X. Repka, MD, MBA (AAO); Steven Krug, MD (AAP); John Bishop, MD (AAP)					
Specialty Society(ies):	AAO, AAP					
CPT Code:	67340					
Sample Size:	1093	**Resp N:**	33			
Description of Sample:	Random sample of US practicing members of AAO, AAPOS, and AAP Ophthalmology					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	**2.00**	3.00	12.00
Survey RVW:	1.50	5.00	**6.25**	10.00	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	18.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	67340	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14302	ZZZ	3.73	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	128,927

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 2 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
22585	ZZZ	5.52	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 78.7 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 67340	Top Key Reference CPT Code: 11008	2nd Key Reference CPT Code: **14302**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	60.00	40.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**60.00**	**40.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	8%	19%	73%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	8%	92%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	8%	92%
Physical effort required	0%	15%	85%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	8%	92%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	25%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT +67340, *Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)* is part of a family of five 090-day global base codes and six ZZZ add-on codes comprising the entirety of strabismus eye muscle surgery procedures in CPT. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was flagged because five of the add-on codes (CPT +67320, +67331, +67332, +67334, and +67340) carried postoperative visits in

the database. While this was a clerical error as the work value associated with the visits had been removed in 1999, all eleven codes are being presented to the RUC for valuation.

As described in the SOR for CPT +67320, this code has 4 postoperative visits as well as pre- and post-time listed incorrectly in the database. The procedure was changed from a 090-day global to a ZZZ code and work values were correspondingly reduced in 1999. However, the pre- and post-service times and postoperative visits were not removed from the "Physician Time" tab in the RUC database. Therefore, the pre- and post-service times and postoperative visits and the IWPUTs based on those incorrect times must be disregarded when comparing current values with the recommended times and WRVUs. We have removed the incorrect times and postoperative visits from the "Current" row in the Summary Spreadsheets in order to provide a correct relativity comparison. We have also added a row showing the pre-reduction data from 1998.

The six add-on codes (CPT +67320, +67331, +67332, +67334, +67335, and +67340) are all performed with one or more of the base codes (CPT 67311-67318). There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create any new combined codes.

Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly distinguish the add-ons from any base procedure they are reported with. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT +67320 (transposition), +67331 (prior eye surgery), and +67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT +67332, a re-operation with scarring of the extraocular muscles being operated, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT +67335 (adjustable suture) and +67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Academy of Pediatrics Section of Ophthalmology (AAP/O), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) members. Issues with the survey related to disclosure of current WRVUs and the decision to use pre-disclosure data to support work value recommendations are discussed in the SOR for CPT 67311. We have included separate rows in the Summary Spreadsheet for pre-disclosure, post-disclosure, and all-survey data for ease of comparison. For clarity, we included the entire survey response data parenthetically as (full:) in each SOR Rationale after the pre-disclosure data.

As with the base codes, the survey results in the family of add-on codes presented a challenge due to the key reference services chosen having significantly longer times than the surveyed times. Use of the 25th percentile estimates of work for all six of the codes resulted in some rank order anomalies, as did use of crosswalks to median times for all six codes. We therefore used a mix of 25th percentile work estimates and crosswalks to the median times in order to preserve the proper order of intensity and complexity for the family of codes.

CPT +67340 is an add-on procedure typically performed for patients with a detached extraocular muscle. These are uncommon procedures, typically in young patients after prior ocular surgery or trauma. The muscle is typically retracted into the posterior orbit and must be found via a lengthy exploration prior to reattachment.

This procedure requires more time than CPT +67320, +67331, +67332, or +67334 but is less intense than they are. It does not require unusual muscle placement or dissection of scar tissue like those codes. However, the exploration to locate the retracted muscle is lengthy. CPT +67340 is of similar intensity to that of the one-muscle base codes and the other lengthy add-on code for an adjustable suture, CPT +67335.

For +67340 there were 33 respondents (full: 120), 97% (full: 93%) of whom found the vignette to be typical. The median WRVU was 6.25 (full: 7.20). The 25th percentile was 5.00 (full: 5.61). The current value of the code is 9.85 WRVU. The median IST was 45 minutes (full: 45).

The top key reference service, chosen by 79% (full: 84%) of respondents, was CPT 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (RUC 2004), with a WRVU of 5.00 and an IST of 60 minutes. The second reference service, chosen by 12% (full: 9%) of respondents, was CPT 14302, *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (RUC 2009), with a WRVU of 3.73 and an IST of 40 minutes. The survey time was significantly shorter than the selected KRS times. The majority of respondents ranked the surveyed code much higher than either reference service on overall intensity and complexity and all of the individual submeasures (full: same).

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel accepted the median IST of 45 minutes (full: 45).

As discussed in the SORs for CPT 67311 and +67320, in order to preserve a proper rank order, we used crosswalks to value some of the codes in this family and magnitude estimation of work to value others.

One option was to use a crosswalk to CPT 22585, *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (RUC 2010), with a matching IST of 45 minutes and 5.52 WRVU. However, this value is above the survey 25th percentile. It also results in an IWPUT of 0.123, closer to that of some of the more difficult codes in the family than to those of similar intensity.

Instead, we chose to value CPT +67340 based on the survey 25th percentile magnitude estimation of work at 5.00 WRVU. This is a reduction from the code's current value of 6.00 WRVU. The recommended value results in an IWPUT of 0.111, lower than that of most of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. It is appropriately similar to that of the single-muscle base codes and the adjustable suture add-on procedure, CPT +67335.

We recommend a work value based on the survey 25th percentile of 5.00 WRVU for CPT +67340, with an intraservice time of 45 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 450
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate based on RUC DB and presumed percentage of cases covered by commercial insurance.

Specialty Ophthalmology Frequency 450 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 88 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From RUC database.

Specialty Ophthalmology Frequency 88 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number +67340

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Strabismus Surgery

TAB: 18

CPT 67311 - 1 horizontal

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	67904	90	Repair of blepharoptosis; (tarso) levator resection or	24	0.089			7.97			185	10	10	15			45			15						0.5			1	3						
2nd REF	67966	90	Excision and repair of eyelid, involving lid margin, tar	11	0.084			8.97			200	10	10	15			60			15						0.5			1	3						
CURRENT	67311	90	Strabismus surgery, recession or resection procedur	Hvd	0.094			7.77			174	25		15			35			18									3.5						
SVY	67311	90	Strabismus surgery, recession or resection procedur	62	0.168	6.05	8.22	9.18	10.63	18.00	177	10	5	15	5	20	25	30	60	15						1.0			3			4	50	75	148	330
XWALK	53854	90	Transurethral destruction of prostate tissue; by radiofreque		0.085			5.93			137	17	6	5			25			15									3						
REC	67311	90	Strabismus surgery, recession or resection procedure; 1 ho		0.103			5.93			144	10	5	15			25			15						0.5			1	2					

CPT 67312 - 2 horizontals

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	67904	90	Repair of blepharoptosis; (tarso) levator resection or	11	0.089			7.97			185	10	10	15			45			15						0.5			1	3						
2nd REF	67966	90	Excision and repair of eyelid, involving lid margin, tar	10	0.084			8.97			200	10	10	15			60			15						0.5			1	3						
CURRENT	67312	90	Strabismus surgery, recession or resection procedur	Hvd	0.097			9.66			191	19		15			54			22									3.5						
SVY	67312	90	Strabismus surgery, recession or resection procedur	57	0.144	7.00	9.50	10.75	12.50	25.00	192	10	5	15	20	32	40	50	90	15						1.0			3			3	25	40	75	215
REC	67312	90	Strabismus surgery, recession or resection procedure; 2 ho		0.153			9.50			159	10	5	15			40			15						0.5			1	2					

CPT 67314 - 1 vertical

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	67904	90	Repair of blepharoptosis; (tarso) levator resection or	15	0.089			7.97			185	10	10	15			45			15						0.5			1	3						
2nd REF	67966	90	Excision and repair of eyelid, involving lid margin, tar	11	0.084			8.97			200	10	10	15			60			15						0.5			1	3						
CURRENT	67314	90	Strabismus surgery, recession or resection procedur	Hvd	0.100			8.79			182	19		15			40			16									4						
SVY	67314	90	Strabismus surgery, recession or resection procedur	54	0.193	4.50	9.00	10.00	12.00	20.00	178	10	5	15	10	20	26	30	57	15						1.0			3			6	17	30	50	150
XWALK	53854	90	Transurethral destruction of prostate tissue; by radiofreque		0.085			5.93			137	17	6	5			25			15									3						
REC	67314	90	Strabismus surgery, recession or resection procedure; 1 ve		0.099			5.93			145	10	5	15			26			15						0.5			1	2					

CPT 67316 - 2 verticals

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	67036	90	Vitrectomy, pars plana	10	0.108			12.13			250	33	3	15			50			15						0.5			5							
2nd REF	67966	90	Excision and repair of eyelid, involving lid margin, tar	9	0.084			8.97			200	10	10	15			60			15						0.5			1	3						
CURRENT	67316	90	Strabismus surgery, recession or resection procedur	Hvd	0.098			10.93			208	21		15			62			18									4						
SVY	67316	90	Strabismus surgery, recession or resection procedur	50	0.145	7.97	10.31	11.50	14.00	28.61	197	10	5	15	20	40	45	60	240	15						1.0			3			1	5	10	24	50

SS Rec Summary

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
REC	67316	90	Strabismus surgery, recession or resection procedure; 2 or		0.154			10.31			164	10	5	15			45			15					0.5				1	2						

CPT 67318 - superior oblique

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	66170	90	Fistulization of sclera for glaucoma; trabeculectomy	11	0.129			13.94			278	19	1	5			45			10					0.5				5	4						
2nd REF	66184	90	Revision of aqueous shunt to extraocular equatorial p	10	0.048			9.58			254	19	1	5			60			10					0.5				4	3						
CURRENT	67318	90	Strabismus surgery, any procedure, superior oblique	Hvd	0.100			9.12			187	20		15			43			17									4							
SVY	67318	90	Strabismus surgery, any procedure, superior oblique	50	0.164	7.97	9.80	11.55	13.50	22.46	192	10	5	15	15	30	40	49	70	15					1.0				3			1	3	5	12	60
REC	67318	90	Strabismus surgery, any procedure, superior oblique muscl		0.149			9.80			166	10	5	15			40			15					0.5				2	1						

ISSUE: Strabismus Surgery

TAB: 18

CPT 67320 - Transposition

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	14302	ZZZ	Adjacent tissu	21	0.093			3.73			40						40																			
2nd REF	11008	ZZZ	Removal of pr	17	0.083			5.00			60						60																			
1998	67320	ZZZ	Transposition	Hvd	0.070			8.66			201	22		15			54			18							4								
CURRENT	67320	ZZZ	Transposition	Hvd	0.100			5.40			54						54																		
SVY	67320	ZZZ	Transposition	51	0.185	1.80	3.73	4.25	5.88	10.00	23				6	18	23	30	60													1	3	5	15	175
XWALK	36907	ZZZ	Transluminal balloo		0.120			3.00			25						25																		
REC	67320	ZZZ	Transposition proce		0.130			3.00			23						23																		

CPT 67331 Non-EOM Scar

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	11008	ZZZ	Removal of pr	17	0.083			5.00			60						60																			
2nd REF	14302	ZZZ	Adjacent tissu	11	0.093			3.73			40						40																			
1998	67331	ZZZ	Strabismus su	Hvd	0.057			8.12			202	21		15			57			17							4								
CURRENT	67331	ZZZ	Strabismus su	Hvd	0.090			5.13			57						57																		
SVY	67331	ZZZ	Strabismus su	51	0.267	0.63	2.00	4.00	5.50	8.00	15				3	10	15	30	90													1	3	9	20	125
REC	67331	ZZZ	Strabismus surgery		0.133			2.00			15						15																		

CPT 67332 EOM Scar

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	14302	ZZZ	Adjacent tissu	19	0.093			3.73			40						40																			
2nd REF	11008	ZZZ	Removal of pr	19	0.083			5.00			60						60																			
1998	67332	ZZZ	Strabismus su	Hvd	0.058			8.99			218	22		15			71			18							4								
CURRENT	67332	ZZZ	Strabismus su	Hvd	0.078			5.56			71						71																		
SVY	67332	ZZZ	Strabismus su	53	0.205	1.50	3.50	4.93	6.50	15.24	24				6	15	24	30	75													3	15	25	40	265
REC	67332	ZZZ	Strabismus surgery		0.146			3.50			24						24																		

CPT 67334 Posterior fixation suture

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	14302	ZZZ	Adjacent tissu	16	0.093			3.73			40						40																			
2nd REF	11008	ZZZ	Removal of pr	11	0.083			5.00			60						60																			
1998	67334	ZZZ	Strabismus su	Hvd	0.066			7.96			192	21		15			47			17							4								
CURRENT	67334	ZZZ	Strabismus su	Hvd	0.107			5.05			47						47																		
SVY	67334	ZZZ	Strabismus su	46	0.258	1.50	2.06	3.87	5.31	20.00	15				4	12	15	20	60													1	2	5	10	100
REC	67334	ZZZ	Strabismus surgery		0.137			2.06			15						15																		

CPT 67335 Adjustable suture

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	14302	ZZZ	Adjacent tissu	11	0.093			3.73			40						40																			
2nd REF	11008	ZZZ	Removal of pr	10	0.083			5.00			60						60																			
CURRENT	67335	ZZZ	Placement of	Hvd	0.048			2.49			52						52																			
SVY	67335	ZZZ	Placement of	35	0.133	1.50	3.23	4.00	5.13	115.94	30				10	21	30	43	360													1	3	10	50	355
REC	67335	ZZZ	Placement of adjusta		0.108			3.23			30						30																			

CPT 67340 Detached EOM

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	11008	ZZZ	Removal of pr	26	0.083			5.00			60						60																			
2nd REF	14302	ZZZ	Adjacent tissu	4	0.093			3.73			40						40																			
1998	67340	ZZZ	Strabismus su	Hvd	0.060			9.85			231	24		15			81			19							4								
CURRENT	67340	ZZZ	Strabismus su	Hvd	0.074			6.00			81						81																		
SVY	67340	ZZZ	Strabismus su	33	0.139	1.50	5.00	6.25	10.00	25.00	45				18	30	45	60	120													1	1	2	3	12
REC	67340	ZZZ	Strabismus surgery		0.111			5.00			45						45																		

FACILITY DIRECT PE INPUTS **CPT CODE(S):_67311___**

SPECIALTY SOCIETY(IES):__AAO, AAP_

PRESENTER(S):_David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   Strabismus surgery is major surgery with a 90-day global, typically performed in children under general

anesthesia in the facility setting. Standard inputs are used during the pre service period consistent with PEAC recommendations for 90-day global procedures.

b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam
Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):**_67312 ___
SPECIALTY SOCIETY(IES):__AAO, AAP_
PRESENTER(S):_David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   Strabismus surgery is major surgery with a 90-day global, typically performed in children under general

anesthesia in the facility setting. Standard inputs are used during the pre service period consistent with PEAC recommendations for 90-day global procedures.

b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam
Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_67314___**

SPECIALTY SOCIETY(IES):__AAO, AAP_

PRESENTER(S):_ David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67314	Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Strabismus surgery is major surgery with a 90-day global, typically performed in children under general anesthesia in the facility setting. Standard inputs are used during the pre service period consistent with PEAC recommendations for 90-day global procedures.

b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam
Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A.

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used.
Screening lane: Standard office visit formula used.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_67316___**

SPECIALTY SOCIETY(IES):__AAO, AAP_

PRESENTER(S):_ David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67316	Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Strabismus surgery is major surgery with a 90-day global, typically performed in children under general anesthesia in the facility setting. Standard inputs are used during the pre service period consistent with PEAC recommendations for 90-day global procedures.

b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam
Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A.

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used.
Screening lane: Standard office visit formula used.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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FACILITY DIRECT PE INPUTS **CPT CODE(S):_67318___**

SPECIALTY SOCIETY(IES):__AAO, AAP_

PRESENTER(S):_ David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67318	Strabismus surgery, any procedure, superior oblique muscle	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   Strabismus surgery is major surgery with a 90-day global, typically performed in children under general

anesthesia in the facility setting. Standard inputs are used during the pre service period consistent with PEAC recommendations for 90-day global procedures.

b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam
Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_67320___**

SPECIALTY SOCIETY(IES):__AAO, AAP_

PRESENTER(S):_ David Glasser, Ankoor Shah, Michael Repka, Steven Krug, John Bishop_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code utilized is the existing code.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A.

7. Please provide a brief description of the clinical staff work for the following:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

a. Pre-Service period:

For this ZZZ code, no additional pre-service time is required beyond the base code.

b. Service period (includes pre, intra and post):

For this ZZZ code, no additional service time is required beyond the base code.

c. Post-service period:

For this ZZZ code, no additional post-service time is required beyond the base code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? N/A.

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment? N/A.

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**CPT Code # 67311**		**CPT Code # 67311**		**CPT Cod**
3		***RUC Collaboration Website***				Strabismus surgery, recession or resection procedure; 1 horizontal muscle		Strabismus surgery, recession or resection procedure; 1 horizontal muscle		Strabismu recess resection 2 horizont
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 99.93**	**$ -**	**$ 76.46**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**192.0**	**0.0**	**156.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**126.0**	**0.0**	**90.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 72.96**	**$ -**	**$ 59.28**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CS	0.38				5	
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CS	0.38				20	
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CS	0.38				8	
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CS	0.38				20	
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CS	0.38				7	
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CS	0.38					
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CS	0.38					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CS	0.38		60			
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037C	Orthoptist	0.37					
24			L038A	COMT/COT/RN/CS	0.38					
27		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
30		**End: When patient enters office/facility for surgery/procedure**								
31		**SERVICE PERIOD**								
32		**Start: When patient enters office/facility for surgery/procedure:**								
33		**Pre-Service (of service period)**								
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L038A	COMT/COT/RN/CS	0.38					
35	CA010	Obtain vital signs	L038A	COMT/COT/RN/CS	0.38					
36	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CS	0.38					
37	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CS	0.38					
38	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CS	0.38					
39	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CS	0.38					
40	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CS	0.38					
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CS	0.38					
42	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CS	0.38					
43			L038A	COMT/COT/RN/CS	0.38					
46		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
49		**Intra-service (of service period)**								
50	CA018	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
51	CA019	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
52	CA020	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
53	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CS	0.38		6			
56			L038A	COMT/COT/RN/CS	0.38					
57		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
60		**Post-Service (of service period)**								
61	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CS	0.38					
62	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CS	0.38					
63	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CS	0.38					
64	CA025	Clean scope	L038A	COMT/COT/RN/CS	0.38					
65	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CS	0.38					
66	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CS	0.38					
67	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CS	0.38					
68	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CS	0.38					
69	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L038A	COMT/COT/RN/CS	0.38					
70	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CS	0.38					
71	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L038A	COMT/COT/RN/CS	0.38					
72	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CS	0.38					
73	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L038A	COMT/COT/RN/CS	0.38					
74	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CS	0.38					
75	CA036	Discharge day management	L038A	COMT/COT/RN/CS	0.38	**n/a**		**n/a**	6	**n/a**
76			L038A	COMT/COT/RN/CS	0.38					
79		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
82		**End: Patient leaves office/facility**								
83		**POST-SERVICE PERIOD**								
84		**Start: Patient leaves office/facility**								
85	CA037	Conduct patient communications	L038A	COMT/COT/RN/CS	0.38					
86	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CS	0.38		126			
87	CA038	Coordinate post-procedure services	L037C	Orthoptist	0.37					
88		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes	16							
90		99212 27 minutes	27						2	
91		99213 36 minutes	36						1	
92		99214 53 minutes	53							
93		99215 63 minutes	63							
94	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CS	0.38	**0.0**	**0.0**	**0.0**	**90.0**	**0.0**
95			L038A	COMT/COT/RN/CS	0.38					
98		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
101		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**CPT Code # 67311**		**CPT Code # 67311**		**CPT Cod**
3		***RUC Collaboration Website***				Strabismus surgery, recession or resection procedure; 1 horizontal muscle		Strabismus surgery, recession or resection procedure; 1 horizontal muscle		Strabismu recess resection 2 horizont
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 99.93**	**$ -**	**$ 76.46**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**192.0**	**0.0**	**156.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**126.0**	**0.0**	**90.0**	**0.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 12.26**	**$ -**	**$ 6.86**	**$ -**
104	SA050	pack, ophthalmology visit (no dilation)	1.9525	pack			3.5		2.0	
105	SA082	pack, ophthalmology visit (w-dilation)	2.9535	pack			0.0		1.0	
106	SG046	eye pad, sterile, strabismus	1.353	item			1.0		0.0	
107	SG049	eye shield, non-fog	0.59	item			1.0		0.0	
108	SG079	tape, surgical paper 1in (Micropore)	0.006	inch			36.0		0.0	
109	SH011	atropine 1% ophth	0.291	ml			0.4		0.0	
110	SH074	water, sterile for irrigation (250-1000ml uou)	2.47	item			1.0		0.0	
111	SJ041	povidone soln (Betadine)	0.137	ml			5.0		0.0	
112		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
114	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
115		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 14.71**	**$ -**	**$ 10.32**	**$ -**
116	EL005	lane, exam (oph)	37169.005		0.116737051		126		36	
117	EL006	lane, screening (oph)	36070.7625		0.11328779				54	
118										
119										
120										
121										
122		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R	S	T	U
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMM**
2			**e # 67312**	**CPT Code # 67312**		**CPT Code # 67314**		**CPT Code # 67314**		**CPT Code # 67316**		**CPT Cod**
3		***RUC Collaboration Website***	s surgery,	Strabismus surgery, recession or resection procedure; 2 horizontal muscles		Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior		Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior		Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding		Strabismu
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO**	sion or procedure; al muscles									recess resection 2 or mor muscles (
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**		**090**		**090**		**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 104.73**	**$ -**	**$ 76.46**	**$ -**	**$ 112.54**	**$ -**	**$ 76.46**	**$ -**	**$ 112.54**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**192.0**	**0.0**	**156.0**	**0.0**	**210.0**	**0.0**	**156.0**	**0.0**	**210.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**126.0**	**0.0**	**90.0**	**0.0**	**144.0**	**0.0**	**90.0**	**0.0**	**144.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 72.96**	**$ -**	**$ 59.28**	**$ -**	**$ 79.80**	**$ -**	**$ 59.28**	**$ -**	**$ 79.80**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms			5				5			
16	CA002	Coordinate pre-surgery services (including test results)			20				20			
17	CA003	Schedule space and equipment in facility			8				8			
18	CA004	Provide pre-service education/obtain consent			20				20			
19	CA005	Complete pre-procedure phone calls and prescription			7				7			
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	60				60				60	
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
24												
27		*Other activity: please include short clinical description here and type*										
30		**End: When patient enters office/facility for surgery/procedure**										
31		**SERVICE PERIOD**										
32		**Start: When patient enters office/facility for surgery/procedure:**										
33		**Pre-Service (of service period)**										
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are										
35	CA010	Obtain vital signs										
36	CA011	Provide education/obtain consent										
37	CA012	Review requisition, assess for special needs										
38	CA013	Prepare room, equipment and supplies										
39	CA014	Confirm order, protocol exam										
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		**Intra-service (of service period)**										
50	CA018	Assist physician or other qualified healthcare professional---directly										
51	CA019	Assist physician or other qualified healthcare professional---directly										
52	CA020	Assist physician or other qualified healthcare professional---directly										
53	CA021	Perform procedure/service---NOT directly related to physician work time	6				6				6	
56												
57		*Other activity: please include short clinical description here and type*										
60		**Post-Service (of service period)**										
61	CA022	Monitor patient following procedure/service, multitasking 1:4										
62	CA023	Monitor patient following procedure/service, no multitasking										
63	CA024	Clean room/equipment by clinical staff										
64	CA025	Clean scope										
65	CA026	Clean surgical instrument package										
66	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
67	CA028	Review/read post-procedure x-ray, lab and pathology reports										
68	CA029	Check dressings, catheters, wounds										
69	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
70	CA031	Review examination with interpreting MD/DO										
71	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
72	CA033	Perform regulatory mandated quality assurance activity (service period)										
73	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
74	CA035	Review home care instructions, coordinate visits/prescriptions										
75	CA036	Discharge day management		**n/a**	6	**n/a**		**n/a**	6	**n/a**		**n/a**
76												
79		*Other activity: please include short clinical description here and type*										
82		**End: Patient leaves office/facility**										
83		**POST-SERVICE PERIOD**										
84		**Start: Patient leaves office/facility**										
85	CA037	Conduct patient communications										
86	CA038	Coordinate post-procedure services	126				144				144	
87	CA038	Coordinate post-procedure services										
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes										
90		99212 27 minutes			2				2			
91		99213 36 minutes			1				1			
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**90.0**	**0.0**	**0.0**	**0.0**	**90.0**	**0.0**	**0.0**	**0.0**
95												
98		*Other activity: please include short clinical description here and type*										
101		**End: with last office visit before end of global period**										

	A	B	L	M	N	O	P	Q	R	S	T	U
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMM**
2			**e # 67312**	**CPT Code # 67312**		**CPT Code # 67314**		**CPT Code # 67314**		**CPT Code # 67316**		**CPT Cod**
3		***RUC Collaboration Website***	s surgery,	Strabismus surgery, recession or resection procedure; 2 horizontal muscles		Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior		Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior		Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding		Strabismu
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO**	sion or procedure; al muscles									recess resection 2 or mor muscles (
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**		**090**		**090**		**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 104.73**	**$ -**	**$ 76.46**	**$ -**	**$ 112.54**	**$ -**	**$ 76.46**	**$ -**	**$ 112.54**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**192.0**	**0.0**	**156.0**	**0.0**	**210.0**	**0.0**	**156.0**	**0.0**	**210.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**126.0**	**0.0**	**90.0**	**0.0**	**144.0**	**0.0**	**90.0**	**0.0**	**144.0**	**0.0**
102	**Supply Code**	**MEDICAL SUPPLIES**										
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 17.06**	**$ -**	**$ 6.86**	**$ -**	**$ 18.04**	**$ -**	**$ 6.86**	**$ -**	**$ 18.04**	**$ -**
104	SA050	pack, ophthalmology visit (no dilation)	3.5		2.0		4.0		2.0		4.0	
105	SA082	pack, ophthalmology visit (w-dilation)	0.0		1.0		0.0		1.0		0.0	
106	SG046	eye pad, sterile, strabismus	1.0		0.0		1.0		0.0		1.0	
107	SG049	eye shield, non-fog	1.0		0.0		1.0		0.0		1.0	
108	SG079	tape, surgical paper 1in (Micropore)	36.0		0.0		36.0		0.0		36.0	
109	SH011	atropine 1% ophth	0.4		0.0		0.4		0.0		0.4	
110	SH074	water, sterile for irrigation (250-1000ml uou)	1.0		0.0		1.0		0.0		1.0	
111	SJ041	povidone soln (Betadine)	40.0		0.0		40.0		0.0		40.0	
112		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
114	**Equipment Code**	**EQUIPMENT**										
115		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 14.71**	**$ -**	**$ 10.32**	**$ -**	**$ 14.71**	**$ -**	**$ 10.32**	**$ -**	**$ 14.71**	**$ -**
116	EL005	lane, exam (oph)	126		36		126		36		126	
117	EL006	lane, screening (oph)			54				54			
118												
119												
120												
121												
122		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	V	W	X	Y	Z
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**CURRENT**		**RECOMMENDED**	
2			**e # 67316**	**CPT Code # 67318**		**CPT Code # 67318**	
3		***RUC Collaboration Website***	s surgery,	Strabismus surgery,		Strabismus surgery,	
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO**	ion or rocedure; e vertical excluding	any procedure, superior oblique muscle		any procedure, superior oblique muscle	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 76.46**	**$ -**	**$ 120.68**	**$ -**	**$ 82.02**
8		**TOTAL CLINICAL STAFF TIME**	**156.0**	**0.0**	**232.0**	**0.0**	**165.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**71.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**90.0**	**0.0**	**155.0**	**0.0**	**99.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 59.28**	**$ -**	**$ 87.94**	**$ -**	**$ 62.70**
13		**PRE-SERVICE PERIOD**					
14		**Start: Following visit when decision for surgery/procedure made**					
15	CA001	Complete pre-service diagnostic and referral forms	5				5
16	CA002	Coordinate pre-surgery services (including test results)	20				20
17	CA003	Schedule space and equipment in facility	8				8
18	CA004	Provide pre-service education/obtain consent	20				20
19	CA005	Complete pre-procedure phone calls and prescription	7				7
20	CA006	Confirm availability of prior images/studies					
21	CA007	Review patient clinical extant information and questionnaire					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)			60		
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)			11		
24							
27		*Other activity: please include short clinical description here and type*					
30		**End: When patient enters office/facility for surgery/procedure**					
31		**SERVICE PERIOD**					
32		**Start: When patient enters office/facility for surgery/procedure:**					
33		**Pre-Service (of service period)**					
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are					
35	CA010	Obtain vital signs					
36	CA011	Provide education/obtain consent					
37	CA012	Review requisition, assess for special needs					
38	CA013	Prepare room, equipment and supplies					
39	CA014	Confirm order, protocol exam					
40	CA015	Setup scope (nonfacility setting only)					
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient					
42	CA017	Sedate/apply anesthesia					
43							
46		*Other activity: please include short clinical description here and type*					
49		**Intra-service (of service period)**					
50	CA018	Assist physician or other qualified healthcare professional---directly					
51	CA019	Assist physician or other qualified healthcare professional---directly					
52	CA020	Assist physician or other qualified healthcare professional---directly					
53	CA021	Perform procedure/service---NOT directly related to physician work time			6		
56							
57		*Other activity: please include short clinical description here and type*					
60		**Post-Service (of service period)**					
61	CA022	Monitor patient following procedure/service, multitasking 1:4					
62	CA023	Monitor patient following procedure/service, no multitasking					
63	CA024	Clean room/equipment by clinical staff					
64	CA025	Clean scope					
65	CA026	Clean surgical instrument package					
66	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions					
67	CA028	Review/read post-procedure x-ray, lab and pathology reports					
68	CA029	Check dressings, catheters, wounds					
69	CA030	Technologist QC's images in PACS, checking for all images, reformats,					
70	CA031	Review examination with interpreting MD/DO					
71	CA032	Scan exam documents into PACS. Complete exam in RIS system to					
72	CA033	Perform regulatory mandated quality assurance activity (service period)					
73	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry					
74	CA035	Review home care instructions, coordinate visits/prescriptions					
75	CA036	Discharge day management	6	**n/a**		**n/a**	6
76							
79		*Other activity: please include short clinical description here and type*					
82		**End: Patient leaves office/facility**					
83		**POST-SERVICE PERIOD**					
84		**Start: Patient leaves office/facility**					
85	CA037	Conduct patient communications					
86	CA038	Coordinate post-procedure services			144		
87	CA038	Coordinate post-procedure services			11		
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes					
90		99212 27 minutes	2				1
91		99213 36 minutes	1				2
92		99214 53 minutes					
93		99215 63 minutes					
94	CA039	Post-operative visits (total time)	**90.0**	**0.0**	**0.0**	**0.0**	**99.0**
95							
98		*Other activity: please include short clinical description here and type*					
101		**End: with last office visit before end of global period**					

	A	B	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		MENDED	CURRENT		RECOMMENDED	
2			e # 67316	CPT Code # 67318		CPT Code # 67318	
3		*RUC Collaboration Website*	s surgery,	Strabismus surgery, any procedure, superior oblique muscle		Strabismus surgery, any procedure, superior oblique muscle	
4	Clinical Activity Code	Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO	ion or rocedure; e vertical excluding				
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	090		090		090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 76.46	$ -	$ 120.68	$ -	$ 82.02
8		TOTAL CLINICAL STAFF TIME	156.0	0.0	232.0	0.0	165.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	0.0	71.0	0.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	6.0	0.0	6.0	0.0	6.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	90.0	0.0	155.0	0.0	99.0
102	Supply Code	MEDICAL SUPPLIES					
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 6.86	$ -	$ 18.04	$ -	$ 7.86
104	SA050	pack, ophthalmology visit (no dilation)	2.0		4.0		1.0
105	SA082	pack, ophthalmology visit (w-dilation)	1.0		0.0		2.0
106	SG046	eye pad, sterile, strabismus	0.0		1.0		0.0
107	SG049	eye shield, non-fog	0.0		1.0		0.0
108	SG079	tape, surgical paper 1in (Micropore)	0.0		36.0		0.0
109	SH011	atropine 1% ophth	0.0		0.4		0.0
110	SH074	water, sterile for irrigation (250-1000ml uou)	0.0		1.0		0.0
111	SJ041	povidone soln (Betadine)	0.0		40.0		0.0
112		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*					
114	Equipment Code	EQUIPMENT					
115		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 10.32	$ -	$ 14.71	$ -	$ 11.46
116	EL005	lane, exam (oph)	36		126		72
117	EL006	lane, screening (oph)	54				27
118							
119							
120							
121							
122		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*					

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**CPT Code # 67320**		**CPT Code # 67320**		**CPT Cod**
3		***RUC Collaboration Website***				Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle		Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle		Strabismu on pati previous e or injury th involv
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**								
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CS	0.38					
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CS	0.38					
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CS	0.38					
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CS	0.38					
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CS	0.38					
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CS	0.38					
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CS	0.38					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CS	0.38					
23			L038A	COMT/COT/RN/CS	0.38					
26		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L038A	COMT/COT/RN/CS	0.38					
34	CA010	Obtain vital signs	L038A	COMT/COT/RN/CS	0.38					
35	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CS	0.38					
36	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CS	0.38					
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CS	0.38					
38	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CS	0.38					
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CS	0.38					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CS	0.38					
41	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CS	0.38					
42			L038A	COMT/COT/RN/CS	0.38					
45		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
50	CA019	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
51	CA020	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CS	0.38					
55			L038A	COMT/COT/RN/CS	0.38					
56		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CS	0.38					
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CS	0.38					
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CS	0.38					
63	CA025	Clean scope	L038A	COMT/COT/RN/CS	0.38					
64	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CS	0.38					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CS	0.38					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CS	0.38					
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CS	0.38					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L038A	COMT/COT/RN/CS	0.38					
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CS	0.38					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L038A	COMT/COT/RN/CS	0.38					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CS	0.38					
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L038A	COMT/COT/RN/CS	0.38					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CS	0.38					
74	CA036	Discharge day management	L038A	COMT/COT/RN/CS	0.38	**n/a**		**n/a**		**n/a**
75			L038A	COMT/COT/RN/CS	0.38					
78		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L038A	COMT/COT/RN/CS	0.38					
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CS	0.38					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27							
89		99213 36 minutes	36							
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CS	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L038A	COMT/COT/RN/CS	0.38					
96		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**CPT Code # 67320**		**CPT Code # 67320**		**CPT Cod**
3		***RUC Collaboration Website***				Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle		Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle		Strabismu on pati previous e or injury th involv
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**								
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102										
103										
104										
105										
106										
107										
108										
109										
110		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
112	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
113		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
114										
115										
116										
117										
118										
119										
120		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R	S	T	U
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMM**
2			**e # 67331**	**CPT Code # 67331**		**CPT Code # 67332**		**CPT Code # 67332**		**CPT Code # 67334**		**CPT Cod**
3		***RUC Collaboration Website***	ıs surgery	Strabismus surgery		Strabismus surgery		Strabismus surgery		Strabismus surgery		Strabismu
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO**	ent with ye surgery ıat did not e the	on patient with previous eye surgery or injury that did not involve the		on patient with scarring of extraocular muscles (eg, prior ocular		on patient with scarring of extraocular muscles (eg, prior ocular		by posterior fixation suture technique, with or without muscle recession		by posteri suture te with or muscle r
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**										
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
41	CA017	Sedate/apply anesthesia										
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018	Assist physician or other qualified healthcare professional---directly										
50	CA019	Assist physician or other qualified healthcare professional---directly										
51	CA020	Assist physician or other qualified healthcare professional---directly										
52	CA021	Perform procedure/service---NOT directly related to physician work time										
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022	Monitor patient following procedure/service, multitasking 1:4										
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff										
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds										
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
69	CA031	Review examination with interpreting MD/DO										
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
71	CA033	Perform regulatory mandated quality assurance activity (service period)										
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
73	CA035	Review home care instructions, coordinate visits/prescriptions										
74	CA036	Discharge day management		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037	Conduct patient communications										
85	CA038	Coordinate post-procedure services										
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	L	M	N	O	P	Q	R	S	T	U
1	RUC Practice Expense Spreadsheet		RENT	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMM
2			e # 67331	CPT Code # 67331		CPT Code # 67332		CPT Code # 67332		CPT Code # 67334		CPT Cod
3		*RUC Collaboration Website*	s surgery	Strabismus surgery		Strabismus surgery		Strabismus surgery		Strabismus surgery		Strabismu
4	Clinical Activity Code	Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO	ent with ye surgery hat did not ve the	on patient with previous eye surgery or injury that did not involve the		on patient with scarring of extraocular muscles (eg, prior ocular		on patient with scarring of extraocular muscles (eg, prior ocular		by posterior fixation suture technique, with or without muscle recession		by posteri suture te with or muscle r
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD										
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES										
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102												
103												
104												
105												
106												
107												
108												
109												
110		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
112	Equipment Code	EQUIPMENT										
113		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
114												
115												
116												
117												
118												
119												
120		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	V	W	X	Y	Z	AA	AB	AC	AD
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**e # 67334**	**CPT Code # 67335**		**CPT Code # 67335**		**CPT Code # 67340**		**CPT Code # 67340**	
3		***RUC Collaboration Website***	s surgery	Placement of		Placement of		Strabismus surgery		Strabismus surgery	
4	**Clinical Activity Code**	**Meeting Date: October 2020** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO**	or fixation chnique, without ecession	adjustable suture(s) during strabismus surgery, including postoperative		adjustable suture(s) during strabismus surgery, including postoperative		involving exploration and/or repair of detached extraocular muscle(s)		involving exploration and/or repair of detached extraocular muscle(s)	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**									
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms									
16	CA002	Coordinate pre-surgery services (including test results)									
17	CA003	Schedule space and equipment in facility									
18	CA004	Provide pre-service education/obtain consent									
19	CA005	Complete pre-procedure phone calls and prescription									
20	CA006	Confirm availability of prior images/studies									
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
23											
26		*Other activity: please include short clinical description here and type*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are									
34	CA010	Obtain vital signs									
35	CA011	Provide education/obtain consent									
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies									
38	CA014	Confirm order, protocol exam									
39	CA015	Setup scope (nonfacility setting only)									
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient									
41	CA017	Sedate/apply anesthesia									
42											
45		*Other activity: please include short clinical description here and type*									
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly									
50	CA019	Assist physician or other qualified healthcare professional---directly									
51	CA020	Assist physician or other qualified healthcare professional---directly									
52	CA021	Perform procedure/service---NOT directly related to physician work time									
55											
56		*Other activity: please include short clinical description here and type*									
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4									
61	CA023	Monitor patient following procedure/service, no multitasking									
62	CA024	Clean room/equipment by clinical staff									
63	CA025	Clean scope									
64	CA026	Clean surgical instrument package									
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
66	CA028	Review/read post-procedure x-ray, lab and pathology reports									
67	CA029	Check dressings, catheters, wounds									
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,									
69	CA031	Review examination with interpreting MD/DO									
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to									
71	CA033	Perform regulatory mandated quality assurance activity (service period)									
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry									
73	CA035	Review home care instructions, coordinate visits/prescriptions									
74	CA036	Discharge day management		**n/a**		**n/a**		**n/a**		**n/a**	
75											
78		*Other activity: please include short clinical description here and type*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications									
85	CA038	Coordinate post-procedure services									
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes									
89		99213 36 minutes									
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93											
96		*Other activity: please include short clinical description here and type*									
99		**End: with last office visit before end of global period**									

	A	B	V	W	X	Y	Z	AA	AB	AC	AD
1	RUC Practice Expense Spreadsheet		MENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2			e # 67334	CPT Code # 67335		CPT Code # 67335		CPT Code # 67340		CPT Code # 67340	
3		*RUC Collaboration Website*	s surgery	Placement of adjustable suture(s) during strabismus surgery, including postoperative		Placement of adjustable suture(s) during strabismus surgery, including postoperative		Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)		Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)	
4	Clinical Activity Code	Meeting Date: October 2020 Revision Date (if applicable): Tab: 18 Specialty: AAO	or fixation chnique, without ecession								
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD									
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES									
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102											
103											
104											
105											
106											
107											
108											
109											
110		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
112	Equipment Code	EQUIPMENT									
113		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
114											
115											
116											
117											
118											
119											
120		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source

October 2020

X-Rays at Surgery Add-On – Tab 19

In October 2018, CPT codes 74300 and 74328 were identified via the CMS/Other Source codes with 2017e Medicare utilization over 30,000 screen. The RUC reviewed the specialty societies' action plan in which they said they would survey 74300 and 74328, along with 74329 and 74330 as part of this family of services in April 2019. On the action plan, the specialty societies also identified 74301 and recommended referral to CPT for deletion. The RUC recommended 74301 for deletion and the specialty societies submitted a CCA to delete CPT code 74301 at the February 2020 CPT meeting. However, the specialty societies withdrew the deletion request after receiving feedback from the dominant provider of 74301 (general surgery), indicating the code is still necessary and should not be deleted. The general surgeons noted that 74301 would be primarily reported by hepatobiliary surgeons who are using cholangiography to help identify the anatomy prior to, during, and after a resection of likely the extrahepatic biliary tree, liver and potentially pancreatic head. For example, the Frey and Beger procedures in which the head of the pancreas is cored out and the bile duct is preserved. Although intraoperative ultrasound is largely replacing cholangiography, as documented by decreasing utilization of 74301, ultrasound has not yet completely replaced cholangiography for evaluating the biliary and pancreatic system and code 74301 is still applicable to reporting a second cholangiogram, when medically necessary. Since code 74301 was not surveyed with the X-Ray Bile Ducts family in April 2019, it was scheduled for survey at the April 2020 RUC meeting. This issue was postponed until October 2020.

74301 ***Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)***
The RUC recommends maintaining the work RVU of 0.21 for CPT code 74301. The RUC recommends 5 minutes of intra-service time and 1 minute of immediate post-service time. The specialty societies did not resurvey CPT code 74301 due to its low utilization (2019 Medicare utilization = 63) and the difficulty of obtaining 30 survey responses from providers with experience in the past 12 months. The RUC compared 74301 to 74300 *Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation* (April 2019 RUC recommended work RVU = 0.32). The RUC agreed with the specialty societies that add-on code 74301 will not require any additional pre-service work beyond the work required by the base code 74300. CPT code 74301 will require the same intra-service work and time as 74300, 5 minutes for the additional intraoperative cholangiography or pancreatography, and 1 minute to account for the physician work related to the report for the additional cholangiogram. The additional one minute is appropriate related to the two minutes required for 74300, which includes time for communicating results and recommendations that will not be duplicated. Based on comparison of the physician work and time for recently surveyed CPT code 74300, the RUC agreed that the current work RVU of 0.21 and total time of 6 minutes for CPT code 74301 is appropriate.

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For additional support the RUC referenced CPT code 93352 *Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)* (work RVU = 0.19 and 5 minutes intra-service and total time) and CPT code 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.21 and 6 minutes intra-service time, 8 minutes total time). **The RUC recommends 0.21 work RVUs for CPT code 74301**.

Affirm RUC Recommendations
The RUC affirms its April 2019 work RVU recommendations of 0.32 for CPT code 74300, 0.47 for CPT code 74328, 0.50 for CPT code 74329 and 0.70 for CPT code 74330.

Practice Expense
CPT code 74301 is typically performed in the facility setting; thus, no direct practice expense inputs are recommended.

RUC Database Flag
The RUC will flag CPT code 74301 as "do not use for comparison" in the RUC database since the work RVU recommendation was not based on a survey.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
74300 (f)	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	XXX	0.32 Affirmed April 2019 RUC recommendation
74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	ZZZ	0.21 (No Change)
74328 (f)	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	XXX	0.47 Affirmed April 2019 RUC recommendation

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74329 (f)	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	XXX	0.50 Affirmed April 2019 RUC recommendation
74330 (f)	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	XXX	0.70 Affirmed April 2019 RUC recommendation

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March 20, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVU Update Committee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Subject: Request to Reaffirm Physician Work and Practice Expense Recommendations for X-Ray Bile Ducts CPT codes (74328, 74329, 74300, 74330) From April 2019 RUC Meeting

Dear Dr. Smith,

In October 2018, CPT codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified on the CMS/Other Source codes with 2017e Medicare utilization over 30,000 screen. The American College of Radiology (ACR) drafted an action plan, which was presented to the Relativity Assessment Workgroup at the January 2019 RUC meeting. In the action plan, the ACR expanded the code family to include CPT codes 74329 *(Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation)* and 74330 *(Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation)* for survey, and referred CPT code 74301 *(Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure))* and recommended referral to CPT for deletion. At the April 2019 RUC meeting, the ACR surveyed CPT codes 74328, 74329, 74300, and 74330. The American Gastroenterological Association (AGA), American College of Gastroenterology (ACG), and American Society for Gastrointestinal Endoscopy (ASGE) surveyed the code family, excluding CPT code 74300.

At the February 2020 CPT meeting, the ACR, Radiological Society of North America (RSNA), and American Roentgen Ray Society (ARRS) submitted a code change application (CCA) to delete CPT code 74301. However, the societies withdrew the deletion request in November 2019 prior to the CPT meeting, after receiving feedback from the American College of Surgeons (ACS) and Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) that this code is still being used and should not be deleted. A separate recommendation letter for CPT code 74301 has been provided to the RUC for review at the April 2020 RUC meeting.

CPT codes 74328, 74329, 74300, and 74330 were recently reviewed and approved at the April 2019 RUC meeting Therefore, the ACR, AGA, ACG, and ASGE request to reaffirm the RUC recommendations for physician work and practice expense for these codes. These values are supported by survey data and the societies believe that the recommendation for CPT code 74301 will continue to maintain rank order. The physician work recommendations for all five codes are displayed in the table below. Additionally, the data summary and practice expense letter from the April 2019 RUC meeting are provided as attachments.

HEADQUARTERS
1891 Preston White Dr.
Reston, VA 20191-4326
703-648-8900

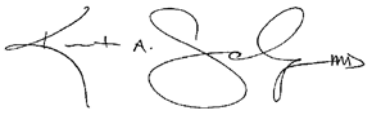
GOVERNMENT RELATIONS
505 Ninth St. N.W., Suite 910
Washington, DC 20004-2173
202-223-1670

CLINICAL RESEARCH
1818 Market St., Suite 1600
Philadelphia, PA 19103-3609
215-574-3150

CPT Code	Descriptor	Global Period	RUC Meeting	Proposed RVU	Pre Time	Intra Time	Post Time	Total Time
74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	ZZZ	April 2020	0.21	0	5	1	6
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	XXX	April 2019	0.32	2	5	2	9
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	XXX	April 2019	0.47	5	10	5	20
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	XXX	April 2019	0.50	5	10	5	20
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	XXX	April 2019	0.70	6	12	6	24

Thank you for your consideration of our request.

Sincerely,



Kurt A. Schoppe, MD
ACR RUC Advisor



Curtis Anderson, MD
SIR RUC Advisor



Shivan Mehta, MD
AGA RUC Advisor



R. Bruce Cameron, MD, FACG
ACG RUC Advisor



Seth A. Gross, MD, FACG
ASGE RUC Advisor

Enclosed:
X-Ray Bile Ducts Data Summary approved at the April 2019 RUC Meeting
X-Ray Bile Ducts PE Letter approved at the April 2019 RUC Meeting

March 30, 2020

Peter Smith, MD
Chair, AMA/Specialty Society RVS Update Committee (RUC)
American Medical Association
330 North Wabash Ave.
Chicago, IL 60611-5885

Re: Tab 19, CPT Code 74301, *Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)*

Dear Dr. Smith,

In October 2018, CPT code 74300 was identified as a CMS/Other source code with 2017e Medicare utilization over 30,000. The professional component for this code is typically provided by diagnostic radiology (81%).

In January 2019, the American College of Radiology (ACR) submitted an Action Plan to the RAW. Add-on code 74301 was indicated as a family code to 74300. In their Action Plan, the ACR recommended referring 74301 to CPT for further review and possible deletion.

In November 2019, the ACR, the Radiological Society of North America (RSNA) and the American Roentgen Ray Society (ARRS) submitted a code change application (CCA) to delete code 74301 based on "a very low volume of less than 100 claims in 2017 according to the 2019 RUC database." Surgical societies were not asked to co-sponsor the code change application as a simple oversight.

Code 74301 is typically provided by surgeons (62%, 2018 Medicare utilization = 113); primarily general surgeons, but also surgical oncologists and colon and rectal surgeons. The American College of Surgeons' Advisor comments to the CPT Editorial Panel indicated support for deletion of code 74301, but questioned how additional medically-necessary cholangiography or pancreatography would be reported: " *If two (or more) injections are necessary, will you be able to report 74300, 74300-59 to account for the second set?*" This question was prompted because the proposed instructional note stated (74301 has been deleted. To report, use 74300), but there was no guidance on reporting multiple units. Due to this confusion, the CCA was withdrawn. The RUC staff subsequently placed code 74301 on an LOI for survey.

We believe that 74301 would be primarily reported by hepatobiliary surgeons who are using cholangiography to help identify the anatomy prior to, during, and after a resection of likely the extrahepatic biliary tree, liver and potentially pancreatic head. For example, the Frey and Beger procedures in which the head of the pancreas is cored out and the bile duct is preserved. Although intraoperative ultrasound is largely replacing cholangiography, as documented by decreasing utilization of 74301, ultrasound has not yet completely replaced cholangiography for evaluating the biliary and pancreatic system and code 74301 is still applicable to reporting a second set.

We have not surveyed this code because of the low utilization. Clearly, we would have great difficulty in getting a response from 30 providers who have reported this code in the past 12 months—or even in the past 5 years. In hindsight, the issue of volume should have been brought up at the RAW with a recommendation that 74301 not require a survey.

With respect to the time and work RVU value for add-on code 74301, we recommend maintaining the current inputs of 6 minutes and 0.21 work RVUs based on a comparison to the base code 74300.

74300/74301 Comparison of Pre-, Intra- and Post-Work and Time

- **Add-on code 74301 will not require additonal pre-work as described for 74300 because pre-work is completed prior to the surgical procedure and a need for a second cholangiogram is not known at this time.**
  Pre-time = zero.

Pre-service description for 74300: *Review the indication for the examination, any pertinent clinical history and prior imaging studies to become familiar with the patient's clinical scenario and anatomy. Confirm that evaluation of the biliary or pancreatic ductal system is appropriate and plan for the procedure, including reviewing any potential contraindications. The physician dresses in protective radiation appropriate attire for the procedure and instructs the radiology technologist to prepare and operate the imaging equipment required and the proper settings for the imaging equipment for the procedure. The physician also reviews the procedure with the patient and any family present, provides the patient with examination instructions, confirms understanding and answers any questions as needed.*

- **Add-on code 74301 wil require all of the intra-work described in 74300.**
  Intra-time = 5 minutes (same as 74300)

Intra-service description for 74300: *After the endoscopist accesses the sphincter and the desired ductal system (procedure details reported separately), the physician positions or re-positions the patient and uses fluoroscopy and angulation of the image intensifier to help direct the guidewire and contrast injection into an appropriate position. Inject contrast and perform imaging and re-position the patient as needed for evaluation and mapping of the appropriate path and real-time evaluation of anatomy and pathology. Obtain or supervise acquisition of spot images or other imaging confirmation as needed. Interpret all images obtained during the examination and compare with any prior examinations and/or relevant images. Dictate the report.*

- **Add-on code 74301 wil require one-half of the post-work described in 74300; primarily the work related to the report for the additional cholangiogram. The work related to communicating results and recommendations will not be duplicated**
  Post-time = 1 minute (one-half of the time for 74300)

Post-service description for 74300: *Review, edit and sign the report for the medical record that describes the image guidance procedure, including pertinent anatomic and pathologic findings. Communicate the results of the procedure to the referring physician and patient/family. Recommend any follow up actions based on findings on imaging.*

Based on comparison of pre-, intra- and post-work for recently surveyed and high volume code 74300 to low volume add-on code 74301, we believe the current work RVU (0.21) and time (6 minutes) for 74301 is supported; both the time and work RVU for 74301 is two-thirds of the RUC recommended values for 74300.

Code	Descriptor	Global	RVU	IWPUT	WPUT	Total	Pre	Intra	Post
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	**XXX**	**0.32**	0.046	0.036	**9**	2	5	2
74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	**ZZZ**	**0.21**	0.038	0.035	**6**	0	5	1

Regarding practice expense, this is an add-on service that would only be reported in the facility setting and therefore no practice expense inputs are recommended.

Thank you for consideration of this information and recommendation.

Sincerely,

Charles Mabry, MD, FACS
American College of Surgeons RUC Advisor

Don Selzer, MD, FACS
Society of American Gastrointestinal and Endoscopic Surgeons RUC Advisor

Kurt A. Schoppe, MD
American College of Radiology RUC Advisor

Curtis Anderson, MD
Society of Interventional Radiology RUC Advisor

SS Rec Summary

ISSUE: X-Rays At Surgery Add-On

TAB: 19

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	74021	Radiologic examination, abdomen; 3 or more views	6	0.0563			0.27			6	1					4			1					
2nd REF	93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	4	0.0271			0.45			18	3					10			5					
3rd REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic	4	0.0223			0.38			17	2					15								
CMS/Other	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation		#DIV/0!			0.36			9														
SVY	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	30	0.0701	0.23	0.32	0.44	0.70	1.00	9	2			2	4	5	6	25	2	0	10	20	30	600
SVY - Subset	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	24	0.0721	0.23	0.32	0.45	0.73	1.00	9	2			3	4	5	5	12	2	0	10	25	35	600
SVY - Random	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	6	0.0576	0.29	0.36	0.40	0.48	1.00	10	3			2	4	5	7	25	2	0	1	8	14	100
REC	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation		0.0461			0.32			9	2					5			2					

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic	13	0.0223			0.38			17	2					15								
2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device)	9	0.0184			1.50			75	15					45			15					
CMS/Other	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation		#DIV/0!			0.70			16														
SVY	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	65	0.0576	0.23	0.47	0.80	1.00	12.00	20	5			3	5	10	30	90	5	0	20	50	120	350
SVY - ACR	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	30	0.0936	0.23	0.36	0.58	0.87	1.25	10	3			3	4	5	6	18	2	0	6	18	50	300
SVY - Subset	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	24	0.1136	0.23	0.37	0.68	0.89	1.10	10	3			3	4	5	6	18	2	0	10	23	53	300
SVY - Random	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	6	0.0831	0.31	0.38	0.55	0.67	1.25	11	4			3	5	5	6	15	2	0	0	8	19	44
SVY - GI	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	35	0.0154	0.30	0.69	0.91	1.60	12.00	50	10			5	13	30	53	90	10	5	55	100	165	350
REC	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation		0.0246			0.47			20	5					10			5					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
5						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
28						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
29	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
30	1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic	13	0.0223			0.38			17		2				15								
31	2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device)	8	0.0184			1.50			75	15					45			15					
32	CMS/Other	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation		#DIV/0!			0.70			15														
33	SVY	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	64	0.0576	0.23	0.50	0.80	1.13	15.00	20	5			3	5	10	35	120	5	0	5	18	50	500
34	SVY - ACR	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	30	0.0866	0.23	0.39	0.59	0.93	1.33	12	4			3	4	5	7	18	3	0	3	10	20	100
35	SVY - Subset	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	24	0.0951	0.23	0.37	0.61	0.94	1.32	11	3			3	4	5	7	18	3	0	3	11	21	100
36	SVY - Random	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	6	0.0635	0.31	0.43	0.56	0.67	1.33	14	5			3	5	6	6	16	3	0	0	3	12	20
37	SVY - GI	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	34	0.0128	0.30	0.73	0.96	1.50	15.00	57	11			5	11	33	60	120	13	4	15	28	80	500
38	REC	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation		0.0276			0.50			20	5					10			5					
39																									
40						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
41	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
42	1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic	13	0.0223			0.38			17		2				15								
43	2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device)	10	0.0184			1.50			75	15					45			15					
44	Aug-95	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation		0.0300			0.90			30						30								
45	SVY	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	65	0.0534	0.23	0.70	0.91	1.50	18.00	24	6			3	6	12	40	120	6	0	10	30	50	500
46	SVY - ACR	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	30	0.0972	0.23	0.39	0.74	0.95	1.90	13	4			3	5	6	9	25	3	0	1	10	25	500
47	SVY - Subset	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	24	0.1059	0.23	0.38	0.77	0.98	1.90	12	3			3	5	6	8	25	3	0	3	10	26	500
48	SVY - Random	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	6	0.0673	0.34	0.60	0.65	0.85	1.50	15	5			4	6	7	9	15	3	0	0	5	18	32
49	SVY - GI	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	35	0.0132	0.35	0.80	1.00	1.83	18.00	57	12			6	15	30	68	120	15	3	28	50	90	450
50	REC	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation		0.0359			0.70			24	6					12			6					

SS Rec Summary

ISSUE: Excision of bone

TAB: 84

source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5				1	1.0								1							
2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5					1.0								1	1					
CURRENT	55555	abc		0.053			5.00			133	17					27			8				1	1.0								1						
SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0								1						
REC	55555	abc		0.020			4.25			142	17	1	3			30			10								1	1.0				1						

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
3	**ISSUE:** X-Rays at Surgery Add-On																								
4	**TAB:** 19																								
5						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
7	APR2019 REC	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation		0.0461			0.32			9	2					5			2					
8	CMS/Other	74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)					0.21			6														
9	REC	74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)		0.0375			0.21			6						5			1					

SS Rec Summary

ISSUE: Excision of bone

TAB: 84

source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5				1	1.0								1							
2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5					1.0								1	1					
CURRENT	55555	abc		0.053			5.00			133	17					27			8				1	1.0								1						
SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0								1						
REC	55555	abc		0.020			4.25			142	17	1	3			30			10								1	1.0				1						

April 2, 2019

Peter Smith, MD, RUC Chair
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Subject: Practice Expense Recommendations for X-Ray Bile Ducts

Dear Dr. Smith,

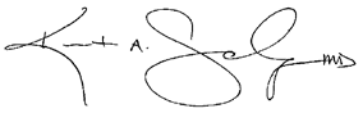
The American College of Radiology (ACR), American Society for Gastrointestinal Endoscopy (ASGE), American Gastroenterological Association (AGA), and American College of Gastroenterology (ACG) have reviewed the RUC database practice expense inputs for the x-ray of the bile ducts codes listed below.

- **74300** - *Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation*
- **74328** - *Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation*
- **74329** - *Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation*
- **74330** - *Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation*

We have determined that these procedures are only performed in the facility setting. Therefore, the specialties will not be submitting practice expense recommendations for the x-ray of the bile ducts family.

Should you have any questions, please feel free to contact ACR RUC staff, Stephanie Le, at 800-227-5463, ext. 4584 or via email sle@acr.org.

Sincerely,



Kurt A. Schoppe, MD
ACR RUC Advisor



Seth Gross, MD, FACG
ASGE RUC Advisor



Shivan Mehta, MD
AGA RUC Advisor



Bruce Cameron, MD, FACG
ACG RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Utilization over 30,000

April 2019

X-Ray Bile Ducts – Tab 16

In January 2019, the Relativity Assessment Workgroup (RAW) reviewed CMS/Other Source codes with 2017e Medicare utilization over 30,000 and codes 74300 and 74328 were both identified as part of this screen. The RUC recommended these services be surveyed for April 2019. Codes 74329 and 74330 were also included as part of the same code family. CPT code 74301 was referred to CPT for deletion.

74300 ***Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation***
The RUC reviewed the survey results from 30 radiologists and recommends the survey 25th percentile work RVU of 0.32 and the following physician time components: 2 minutes of pre-service time, 5 minutes of intra-service time and 2 minutes of post-service time. To justify a work value of 0.32, the RUC compared the survey code to CPT codes 73522 *Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views* (work RVU= 0.29, intra-service time of 5 minutes, total time of 7 minutes) and 71048 *Radiologic examination, chest; 4 or more views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 7 minutes) and noted that all three services involve identical intra-service time. The survey code involves 2 more minutes of total time, justifying the slightly higher valuation and placing it in appropriate rank order with both reference codes. **The RUC recommends a work RVU of 0.32 for CPT code 74300.**

74328 ***Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation***
The RUC reviewed the survey results from 65 radiologists and gastroenterologists and recommends the survey 25th percentile work RVU of 0.47 and the following physician time components: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. To justify a work value of 0.47, the RUC compared the survey code to MPC code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)* (work RVU= 0.45, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services involve identical intra-service time, whereas the survey code involves more total time and should be valued somewhat higher. The RUC also compared the survey code to CPT code 96573 *Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a*

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physician or other qualified health care professional, per day (work RVU= 0.48, intra-service time of 10 minutes, total time of 20 minutes) and noted that both services involve an identical amount of intra-service and total time, as well as similar physician work intensity, and therefore should be valued similarly. **The RUC recommends a work RVU of 0.47 for CPT code 74328.**

74329 *Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation*
The RUC reviewed the survey results from 64 radiologists and gastroenterologists and recommends the survey 25th percentile work RVU of 0.50 and the following physician time components: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC noted that although codes 74328 and 74329 involve an identical amount of time, CPT code 74329 is a somewhat more intense service to perform because the evaluation of the pancreatic ductal system is more intense than the evaluation of the biliary system due to differences in anatomy. To justify a work value of 0.50, the RUC compared the survey code to CPT code 93931 *Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study* (work RVU= 0.50, intra-service time of 10 minutes and total time of 20 minutes) and noted that both services involve an identical amount of time and physician work intensity and should be valued the same. The RUC also compared the survey code to CPT code 78014 *Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)* (work RVU= 0.50, intra-service time of 10 minutes, total time of 20 minutes) and noted that both services involve an identical amount of time and physician work intensity and should be valued the same. **The RUC recommends a work RVU of 0.50 for CPT code 74329.**

74330 *Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation*
The RUC reviewed the survey results from 65 radiologists and gastroenterologists and recommends the survey 25th percentile work RVU of 0.70 and the following physician time components: 6 minutes of pre-service time, 12 minutes of intra-service time and 6 minutes of post-service time. To justify a work value of 0.70, the RUC compared the survey code to CPT code 76641 *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete* (work RVU= 0.73, intra-service time of 12 minutes, total time of 22 minutes) and noted that both services involve identical intra-service, similar total times and a similar amount of physician work. The RUC also compared the survey code to CPT code 95976 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVU= 0.73, intra-service time of 11 minutes, total time of 23 minutes) and noted that the survey code involves 1 more minute of intra-service time and total time; both services involve a similar intensity and amount of physician work and should be valued similarly. **The RUC recommends a work RVU of 0.70 for CPT code 74330.**

Practice Expense
These services are facility-only and have no direct practice inputs.

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Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	XXX	0.32
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	XXX	0.47
74329 **(f)**	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	XXX	0.50
74330 **(f)**	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	XXX	0.70

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74300 Tracking Number Original Specialty Recommended RVU: **0.32**
Presented Recommended RVU: **0.32**
Global Period: XXX Current Work RVU: **0.36** RUC Recommended RVU: **0.32**

CPT Descriptor: Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female undergoes cholecystectomy for gallstones. Intra-operative imaging is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the indication for the examination, any pertinent clinical history and prior imaging studies to become familiar with the patient's clinical scenario and anatomy. Confirm that evaluation of the biliary or pancreatic ductal system is appropriate and plan for the procedure, including reviewing any potential contraindications. The physician dresses in protective radiation appropriate attire for the procedure and instructs the radiology technologist to prepare and operate the imaging equipment required and the proper settings for the imaging equipment for the procedure. The physician also reviews the procedure with the patient and any family present, provides the patient with examination instructions, confirms understanding and answers any questions as needed.

Description of Intra-Service Work: After the endoscopist accesses the sphincter and the desired ductal system (procedure details reported separately), the physician positions or re-positions the patient and uses fluoroscopy and angulation of the image intensifier to help direct the guidewire and contrast injection into an appropriate position. Inject contrast and perform imaging and re-position the patient as needed for evaluation and mapping of the appropriate path and real-time evaluation of anatomy and pathology. Obtain or supervise acquisition of spot images or other imaging confirmation as needed. Interpret all images obtained during the examination and compare with any prior examinations and/or relevant images. Dictate the report.

Description of Post-Service Work: Review, edit and sign the report for the medical record that describes the image guidance procedure, including pertinent anatomic and pathologic findings. Communicate the results of the procedure to the referring physician and patient/family. Recommend any follow up actions based on findings on imaging.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2019		
Presenter(s):	Kurt Schoppe, MD; Andrew Moriarity, MD; Lauren Golding, MD;		
Specialty Society(ies):	American College of Radiology		
CPT Code:	74300		
Sample Size:	2750	**Resp N:** 30	**Response:** 1.0 %
Description of Sample:	The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastorintestinal procedures).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	30.00	600.00
Survey RVW:	0.23	0.32	**0.44**	0.70	1.00
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	4.00	**5.00**	6.00	25.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74300	**Recommended Physician Work RVU: 0.32**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**2.00**	**0.00**	**2.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74021	XXX	0.27	**RUC Time**

CPT Descriptor Radiologic examination, abdomen; 3 or more views

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93971	XXX	0.45	**RUC Time**

CPT Descriptor Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	95,291

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71111	XXX	0.32	**RUC Time**	30,514

CPT Descriptor 2 Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views

Other Reference CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 20.0 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 13.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 74300	Top Key Reference CPT Code: 74021	2nd Key Reference CPT Code: 93971
Median Pre-Service Time	2.00	1.00	3.00
Median Intra-Service Time	5.00	4.00	10.00
Median Immediate Post-service Time	2.00	1.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**9.00**	**6.00**	**18.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	67%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	17%	67%
Physical effort required	17%	33%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	50%	33%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	25%	50%
Physical effort required	0%	75%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	0%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified on the CMS/Other – Utilization Over 30,000 screen. An action plan was

submitted for the January 2019 meeting, expanding the family to include CPT codes 74329 *(Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation)*, 74330 *(Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation)*, and 74301 *(Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure))*. The specialties agreed to survey 74300, 74328, 74329, and 74330 for the April 2019 RUC, while concurrently sending CPT code 74301 to CPT for review and possible deletion.

Survey Process

The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures).

Both specialties surveyed CPT codes 74328, 74329, and 74330, but only ACR surveyed CPT code 74300.

Work RVU Recommendation

The specialties recommend the 25th percentile survey value for all four x-ray bile duct codes.

For CPT code 74300, the specialties recommend 0.32 RVUs, which is below the current CMS/Other value of 0.36 RVUs.

Time Recommendation

The expert panel recommends the median survey times for CPT code 74300: 2 minutes pre, 5 minutes intra, and 2 minutes post, for a total of 9 minutes.

Key Reference Services

The most commonly chosen reference codes were:

- **74021** *(Radiologic examination, abdomen; 3 or more views)*, chosen by 20% of respondents,
- **93971** *(Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study)*, chosen by 13% of respondents, and
- **77001** *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure))*, chosen by 13% of respondents.

CPT code 74300 involves interpretation of radiographic images obtained during a procedure and compares well with the first key reference service, 74021, which is an x-ray code also involving image interpretation. CPT code 74021 has one minute less of intra-service time, resulting in less total time and a slightly lower RVU.

CPT code 74300 also compares well to the second key reference service, 93971, which involves interpretation of ultrasound images and has 5 minutes more of intra-service time, resulting in a higher RVU. An equal number of survey respondents chose CPT code 77001 as the second key reference service, which is a ZZZ fluoroscopy procedure with higher total time and a resulting higher RVU. Despite the different global period, the ZZZ code is an appropriate comparison because it describes similar work as the surveyed code (using imaging and its interpretation to guide an underlying procedure).

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT	Global
74021	Radiologic examination, abdomen; 3 or	0.27	1	4	1	6	0.0563	XXX

	more views							
74300	**Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**	**0.32**	**2**	**5**	**2**	**9**	**0.0461**	**XXX**
77001	Fluoro guidance for CVA device placement, replacement, or removal	0.38	2	15		17	0.0223	ZZZ
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	0.45	3	10	5	18	0.0271	XXX

MPC Codes

CPT code 74300 compares well to MPC code 71111 *(Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views)* which is an x-ray code that involves evaluation of the ribs in multiple planes and has an identical total time and RVU.

CPT code 74300 also compares well with 77001 *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)),* which is also a radiology supervision and interpretation code, and one of the two most commonly chosen key reference services by survey participants. Lastly, MPC code 92081 *(Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent))* is a non-radiology code with similar total time and slightly lower RVU, which supports the relativity of 74300 to other codes within the RBRVS.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	0.30	3	7		10	0.0333
71111	Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views	0.32	1	7	1	9	0.0393
74300	**Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**	**0.32**	**2**	**5**	**2**	**9**	**0.0461**
77001	Fluoro guidance for CVA device placement, replacement, or removal	0.38	2	15		17	0.0223

Summary of Recommendation

Our expert panel recommends 0.32 RVUs for CPT code 74300, with service period times of 2, 5, and 2 minutes. This maintains appropriate relativity within the family, as shown in the table below.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
74300	**Cholangiography and/or pancreatography; intraoperative, radiological supervision and**	**0.32**	**2**	**5**	**2**	**9**	**0.0461**

	interpretation						
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	0.47	5	10	5	20	0.0246
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	0.50	5	10	5	20	0.0276
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	0.70	6	12	6	24	0.0359

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74300

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 108171
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74300 is estimated to be provided 108,171 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 89583 Percentage 82.81 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 36,057 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74300 is estimated to be provided 36,057 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 29861 Percentage 82.81 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74300

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74328 Tracking Number Original Specialty Recommended RVU: **0.47**
Presented Recommended RVU: **0.47**
Global Period: XXX Current Work RVU: **0.70** RUC Recommended RVU: **0.47**

CPT Descriptor: Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old patient presents with acute biliary pancreatitis and elevated liver function enzymes. A common bile duct stone is suggested by Magnetic resonance cholangiopancreatography (MRCP). Endoscopic retrograde cholangiopancreatography (ERCP) with catheterization of the biliary ductal system is performed with imaging.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination, any pertinent clinical history and prior imaging studies to become familiar with the patient's anatomy. Confirm that evaluation of the biliary ductal system is appropriate and plan for the procedure, including potential contraindications. The physician dresses in radiation attire and instructs the radiologic technologist to prepare and operate the imaging equipment required and the proper settings for the imaging equipment. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: After the endoscopist accesses the sphincter (reported separately), the physician positions the patient and uses fluoroscopy and angulation of the image intensifier to help direct the guidewire and injection device into an appropriate position. Inject contrast and perform imaging and re-position the patient as needed for evaluation and mapping of the appropriate path and real-time evaluation of anatomy and pathology. Obtain or supervise acquisition of spot images or other imaging confirmation as needed. Interpret all images obtained during the examination and compare with prior examinations. Dictate the report.

Description of Post-Service Work: Review, edit and sign the report for the medical record that describes the guidance procedure, including pertinent anatomic and pathologic findings. Communicate the results of the procedure to the referring physician and patient when appropriate. Recommend any follow up actions based on findings on imaging.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2019		
Presenter(s):	Kurt Schoppe, MD; Andrew Moriarity, MD; Lauren Golding, MD; R. Bruce Cameron, MD; Shivan Mehta, MD; Seth A. Gross, MD		
Specialty Society(ies):	American College of Radiology, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy		
CPT Code:	74328		
Sample Size:	3250	**Resp N:** 65	**Response:** 2.0 %
Description of Sample:	The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures). The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	120.00	350.00
Survey RVW:	0.23	0.47	**0.80**	1.00	12.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	5.00	**10.00**	30.00	90.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74328	**Recommended Physician Work RVU: 0.47**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77021	XXX	1.50	**RUC Time**

CPT Descriptor Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93923	XXX	0.45	**RUC Time**	461,389

CPT Descriptor 1 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	12,744,579

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 20.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 13.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 74328	Top Key Reference CPT Code: 77001	2nd Key Reference CPT Code: **77021**
Median Pre-Service Time	5.00	2.00	15.00
Median Intra-Service Time	10.00	15.00	45.00
Median Immediate Post-service Time	5.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**17.00**	**75.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	8%	23%	23%	46%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	15%	77%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	31%	62%
Physical effort required	8%	38%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	15%	23%	62%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	44%	44%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	22%	78%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	11%	89%
Physical effort required	0%	11%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	11%	89%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified on the CMS/Other – Utilization Over 30,000 screen. An action plan was submitted for the January 2019 meeting, expanding the family to include CPT codes 74329 *(Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation)*, 74330 *(Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation)*, and 74301 *(Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure))*. The specialties agreed to survey 74300, 74328, 74329, and 74330 for the April 2019 RUC, while concurrently sending CPT code 74301 to CPT for review and possible deletion.

Survey Process

The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures).

The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.

Both specialties surveyed CPT codes 74328, 74329, and 74330, but only ACR surveyed CPT code 74300.

Work RVU Recommendation

The specialties recommend the 25th percentile survey value for all four x-ray bile duct codes.

For CPT code 74328, the specialties recommend 0.47 RVUs, which is below the current CMS/Other value of 0.70 RVUs.

Time Recommendation

The expert panel recommends the median survey times for CPT code 74328: 5 minutes pre, 10 minutes intra, and 5 minutes post, for a total of 20 minutes.

There is a bimodal distribution between the surveyed specialties with respect to the service period times. Radiologists uniformly indicated lower service period times than surveyed Gastroenterologists. We believe this accurately reflects the differing work performed by the two specialties as described by this code, and both are consistent with CPT standards. The median values of the aggregated data are presented here, consistent with RUC process.

Key Reference Services

The most commonly chosen reference codes were:

- **77001** *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure))*, chosen by 20% of respondents, and
- **77021** *(Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation)*, chosen by 14% of respondents.

CPT code 74328 involves interpretation of radiographic images obtained during a procedure. It compares well with the first key reference service, 77001, a radiologic supervision and interpretation code with less total time and a lower RVU. Though 77001 is a ZZZ code, it describes a similar type of work as the surveyed code and is a valid comparison.

CPT code 74328 also compares well to the second key reference service, 77021, a radiologic supervision and interpretation code with significantly higher total time, resulting in a proportionally higher RVU. This is appropriate when considering the differences in intensity, as well as pre- and post-service work between these services.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT	Global
77001	Fluoro guidance for CVA device placement, replacement, or removal	0.38	2	15		17	0.0223	ZZZ
74328	**Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**	**0.47**	**5**	**10**	**5**	**20**	**0.0246**	**XXX**
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) RS&I	1.50	15	45	15	75	0.0184	XXX

MPC Codes

CPT code 74328 also compares well to MPC code 93923 *(Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)),* which is an imaging test interpretation code that has identical intra-service time but slightly lower total time, resulting in a slightly lower RVU.

CPT code 74328 also compares well with MPC code 99212 *(Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting*

problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.), which is an office visit code with identical intra-service time and nearly identical RVU.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels, or single level study with provocative functional maneuvers	0.45	3	10	3	16	0.0316
74328	**Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**	**0.47**	**5**	**10**	**5**	**20**	**0.0246**
99212	Office or other outpatient visit for the E&M of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	0.48	2	10	4	16	0.0346

Summary of Recommendation

Our expert panel recommends 0.47 RVUs for CPT code 74328, with service period times of 5, 10, and 5 minutes. This maintains appropriate relativity within the family, as shown in the table below.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	0.32	2	5	2	9	0.0461
74328	**Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**	**0.47**	**5**	**10**	**5**	**20**	**0.0246**
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	0.50	5	10	5	20	0.0276
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	0.70	6	12	6	24	0.0359

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74328

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 183681
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74328 is estimated to be provided 183,681 times nationally in a one-year period.

Specialty Gastroenterology Frequency 68779 Percentage 37.44 %

Specialty Diagnostic Radiology Frequency 106455 Percentage 57.95 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 61,227 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74328 is estimated to be provided 61,227 times nationally in a one-year period to Medicare patients.

Specialty Gastroenterology Frequency 22926 Percentage 37.44 %

Specialty Diagnostic Radiology Frequency 35485 Percentage 57.95 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74328

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74329 Tracking Number Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX Current Work RVU: **0.70** RUC Recommended RVU: **0.50**

CPT Descriptor: Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old patient presents with symptomatic chronic pancreatitis. Magnetic resonance cholangiopancreatography (MRCP) reveals a dilated upstream pancreatic duct with a dominant, focal downstream pancreatic duct stricture. Endoscopic retrograde cholangiopancreatography (ERCP) with catheterization of the pancreatic ductal system is performed with imaging.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination, any pertinent clinical history and prior imaging studies to become familiar with the patient's anatomy. Confirm that evaluation of the pancreatic ductal system is appropriate and plan for the procedure, including potential contraindications. The physician dresses in radiation attire and instructs the radiologic technologist to prepare and operate the imaging equipment required and the proper settings for the imaging equipment. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: After endoscopist accesses the sphincter (reported separately), the physician positions the patient and uses fluoroscopy and angulation of the image intensifier to help direct the guidewire and injection device into an appropriate position. Inject contrast and perform imaging and re-position the patient as needed for evaluation and mapping of the appropriate path and real-time evaluation of anatomy and pathology. Obtain or supervise acquisition of spot images or other imaging confirmation as needed. Interpret all images obtained during the examination and compare with prior examinations. Dictate the report.

Description of Post-Service Work: Review, edit and sign the report for the medical record that describes the guidance procedure, including pertinent anatomic and pathologic findings. Communicate the results of the procedure to the referring physician and patient when appropriate. Recommend any follow up actions based on findings on imaging.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2019		
Presenter(s):	Kurt Schoppe, MD; Andrew Moriarity, MD; Lauren Golding, MD; R. Bruce Cameron, MD; Shivan Mehta, MD; Seth A. Gross, MD		
Specialty Society(ies):	American College of Radiology, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy		
CPT Code:	74329		
Sample Size:	3250	**Resp N:** 64	**Response:** 1.9 %
Description of Sample:	The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures). The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**18.00**	50.00	500.00
Survey RVW:	0.23	0.50	**0.80**	1.13	15.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	5.00	**10.00**	35.00	120.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74329	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77021	XXX	1.50	**RUC Time**

CPT Descriptor Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	12,744,579

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76519	XXX	0.54	**RUC Time**	248,557

CPT Descriptor 2 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

Other Reference CPT Code	Global	Work RVU	Time Source
93923	XXX	0.45	**RUC Time**

CPT Descriptor Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 20.3 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 12.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 74329	**Top Key Reference CPT Code:** 77001	**2nd Key Reference CPT Code:** **77021**
Median Pre-Service Time	5.00	2.00	15.00
Median Intra-Service Time	10.00	15.00	45.00
Median Immediate Post-service Time	5.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**17.00**	**75.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	15%	31%	54%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	8%	85%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	46%	46%
Physical effort required	8%	23%	69%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	15%	77%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	13%	50%	38%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	13%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	13%	88%
Physical effort required	0%	13%	88%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	13%	88%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified on the CMS/Other – Utilization Over 30,000 screen. An action plan was submitted for the January 2019 meeting, expanding the family to include CPT codes 74329 *(Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation)*, 74330 *(Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation)*, and 74301 *(Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure))*. The specialties agreed to survey 74300, 74328, 74329, and 74330 for the April 2019 RUC, while concurrently sending CPT code 74301 to CPT for review and possible deletion.

Survey Process

The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures).

The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.

Both specialties surveyed CPT codes 74328, 74329, and 74330, but only ACR surveyed CPT code 74300.

Work RVU Recommendation

The specialties recommend the 25th percentile survey value for all four x-ray bile duct codes.

For CPT code 74329, the specialties recommend 0.50 RVUs, which is below the current CMS/Other value of 0.70 RVUs.

Time Recommendation

The expert panel recommends the median survey times for CPT code 74329: 5 minutes pre, 10 minutes intra, and 5 minutes post, for a total of 20 minutes.

There is a bimodal distribution between the surveyed specialties with respect to the service period times. Radiologists uniformly indicated lower service period times than surveyed Gastroenterologists. We believe this accurately reflects the differing work performed by the two specialties as described by this code, and both are consistent with CPT standards. The median values of the aggregated data are presented here, consistent with RUC process.

Key Reference Services

The most commonly chosen reference codes were:

- **77001** *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure))*, chosen by 20% of respondents, and
- **77021** *(Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation)*, chosen by 12% of respondents.

CPT code 74329 involves the interpretation of radiographic images obtained during a procedure. It compares well with the first key reference service, 77001, which is a radiologic supervision and interpretation code that has less total time and a lower RVU. Though 77001 is a ZZZ code, it describes a similar type of work as the surveyed code and is a valid comparison.

CPT code 74329 also compares well to the second key reference service, 77021, which is a radiologic supervision and interpretation code with significantly higher total time, resulting in a proportionally higher RVU. This is appropriate when considering the differences in intensity, as well as pre- and post-service work, between these services.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT	Global
77001	Fluoro guidance for CVA device placement, replacement, or removal	0.38	2	15		17	0.0223	ZZZ
74329	**Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**	**0.50**	**5**	**10**	**5**	**20**	**0.0276**	**XXX**
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) RS&I	1.50	15	45	15	75	0.0184	XXX

MPC Codes

CPT code 74329 compares well to MPC code 93923 *(Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)),* which is an imaging test interpretation code that has identical intra-service and total time, with similar RVU.

CPT code 74329 compares well with MPC code 99212 *(Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or*

family.), which is an office visit code with identical intra-service time and less total time, resulting in a lower RVU.

CPT code 74329 also compares well with MPC code 76519 *(Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation),* which is an ophthalmic ultrasound interpretation code with identical intra-service time and slightly higher total time, resulting in a slightly higher RVU.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels, or single level study with provocative functional maneuvers	0.45	3	10	3	16	0.0316
99212	Office or other outpatient visit for the E&M of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	0.48	2	10	4	16	0.0346
74329	**Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**	**0.50**	**5**	**10**	**5**	**20**	**0.0276**
76519	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation	0.54	2	10	10	22	0.0271

Summary of Recommendation

Our expert panel recommends 0.50 RVUs for CPT code 74329, with service period times of 5, 10, and 5 minutes. This maintains appropriate relativity within the family, as shown in the table below.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	0.32	2	5	2	9	0.0461
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	0.47	5	10	5	20	0.0246
74329	**Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**	**0.50**	**5**	**10**	**5**	**20**	**0.0276**
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	0.70	6	12	6	24	0.0359

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74329

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8,955
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74329 is estimated to be provided 8,955 times nationally in a one-year period.

Specialty Gastroenterology Frequency 4749 Percentage 53.03 %

Specialty Diagnostic Radiology Frequency 3714 Percentage 41.47 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,985
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74329 is estimated to be provided 2,985 times nationally in a one-year period to Medicare patients.

Specialty Gastroenterology Frequency 1583 Percentage 53.03 %

Specialty Diagnostic Radiology Frequency 1238 Percentage 41.47 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74329

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74330 Tracking Number Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX Current Work RVU: **0.90** RUC Recommended RVU: **0.70**

CPT Descriptor: Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old patient presents with painless jaundice. Imaging demonstrates a pancreatic mass suggesting pancreatic malignancy. Endoscopic retrograde cholangiopancreatography (ERCP) with catheterization of the biliary and pancreatic ductal system is performed with imaging.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination, any pertinent clinical history and prior imaging studies to become familiar with the patient's anatomy. Confirm that evaluation of both the biliary and pancreatic ductal systems is appropriate and plan for the procedure, including potential contraindications. The physician dresses in radiation attire and instructs the radiologic technologist to prepare and operate the imaging equipment required and the proper settings for the imaging equipment. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: After endoscopist accesses the sphincter (reported separately), the physician positions the patient and uses fluoroscopy and angulation of the image intensifier to help direct the guidewire and injection device into an appropriate position. Inject contrast and perform imaging and re-position the patient as needed for evaluation and mapping of the appropriate path and real-time evaluation of anatomy and pathology. Obtain or supervise acquisition of spot images or other imaging confirmation as needed. Interpret all images obtained during the examination and compare with prior examinations. Dictate the report.

Description of Post-Service Work: Review, edit and sign the report for the medical record that describes the guidance procedure, including pertinent anatomic and pathologic findings. Communicate the results of the procedure to the referring physician and patient when appropriate. Recommend any follow up actions based on findings on imaging.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2019		
Presenter(s):	Kurt Schoppe, MD; Andrew Moriarity, MD; Lauren Golding, MD; R. Bruce Cameron, MD; Shivan Mehta, MD; Seth A. Gross, MD		
Specialty Society(ies):	American College of Radiology, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy		
CPT Code:	74330		
Sample Size:	3250	**Resp N:** 65	**Response:** 2.0 %
Description of Sample:	The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures). The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**30.00**	50.00	500.00
Survey RVW:	0.23	0.70	**0.91**	1.50	18.00
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	6.00	**12.00**	40.00	120.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74330	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**6.00**	**0.00**	**6.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**6.00**	**0.00**	**6.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77021	XXX	1.50	**RUC Time**

CPT Descriptor Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76830	XXX	0.69	**RUC Time**	452,210

CPT Descriptor 1 Ultrasound, transvaginal

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93015	XXX	0.75	**RUC Time**	1,043,146

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 20.0 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 15.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 74330	Top Key Reference CPT Code: 77001	2nd Key Reference CPT Code: **77021**
Median Pre-Service Time	6.00	2.00	15.00
Median Intra-Service Time	12.00	15.00	45.00
Median Immediate Post-service Time	6.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**24.00**	**17.00**	**75.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	15%	31%	54%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	8%	92%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	31%	69%
Physical effort required	0%	46%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	8%	85%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	10%	30%	60%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	10%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	20%	80%
Physical effort required	0%	30%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	10%	90%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified on the CMS/Other – Utilization Over 30,000 screen. An action plan was submitted for the January 2019 meeting, expanding the family to include CPT codes 74329 *(Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation)*, 74330 *(Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation)*, and 74301 *(Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure))*. The specialties agreed to survey 74300, 74328, 74329, and 74330 for the April 2019 RUC, while concurrently sending CPT code 74301 to CPT for review and possible deletion.

Survey Process

The ACR surveyed a total of 2,750 members (a random sample of 1,375 members and a separate random sample of 1,375 members who indicated that they perform radiography and/or gastrointestinal procedures).

The ACG, AGA and ASGE used a 500 member random sample of the ASGE's ERCP Special Interest Group (SIG), a group of 1,395 self-identified members with an interest in ERCP.

Both specialties surveyed CPT codes 74328, 74329, and 74330, but only ACR surveyed CPT code 74300.

Work RVU Recommendation

The specialties recommend the 25th percentile survey value for all four x-ray bile duct codes.

For CPT code 74330, the specialties recommend 0.70 RVUs, which is below the current value of 0.90 RVUs.

Time Recommendation

The expert panel recommends the median survey times for CPT code 74330: 6 minutes pre, 12 minutes intra, and 6 minutes post, for a total of 24 minutes.

There is a bimodal distribution between the surveyed specialties with respect to the service period times. Radiologists uniformly indicated lower service period times than surveyed Gastroenterologists. We believe this accurately reflects the differing work performed by the two specialties as described by this code, and both are consistent with CPT standards. The median values of the aggregated data are presented here, consistent with RUC process.

Key Reference Services

The most commonly chosen reference codes were:

- **77001** *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure))*, chosen by 20% of respondents, and
- **77021** *(Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation)*, chosen by 15% of respondents.

CPT code 74330 involves interpretation of radiographic images obtained during a procedure and compares well with the first key reference service code, 77001, which is a radiologic supervision and interpretation code with has less total time and lower RVU. Though 77001 is a ZZZ code, it describes a similar type of work as the surveyed code and is a valid comparison.

CPT code 74330 also compares well to the second key reference service, 77021, which is a radiologic supervision and interpretation code with significantly higher total time, resulting in a proportionally higher RVU. This is appropriate when considering the differences in intensity, as well as pre- and post-service work, between these services.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT	Global
77001	Fluoro guidance for CVA device placement, replacement, or removal	0.38	2	15		17	0.0223	ZZZ
74330	**Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**	**0.70**	**6**	**12**	**6**	**24**	**0.0359**	**XXX**
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) RS&I	1.50	15	45	15	75	0.0184	XXX

MPC Codes

CPT code 74330 compares well to radiology MPC code, 76830 *(Ultrasound, transvaginal)*. MPC code 76830 is an ultrasound imaging code of the uterus that has slightly less intra-service and total time, resulting in a slightly lower RVU.

CPT code 74330 compares well with MPC code 93015 *(Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report),* which involves supervision and interpretation of stress testing, with a slightly higher total time and resulting in a higher RVU.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
76830	Ultrasound, transvaginal	0.69	5	10	8	23	0.0399
74330	**Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**	**0.70**	**6**	**12**	**6**	**24**	**0.0359**
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	0.75	2	20	4	26	0.0308

Summary of Recommendation

Our expert panel recommends 0.70 RVUs for CPT code 74330, with service period times of 6, 12, and 6 minutes. This maintains appropriate relativity within the family, as shown in the table below.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	0.32	2	5	2	9	0.0461

74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	0.47	5	10	5	20	0.0246
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	0.50	5	10	5	20	0.0276
74330	**Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**	**0.70**	**6**	**12**	**6**	**24**	**0.0359**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74330

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Gastroenterology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 52602
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74330 is estimated to be provided 52,602 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 38336 Percentage 72.87 %

Specialty Gastroenterology Frequency 12354 Percentage 23.48 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,534 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74330 is estimated to be provided 17,534 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 12779 Percentage 72.88 %

Specialty Gastroenterology Frequency 4118 Percentage 23.48 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74330

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: X-Ray Bile Ducts

TAB: 16

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	74021	Radiologic examination, abdomen; 3 or more views	6	0.0563			0.27			6	1					4			1					
2nd REF	93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	4	0.0271			0.45			18	3					10			5					
3rd REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	4	0.0223			0.38			17	2					15								
CMS/Other	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation		#DIV/0!			0.36			9														
SVY	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	30	0.0701	0.23	0.32	0.44	0.70	1.00	9	2			2	4	5	6	25	2	0	10	20	30	600
SVY - Subset	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	24	0.0721	0.23	0.32	0.45	0.73	1.00	9	2			3	4	5	5	12	2	0	10	25	35	600
SVY - Random	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	6	0.0576	0.29	0.36	0.40	0.48	1.00	10	3			2	4	5	7	25	2	0	1	8	14	100
REC	74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation		0.0461			0.32			9	2					5			2					

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	13	0.0223			0.38			17	2					15								
2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	9	0.0184			1.50			75	15					45			15					
CMS/Other	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation		#DIV/0!			0.70			16														
SVY	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	65	0.0576	0.23	0.47	0.80	1.00	12.00	20	5			3	5	10	30	90	5	0	20	50	120	350
SVY - ACR	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	30	0.0936	0.23	0.36	0.58	0.87	1.25	10	3			3	4	5	6	18	2	0	6	18	50	300
SVY - Subset	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	24	0.1136	0.23	0.37	0.68	0.89	1.10	10	3			3	4	5	6	18	2	0	10	23	53	300
SVY - Random	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	6	0.0831	0.31	0.38	0.55	0.67	1.25	11	4			3	5	5	6	15	2	0	0	8	19	44
SVY - GI	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	35	0.0154	0.30	0.69	0.91	1.60	12.00	50	10			5	13	30	53	90	10	5	55	100	165	350
REC	74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation		0.0246			0.47			20	5					10			5					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
5						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
28						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
29	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
30	1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	13	0.0223			0.38			17	2					15									
31	2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	8	0.0184			1.50			75	15					45			15					
32	CMS/Other	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation		#DIV/0!			0.70			15														
33	SVY	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	64	0.0576	0.23	0.50	0.80	1.13	15.00	20	5			3	5	10	35	120	5	0	5	18	50	500
34	SVY - ACR	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	30	0.0866	0.23	0.39	0.59	0.93	1.33	12	4			3	4	5	7	18	3	0	3	10	20	100
35	SVY - Subset	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	24	0.0951	0.23	0.37	0.61	0.94	1.32	11	3			3	4	5	7	18	3	0	3	11	21	100
36	SVY - Random	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	6	0.0635	0.31	0.43	0.56	0.67	1.33	14	5			3	5	6	6	16	3	0	0	3	12	20
37	SVY - GI	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	34	0.0128	0.30	0.73	0.96	1.50	15.00	57	11			5	11	33	60	120	13	4	15	28	80	500
38	REC	74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation		0.0276			0.50			20	5					10			5					
39																									
40						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
41	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
42	1st REF	77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	13	0.0223			0.38			17	2					15									
43	2nd REF	77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	10	0.0184			1.50			75	15					45			15					
44	Aug-95	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation		0.0300			0.90			30						30								
45	SVY	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	65	0.0534	0.23	0.70	0.91	1.50	18.00	24	6			3	6	12	40	120	6	0	10	30	50	500
46	SVY - ACR	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	30	0.0972	0.23	0.39	0.74	0.95	1.90	13	4			3	5	6	9	25	3	0	1	10	25	500
47	SVY - Subset	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	24	0.1059	0.23	0.38	0.77	0.98	1.90	12	3			3	5	6	8	25	3	0	3	10	26	500
48	SVY - Random	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	6	0.0673	0.34	0.60	0.65	0.85	1.50	15	5			4	6	7	9	15	3	0	0	5	18	32
49	SVY - GI	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	35	0.0132	0.35	0.80	1.00	1.83	18.00	57	12			6	15	30	68	120	15	3	28	50	90	450
50	REC	74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation		0.0359			0.70			24	6					12			6					

SS Rec Summary

ISSUE: Excision of bone

TAB: 84

source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5				1	1.0								1							
2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5					1.0								1	1					
CURRENT	55555	abc		0.053			5.00			133	17					27			8				1	1.0								1						
SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0								1						
REC	55555	abc		0.020			4.25			142	17	1	3			30			10								1	1.0				1						

April 2, 2019

Peter Smith, MD, RUC Chair
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Subject: Practice Expense Recommendations for X-Ray Bile Ducts

Dear Dr. Smith,

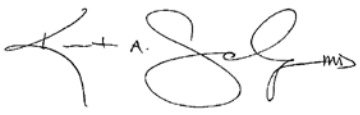
The American College of Radiology (ACR), American Society for Gastrointestinal Endoscopy (ASGE), American Gastroenterological Association (AGA), and American College of Gastroenterology (ACG) have reviewed the RUC database practice expense inputs for the x-ray of the bile ducts codes listed below.

- **74300** - *Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation*
- **74328** - *Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation*
- **74329** - *Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation*
- **74330** - *Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation*

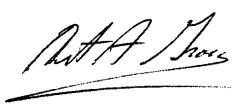
We have determined that these procedures are only performed in the facility setting. Therefore, the specialties will not be submitting practice expense recommendations for the x-ray of the bile ducts family.

Should you have any questions, please feel free to contact ACR RUC staff, Stephanie Le, at 800-227-5463, ext. 4584 or via email sle@acr.org.

Sincerely,



Kurt A. Schoppe, MD
ACR RUC Advisor



Seth Gross, MD, FACG
ASGE RUC Advisor



Shivan Mehta, MD
AGA RUC Advisor



Bruce Cameron, MD, FACG
ACG RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2020

External Cardiovascular Device Monitoring – Tab 20

In October 2019, the Relativity Assessment Workgroup identified codes 93228 and 93229 as part of their screen for services with Medicare utilization of 10,000 or more and a Medicare volume increase of at least 100% from 2013 through 2018e. In January 2020, the RUC recommended to review theses services at the October 2020 meeting.

93228 ***External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional***

The RUC reviewed the survey results from 66 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile that maintains the current work RVU of 0.52 for CPT code 93228, the professional interpretation component only code. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time and 8 minutes post-service time. The 2 minute decrease in intra-service and overall time, relative to when this service was reviewed in 2008, is offset by an increase in the amount of data that the physician needs to review due to the increase in typical wear time.

The specialty societies noted that, since these services were last reviewed in 2008, there have been several changes in the technique and patient population. In the past, these monitors required 5 ECG stickers to be placed across the precordium and connected to a relatively large recording device, which the patient wore on a strap over their shoulder. Batteries and ECG stickers were replaced by the patient as needed. The technique of monitoring now utilizes a much smaller adhesive patch with 2 electrodes (one at either end of the patch) and a small recording unit consisting of a computer and rechargeable battery that clips onto the patch. Patients switch the recording unit every 24 hours while one recharges. The substantially reduced size of these devices along with the simpler format has made it much easier for patients to wear the devices for longer periods of time. This has made it possible to now use these devices to evaluate stroke patients more effectively for possible occult paroxysmal atrial fibrillation as the etiology of their stroke. The specialty societies noted that the average wear time of these devices has increased since 2008 from 14 days to 20 days and provided literature from a study published in 2017 by Derkac Et Al as evidence of this assertion. It was noted that the amount of monitoring time has increased to an average of 20 days, which is likely due to both the reduced size/increased comfort of these newer units as well as the expanded indications of monitoring stroke patients for possible occult paroxysmal atrial fibrillation.

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And with the average wear time increasing from 14 to 20 days, the number of ECG tracings as well as daily reports have also increased. This is offset by the fact that the technology has advanced to make it easier to manage and review the data, which accounts for the reduced intra-service time. The interface for physician interaction with the reports has moved from primarily a fax and paper-based system, which resulted in large amounts of paper reports to now more streamlined digital reports with data better organized and more easily accessible. At the same time, the number of episodes that the physician reviews and adjudicates have increased due to the increased wear time. The RUC agrees that the increased amount of data and the efficiency gained in reviewing that data offset each other.

To justify a work RVU of 0.52, the RUC compared the survey code to top key reference code 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU= 0.52, intra-service time of 7 minutes, total time of 17 minutes) and noted that although the survey code involves more intra-service and total time, both services have a similar amount of physician work overall. The RUC also compared the survey code to MPC code 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU= 0.54, intra-service time of 10 minutes, total time of 22 minutes) and noted that both services typically involve identical intra-service time and the survey code typically involves one more minute of total time. Separately, the RUC also compared the survey code to its review of other external cardiac device monitoring codes for CPT 2021, including codes 93224, 93227, 93241, 93244, 93245 and 93248, and noted that a work value of 0.52 would have appropriate relativity and rank order with the CPT 2021 RUC recommendations for these other external cardiac device monitoring services. **The RUC recommends a work RVU of 0.52 for CPT code 93228.**

Practice Expense

93228 ***External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional***

This code is a physician work interpretation code The specialty societies indicated, however that clinical staff is necessary in the physician office to educate the patient regarding the role of mobile cardiovascular telemetry, the process for obtaining equipment and further instructions to be expected from the IDTF. Consistent with this recommendation, the RUC recommends 10 minutes of pre-service time for this clinical staff activity.

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93229 ***External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional***
The specialty societies noted that the technical component for these services is typically outsourced to independent diagnostic testing facilities (IDTFs). One factor that makes these monitors distinct from other cardiac monitors is that, because they transmit telemetry throughout the wear period, they must be monitored 24/7 in order to provide the service and each company makes its own proprietary device. The technology at each company is different. The specialty societies worked with five of the largest suppliers of these services through an independent third-party consulting company to obtain practice expense data. The third-party company surveyed the providers of this service to collect, analyze and summarize the practice expense data. The specialty societies also discussed the technical component work with several IDTFs to clarify the practice expense work involved in performing this technical component only service. The specialty societies noted that the data does align with their direct patient care experience with other similar cardiac monitoring technologies. These data are included in the report provided by the third-party consulting company that provided detailed information on the types and durations of clinical staff time, supplies and equipment.

The Practice Expense (PE) Subcommittee discussed and accepted compelling evidence as there has been a substantial change in technology and a change in specialty. The patches are being worn now for multiple days, the devices are smaller, and the patient is being monitored for a much longer time than was the case in the early 2000s when this technology first appeared. The second compelling evidence criterion is a change in specialty from cardiologists providing the PE times and inputs to now directly collecting this data from the IDTFs.

The PE Subcommittee spent an extensive amount of time reviewing and discussing the clinical staff inputs with the specialty society presenters. The PE Subcommittee discussed the second clinical staff needed to over-read the individual arrhythmia events at the company before calling the cardiologist responsible for urgent or emergent arrhythmias. The Subcommittee confirmed that this over-reading is a clinical event and is separate from QA or QC activity and also that it is similarly separate and distinct from the activities of the cardiologists who also review the strips and information to validate the arrhythmia. The PE Subcommittee made some minor modifications to the clinical staff time after validating all the other clinical staff time inputs.

The PE Subcommittee validated that the invoices provided for the new MCT electrode patch kit did not include alcohol wipes and acetone wipes, putting them on and taking them off, nor the patient education booklet.

The PE Subcommittee also validated the minutes of equipment time. The specialty societies noted that the average wear time of these devices has increased since 2008 from 14 days to 20 days. They provided literature from a study published in 2017 by Derkac Et Al as evidence of this assertion. It was noted that the amount of monitoring time has increased to an average of 20 days likely due to both the reduced size/increased comfort of these newer units as well as the expanded indications of monitoring stroke patients for possible occult paroxysmal atrial fibrillation.

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The RUC recommends the direct practice expense inputs for both 93228 and 93229 as modified by the Practice Expense Subcommittee.

Updating CMS Inputs for EQ340 Patient Worn Telemetry System
The RUC noted that, due to the proprietary nature of the equipment, invoices were neither provided nor are achievable for updating the equipment item EQ340 *Patient Worn Telemetry System* which was last updated by CMS in 2008. The devices, which have experienced substantial improvements in technology since 2008, are proprietary devices owned and manufactured for each of the independent IDTFs. **The RUC recommends that CMS work directly with the IDTFs to determine the acquisition costs for the equipment item EQ340 *Patient Worn Telemetry System*.** CMS has experience with a similar situation where the Agency worked directly with a cardiac device manufacturer to attain the manufacturing costs and other proprietary information for a separate cardiac device.

CMS currently assigns EQ340 *Patient Worn Telemetry System* 3 years of useful life. The RUC notes that EQ340 is the only equipment item and 93229 is the only CPT code with an equipment item that has more than 500 minutes of equipment time and a useful life of 3 years or less. All other equipment items which are assigned 500 or more minutes for any CPT code have a useful life of more than 3 years. **The RUC recommends that CMS work directly with the IDTFs to review the useful life for the equipment item EQ340 *Patient Worn Telemetry System* as it has not been updated since 2008 and the technology has substantially changed.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional (Report 93228 only once per 30 days) (Do not report 93228 in conjunction with 93224, 93227)	XXX	0.52 (No Change)

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93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional (Report 93229 only once per 30 days) (Do not report 93229 in conjunction with 93224, 93226) (For external cardiovascular monitors that do not perform automatic ECG triggered transmissions to an attended surveillance center, see 93224-93227, 93268-93272)	XXX	0.00 (PE Only)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93228 Tracking Number Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.52**
Global Period: XXX Current Work RVU: **0.52** RUC Recommended RVU: **0.52**

CPT Descriptor: External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ecg data storage (retrievable with query) with ecg triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year old female patient receives a mobile cardiovascular telemetry (MCT) monitor to investigate rapid heartbeats that occur approximately twice a month.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient records to identify indication(s) for wearable MCT monitoring and therapy.

Description of Intra-Service Work: Perform critical review of the data obtained, with awareness of the indication for which the monitor was ordered. Initial review is of the quality of the data obtained and the duration of actual wear time in relation to the recommended wear time. Next, the data trends and statistics are reviewed both for daily reports as well as the overall summation/final report. Reports are reviewed for the predominant rhythm, heart rates (average, maximum, minimum), atrial and ventricular ectopy as well as any sustained arrhythmias. Then, individual ECG recordings are reviewed to verify that technician interpretations are correct and to review any arrhythmias. Last, the patient diary is compared with the corresponding ECG recordings to determine if an arrhythmia may be associated with symptoms.

Description of Post-Service Work: Prepare, approve, sign, and distribute report to patient's record, referring and primary physicians, and attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Christopher Liu, MD; Mark Schoenfeld, MD; David Slotwiner, MD					
Specialty Society(ies):	ACC & HRS					
CPT Code:	93228					
Sample Size:	1730	**Resp N:**	66			
Description of Sample:	random ACC electrophysiologist members & random HRS members					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	27.00	**100.00**	244.00	750.00	
Survey RVW:	0.30	0.52	**0.60**	0.84	75.00	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	6.00	**10.00**	15.00	90.00	
Immediate Post Service-Time:	**8.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	93228	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**8.00**	**0.00**	**8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93298	XXX	0.52	**RUC Time**

CPT Descriptor Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93015	XXX	0.75	**RUC Time**

CPT Descriptor Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76857	XXX	0.50	**RUC Time**	205,984

CPT Descriptor 1 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76519	XXX	0.54	**RUC Time**	187,253

CPT Descriptor 2 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

Other Reference CPT Code	Global	Work RVU	Time Source
99231	XXX	0.76	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 41 **% of respondents:** 62.1 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 9.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 93228	**Top Key Reference CPT Code:** 93298	**2nd Key Reference CPT Code:** **93015**
Median Pre-Service Time	5.00	5.00	2.00
Median Intra-Service Time	10.00	7.00	20.00
Median Immediate Post-service Time	8.00	5.00	4.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**23.00**	**17.00**	**26.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	56%	37%	2%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	63%	30%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	17%	66%	17%
Physical effort required	9%	86%	5%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	68%	32%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	67%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	17%	66%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	17%	67%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	67%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

In October 2019, the Workgroup identified these services with Medicare utilization of 10,000 or more and has increased by at least 100% from 2013 through 2018. In January 2020, the RUC recommended to survey for Oct 2020. The ACC and HRS randomly surveyed electrophysiologists, as designated by membership rolls. The survey was completed by physicians who have experience with the service. The key reference code is 93298 for interrogation device evaluation(s), remote up to

30 days. It was selected by 62% of respondents. Over half of these respondents indicate 93228 was virtually identical. The second reference code was 93015 for cardiovascular stress test. It was selected by 9% of respondents. Two thirds of the respondents indicated that 93228 was more intense/complex overall.

Rationale

Since 2008, when this code was last surveyed, there have been a number of changes in the technique and patient population. In the past, these monitors required 5 ECG stickers to be placed across the precordium and connected to a relatively large recording device which the patient wore on a strap over their shoulder. Batteries and ECG stickers were replaced by the patient as needed. The technique of monitoring now utilizes a much small adhesive patch with 2 electrodes (one at either end of the patch) and a small recording unit consisting of a computer and rechargeable battery that clips onto the patch. Patients switch the recording unit every 24 hours while one recharges. The substantially reduced size of these devices along with the simpler format has made it much easier for patients to wear the devices for longer periods of time. This has made it possible to now use these devices to more effectively evaluate stroke patients for possible occult paroxysmal atrial fibrillation as the etiology of their stroke. The fact that the average wear time of these devices has increased since 2008 from 14 days to 20 days is likely due to both the reduced size/increased comfort of these newer units as well as the expanded indications of monitoring stroke patients for possible occult paroxysmal atrial fibrillation.

Recommendation

Therefore, for code 93228 the societies recommend an RVW of 0.52 with 5 minutes preservice time, 10 minutes intraservice time from the survey median, and 8 minutes postservice time. MPC comparators with similar times and work RVUs bolster this recommendation, and with the average wear time increasing from 14 to 20 days, the number of ECG tracings as well as daily reports has increased. This is somewhat offset by the fact that technology has advanced to make it easier to manage and review the data. In the past, recordings and daily reports were faxed to physician practices, creating large paper files that were difficult to manage. Now, online portals from the IDT vendors as well as integrations with electronic health records makes it less cumbersome for physicians to review and manage the additional data in a chronological and efficient manner.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93228

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty cardiac electrophysiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 372000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on double the Medicare data estimation reported in 2019e.

Specialty cardiology Frequency 240000 Percentage 64.51 %

Specialty cardiac electrophysiology Frequency 66000 Percentage 17.74 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 186,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Fee for service utilization from RUC databased from 2019e for 93228.

Specialty cardiology Frequency 120000 Percentage 64.51 %

Specialty cardiac electrophysiology Frequency 33000 Percentage 17.74 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
EKG monitoring

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93228

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: External Cardiovascular Device Monitoring

TAB: 20

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	93298	XXX	Interrogation device evaluation(s), (remote) up to 30	41	0.0423			0.52			17	5					7			5					
2nd REF	93015	XXX	Cardiovascular stress test using maximal or submaximal	6	0.0308			0.75			26	2					20			4					
CURRENT	93228	XXX	External mobile cardiovascular telemetry with	N/A	0.0191			0.52			25	5					12			8					
SVY	93228	XXX	External mobile cardiovascular telemetry with	66	0.0309	0.30	0.52	0.60	0.84	75.00	23	5	0		1	6	10	15	90	8	0	27	100	244	750
REC	93228	XXX	External mobile cardiovascular telemetry with		0.0229			0.52			23	5					10			8					
MPC	76857	XXX	Ultrasound, pelvic (nonobstetric), real time with		0.0394			0.50			17	5					7			5					
MPC	76519	XXX	Ophthalmic biometry by ultrasound echography, A-		0.0271			0.54			22	2					10			10					
COMP	99231	XXX	Subsequent hospital care, per day, for the evaluation and		0.0536			0.76			20	5					10			5					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 93229, 93228**
SPECIALTY SOCIETY(IES): HRS, ACC
PRESENTER(S): Schoenfeld, Slotwiner, Liu, Wright, Waites, Tuohy

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
93229	A 71-year-old female patient receives a mobile cardiovascular telemetry (MCT) monitor to investigate rapid heartbeats that occur approximately twice a month.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The HRS and ACC specialty panel utilized a consensus expert panel process to develop recommended inputs. This was done in consultation with several IDTFs who provide and bill Medicare directly for 93229. Those providers hired a credible, independent third party, The Moran Company, to be the repository of PE input data submitted separately by each provider and to prepare calculations based on that data. The expert panel relied upon the attached materials to present our understanding of the service.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   93229 is an existing code

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No. No.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   IDTF. 79% No.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

The current inputs are higher than standards. In some instances this reflects shoehorning time into a clinical activity line that best approximates the staff time, in other instances it is simply because the clinical activity takes longer than the standard. We've attempted to demonstrate that level of effort with attached process manuals and an explanation of data collected by IDTFs.

We believe these manuals help demonstrate the significant training and skill of the technologists, support the recommendations for minutes that exceed some standards, and provide a sense of the significant amount of time recommended for these continuous monitoring services.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

Since first valuation in 2008, IDTFs have provided information in the attached report and materials from Moran that indicates techs spend an increased amount of time adjudicating events because newer patches are worn for a longer period of time than previous large numbers of electrodes. This phenomenon was calculated by the IDTFs and shown in published literature such as the attached from Derkac in the *Journal of Cardiovascular Electrophysiology (p. 2)*. We believe this demonstrates that technology has changed clinical staff time.

The addition of a new supply, an MCT patch, as well as updated inclusion of skin prep wipes and adhesive remover for the patient to apply/remove patches through the monitoring period are also additions. We believe this constitutes a change in supply costs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

0

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   b. Service period (includes pre, intra and post):
      - The monitoring center contacts the patient and obtains clinical information from the patient relevant to providing the service (e.g, allergies to electrode patches). An appointment is made with the patient for education and to connect the monitor which may be done by telephone or in person, by a nurse or other appropriate licensed or credentialed healthcare professional. (Line 43)

- The monitor is uniquely configured by linking the sensor to the monitor, and by linking the monitor to both the patient and patient's record. This enables the monitor to transmit electrocardiographic data directly to the appropriate patient record. The monitor, sensor, base, electrodes, assorted accessories, and education materials are sent to the patient. (Lines 49 and 48)
- The monitoring center educates the patient and facilitates the connection. This includes instruction on monitor set up and care, the wireless technology (how the monitor works and automatically transmits electrocardiographic data without patient intervention), electrode placement and care, how to record symptomatic events, and the meaning of and response to alert messages. A baseline electrocardiographic transmission is sent to the monitoring center to ensure the electrodes are connected properly. (Lines 45 and 64)
- During the monitoring period, the monitor automatically transmits ECG data to the monitoring center when the algorithm identifies asymptomatic arrhythmias or when the patient triggers a symptomatic ECG segment. (Line 66)
- The surveillance technician reviews and analyzes each ECG segment and if the arrhythmia meets the notification criteria, the ordering physician is notified immediately and an urgent report is prepared and sent. (Line 67)
- During the monitoring period, the monitor transmits comprehensive ECG data each day that is permanently stored and used to construct a comprehensive daily report which includes a heart rate trend graph and, if applicable, atrial fibrillation burden graph and other recorded ECG data. The daily report is transmitted to the ordering physician. The monitor records and analyzes all heartbeats and stores greater than 24 hours of the most recent recorded heartbeats. The stored ECG data are available to the ordering physician upon request. (Line 66)
- The patients typically contact the monitoring center a number of times to ask questions about the electrodes, or an alert message on the monitor screen or for other technical issues. The monitoring center typically contacts patients for issues such as artifact transmission, and lack of transmitted ECG segment data due to removal of a lead or a possible break in service. A summary report is prepared by the monitoring center that is sent to the ordering physician. The monitoring center transmits the summary report to the ordering physician. (Line 65)
- The MTA makes and end of service call to the patient to alert them to the pending discharge, explaining removal process and arranging for return of the monitor. The patient removes the electrodes, unhooks and packages all the equipment in a pre-paid return box and ships the material to the monitoring center. If the patient is unable to ship the box, arrangements are made by the monitoring center to pick up the equipment. (Line 89)
- At the end of the service, the ED creates a summary report and transmits it to the physician. (Line 85)
- An MTA cleans, downloads data, services and restocks units returned by the patient. (Line 77)

c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

- The MTA calls the patient to obtain clinical information, arrange for the device kit to be delivered, and sets up an appointment for education and to connect to the monitor
- The MTA scans, tests and configures the device for the patient per physician orders
- The MTA prepares the device for shipping complete with education materials and supplies
- The MTA educates the patient on use of the device and service including instruction on the monitor set up and care, how wireless technology works, electrode placement and care, how to record symptomatic events; the meaning of and response to alert messages; and connection of the device
- After the device begins transmitting, the MTA receives and responds to patient questions by telephone and contacts the patient to address issues such as break in service, problem with service, electrode irritation, electrode artifact and other device issues

- The ED confirms that a baseline EG transmission has been accepted into the monitoring center
- The electrodiagnostic technician (ED) reviews and analyzes patient ECG data transmitted to the monitoring center via patient or auto-trigger and determines if MD notification is required. These transmissions occur several times per day.
- If MD notification criteria are met, the ED notifies the physician and prepares an urgent report sent by EHR, email, or fax.
- The ED reviews ECG data of the past 24 hours, identifies any abnormalities in the data, and prepares and transmits a daily report.

- Throughout the wear period, a second, senior surveillance ED technician reviews and analyzes each remarkable ECG segment and if the arrhythmia meets the notification criteria, the ordering physician is notified immediately and an urgent report is prepared and sent.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

n/a

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Three of the IDTFs (including the dominant provider) use a patch instead of electrodes. The average number of patches provided to the patient is five for the three companies that use them. Those that report using electrodes use an average of 69 per patient/test. IDTFs believe the patch is more commonly used than electrodes and recommend that this be added as a new supply item. An invoice is attached for a bulk order by an IDTF. Each case contains 40 patches, for a per-patch price of $4.85.

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

n/a

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

EQ340: The current input of 20,160 minutes reflects 14 days of wear by the patient. Data collected by IDTFs now indicate a weighted-average wear time of 20 days. Therefore, the societies recommend 28,800 minutes of equipment time. This increase was captured in the IDTF response and has also been documented in clinical literature.

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:
93229

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 93229, 93228**
SPECIALTY SOCIETY(IES): HRS, ACC
PRESENTER(S): Schoenfeld, Slotwiner, Liu, Wright, Waites, Tuohy

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2020

CPT Code	Long Descriptor	Global Period
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
93228	A 71-year-old female patient receives a mobile cardiovascular telemetry (MCT) monitor to investigate rapid heartbeats that occur approximately twice a month.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The HRS and ACC specialty panel utilized a consensus expert panel process to develop recommended inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The societies selected related PE-only code 93229 as a comparison because it includes a similar type of patient education.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No. No.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Cardiology. 66% No.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

When the family of two codes was valued it was not thought that clinical staff in the physician office would undertake any activity to support the service. That has not proven to be the case. In the experience of the expert panel, clinical staff in the physician office setting provide education to the patients about the IDTF-performed monitoring before the patient leaves the office. Some of this may be information they hear a second time from the IDTF tech, which is by design. Patients typically need to hear this multiple times to understand, and that process starts at the time the monitor is ordered. Addition of clinical staff minutes to the interpretation code will remedy that shortcoming. We recommend to crosswalk the same 10 minutes that is being recommended for education in the IDTF technical code.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

0

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   b. Service period (includes pre, intra and post):
      - Clinical staff in the physician office educate the patient regarding the role of MCT, the process for obtaining equipment and further instructions to be expected from the IDTF.

   c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

n/a

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

n/a

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

n/a

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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	A	B	D	E	F	I	J	K	L	P	Q	R	S
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**93229**		**93229**		**93228**		**93228**	
3		***RUC Collaboration Website***				External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent	
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 20 Specialty: ACC, HRS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD XXX**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 905.42**	**$ -**	**$ 1,277.98**	**$ -**	**$ -**	**$ -**	**$ 3.70**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12													
13		**TOTAL CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**111.0**	**0.0**	**58.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
14		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**111.0**	**0.0**	**58.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
16		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
17													
18		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
19		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
20		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**
21		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
22		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 107.26**	**$ -**	**$ 131.26**	**$ -**	**$ -**	**$ -**	**$ 3.70**	**$ -**
23		**PRE-SERVICE PERIOD**											
24		**Start: Following visit when decision for surgery/procedure made**											
25	CA001	Complete pre-service diagnostic and referral forms											
39		**End: When patient enters office/facility for surgery/procedure**											
40		**SERVICE PERIOD**											
41		**Start: When patient enters office/facility for surgery/procedure:**											
42		**Pre-Service (of service period)**											
43	CA009	Greet patient, provide gowning, ensure appropriate medical	L026A	Medical/Technical	0.26	8		0					
44	CA010	Obtain vital signs											
45	CA011	Provide education/obtain consent	L026A	Medical/Technical	0.26	22		10					
46	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37							10	
47	CA012	Review requisition, assess for special needs											
48	CA013	Prepare room, equipment and supplies	L026A	Medical/Technical	0.26	5		6					
49	CA014	Confirm order, protocol exam	L026A	Medical/Technical	0.26	19		12					
50	CA015	Setup scope (nonfacility setting only)											
51	CA016	Prepare, set-up and start IV, initial positioning and monitoring of											
53													
56		*Other activity: please include short clinical description here and*											

	A	B	D	E	F	I	J	K	L	P	Q	R	S
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
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6		**GLOBAL PERIOD XXX**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 905.42**	**$ -**	**$ 1,277.98**	**$ -**	**$ -**	**$ -**	**$ 3.70**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
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14		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**111.0**	**0.0**	**58.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
16		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
59		**Intra-service (of service period)**											
63	CA021	Perform procedure/service---NOT directly related to physician	L026A		0.26	3							
64	CA021	Perform procedure/service---NOT directly related to physician	L037A		0.37			1					
65	CA021	Perform procedure/service---NOT directly related to physician	L026A		0.26	33		17					
66	CA021	Perform procedure/service---NOT directly related to physician	L037A		0.37	214		281					
67	CA021	Perform procedure/service---NOT directly related to physician	L037A		0.37			24					
70													
71		*Other activity: please include short clinical description here and*											
74		**Post-Service (of service period)**											
75	CA022	Monitor patient following procedure/service, multitasking 1:4											
76	CA023	Monitor patient following procedure/service, no multitasking											
77	CA024	Clean room/equipment by clinical staff	L026A		0.26	12		3					
78	CA025	Clean scope											
79	CA026	Clean surgical instrument package											
80	CA027	Complete post-procedure diagnostic forms, lab and x-ray											
81	CA028	Review/read post-procedure x-ray, lab and pathology reports											
82	CA029	Check dressings, catheters, wounds											
83	CA030	Technologist QC's images in PACS, checking for all images,											
84	CA031	Review examination with interpreting MD/DO	L026A		0.26	3							
85	CA031	Review examination with interpreting MD/DO	L037A		0.37			8					
86	CA032	Scan exam documents into PACS. Complete exam in RIS											
87	CA033	Perform regulatory mandated quality assurance activity (service											
88	CA034	Document procedure (nonPACS) (e.g. mandated reporting,											
89	CA035	Review home care instructions, coordinate visits/prescriptions	L026A		0.26	3		10					
90	CA035	Review home care instructions, coordinate visits/prescriptions	L026!			3							
91	CA036	Discharge day management				**n/a**		**n/a**		**n/a**		**n/a**	
92													
95		*Other activity: please include short clinical description here and*											
98		**End: Patient leaves office/facility**											
99		**POST-SERVICE PERIOD**											
100		**Start: Patient leaves office/facility**											

	A	B	D	E	F	I	J	K	L	P	Q	R	S
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**93229**		**93229**		**93228**		**93228**	
3		***RUC Collaboration Website***				External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent	
4	**Clinical Activity Code**	**Meeting Date: October 2020 Revision Date (if applicable): Tab: 20 Specialty: ACC, HRS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD XXX**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 905.42**	**$ -**	**$ 1,277.98**	**$ -**	**$ -**	**$ -**	**$ 3.70**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**214.0**	**0.0**	**315.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037A	Electrodiagnostic Technologist	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12													
13		**TOTAL CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**111.0**	**0.0**	**58.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
14		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**111.0**	**0.0**	**58.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
16		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L026A	Medical/Technical Assistant	0.26	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
101	CA037	Conduct patient communications											
102	CA038	Coordinate post-procedure services											
116		**End: with last office visit before end of global period**											
117	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
118		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 14.29**	**$ -**	**$ 26.90**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
119	SD053	electrode, ECG (single)	0.075	item		42							
120	SK062	patient education booklet	2.175	item		1		1					
121	SK095	battery, AA	0.64	item		14		0					
122	SM029	skin prep barrier wipes	0.2	item				2					
123	SG006	adhesive remover, pad (acetone)	0.035	item				2					
124	NEW	*MCT Patch*	$4.85					5					
125													
126	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
127		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 783.87**	**$ -**	**$ 1,119.82**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
128	EQ340	Patient Worn Telemetry System	23515.5	Other Formula	0.03888268	20160		28800					
129													
136													

Resource Inputs Involved in Providing External Mobile Cardiovascular Telemetry (MCT):

Summary Findings from IDTF Providers

August 2020

THE MORAN COMPANY

Resource Inputs Involved in Providing External Mobile Cardiovascular Telemetry (MCT): Summary Findings from IDTF Providers

Introduction

Mobile Cardiovascular Telemetry (MCT) is a remote cardiac diagnostic test used to monitor heart rhythms and detect symptomatic and asymptomatic arrhythmia over an up to 30 day period for ambulatory patients in the community setting. The service is billed on healthcare claims with Current Procedural Terminology (CPT®)[1] code 93229 and is defined as:

> *External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional.*[2]

This service is a "technical component only" service meaning the billing code is a stand- alone code that describes the technical aspects associated with providing the up to 30 day monitoring test and does not include physician work. As this is a technical component only service that involves a remote attended surveillance center operating on a 24/7 basis, the dominant providers of MCT are Independent Diagnostic Testing Facilities (IDTFs).[3]

Under the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS), the technical aspect of MCT is reimbursed primarily based on non facility Practice Expense (PE) Relative Value Units (RVUs). When developing PE RVUs, CMS receives recommendations from the American Medical Association (AMA) Resource-Based Relative Value Scale (RBRVS) Update Committee (RUC) on the resource inputs (i.e., non-physician clinical labor, disposable medical supplies and medical equipment) directly involved in providing a patient service. The original AMA RUC recommendations for code 93229 were developed in calendar year (CY) 2008 and the subcommittee of the RUC focused on PE is currently undertaking a process to update those recommendations.

Given that IDTFs are the typical providers of this service, it is important to gain IDTF input on the PE resources involved in providing up to 30 days of external remote cardiac monitoring and associated technical support. Accordingly, Powers, Pyles, Sutter, and Verville, P.C. (referred to

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[1] CPT® is a trademark of the American Medical Association.

[2] Current Procedural Terminology (CPT) is copyright 2020 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

[3] According to Medicare Fee for Service (FFS) claims data, IDTFs billed 84% of the total paid units for code 93229 in CY2018. Medicare Physician/Supplier Procedure Summary (2018).

here as Powers Law) is working on behalf of IDTF providers who are both members and non-members of the Remote Cardiac Services Provider Group (RCSPG), to provide consensus PE recommendations to the applicable national medical specialty society for consideration in the RUC process. The underlying information used to develop PE input recommendations for MCT requires receipt and review of information IDTFs consider to be sensitive and proprietary that should not be shared in a granular form among competitors.

Therefore, Powers Law engaged The Moran Company (TMC) to serve as an intermediary to receive, maintain and analyze individual IDTF data on a confidential basis and develop summary findings from the underlying submissions. To do so, and to assist Powers Law in the development of consensus input recommendations for MCT code 93229, TMC used a questionnaire to collect resource information from each IDTF participating in this process. The questionnaire focused on the non physician clinical labor activities and disposable medical supplies used to provide the up to 30 day service. As CMS recently reviewed and finalized the equipment assigned to 93229[4], the questionnaire did not include requests for information on capital equipment for MCT. The questionnaire did, however, include a question to identify typical wear time of the monitoring equipment. This question was intended to understand the number of days generally involved in a monitoring service more specifically than the "up to 30 days" listed in the billing code descriptor.

This report provides a synopsis of our work and findings.

Details of our Analysis

Participating IDTFs

Five IDTFs participated in this endeavor including: BioTelemetry Inc.[5], Medicomp Inc., Medi-Lynx Cardiac monitoring LLC, Preventice Services, and Rhythmedix (*RMX Monitoring*). These 5 IDTFs cumulatively provided more than 500,000 MCT services in the most recent 12 month period for which there are complete data. Two of the participating IDTFs provided approximately 88% of these services combined.[6] To account for differences in the size of the provider and to develop a "typical" case scenario, each IDTF's response was volume weighted with the individual IDTF's share of the total volume billed using the all payer service count data submitted by the IDTFs.

Average MCT Wear Time

Using a volume weighted approach, the average MCT wear time is 20 days.[7]

[4] Centers for Medicare and Medicaid Services Physician Fee Schedule for CY2019 final rule.

[5] BioTelemetry is the umbrella for which both the former CardioNet & LifeWatch reside. CardioNet was the prior corporate name of the Company, changed to BioTelemetry on April 13, 2013 and LifeWatch was acquired by BioTelemetry on July 12, 2017.

[6] Underlying total service count information for each IDTF is not provided to maintain confidentiality, however as a matter of perspective, publicly available Medicare FFS data by National Provider Identifier (NPI) is presented in Appendix A of this report. The most recent NPI level Medicare data available is from 2017 and includes IDTFs that participated, and that did not participate, in this initiative.

[7] We understand that this was calculated, for example, by reviewing the number of unique prescriptions in a 12 month period and analyzing the average number of transmission days for the cohort.

Non Physician Clinical Labor

To assess MCT clinical labor activities over the monitoring period, we reviewed those activities currently accounted for as a direct input in MCT valuation, considered the description of activities in the original MCT recommendation, and received input based on IDTF workflows from clinical experts. From this information, we developed a list of non physician clinical labor activities relating to: pre procedure calls and the prescription, patient education and consent, preparation of the monitor and patient, the monitoring period, remote troubleshooting and Quality Assurance (QA), as well as disconnect and discharge, to include in the questionnaire. We asked each IDTF the clinical staff type performing the activity, typical amount of time it takes to provide the activity on a per occurrence (i.e., per patient) basis and the frequency the activity occurs over the typical number of days the patient wears the MCT monitor. We used this information to calculate a total time per activity for each IDTF and volume weight the findings to develop an average total time for each activity. This allowed us to maintain the confidentiality of each IDTF's underlying information, account for instances where IDTFs allocate for their activities slightly differently, and to develop a consensus finding.

Certified Electrodiagnostic Technologist

Across all of the IDTFs, a certified electrodiagnostic technician or a senior/supervisory monitoring technician provides the activities associated with the monitoring itself. Table 1 presents the certified electrodiagnostic technologist monitoring activities and associated volume weighted time per patient across the monitoring period.

Table 1. Volume Weighted Average Total ED Tech Time in Minutes for MCT Monitoring

Intra Service Period - Monitoring. Typically the certified EDT Tech	Vol Wgt AVG Total Time
Activation of device and confirm baseline ECG transmission has been accepted into monitoring center	1
Review and analyze recorded ECG data and/or triggered event data, cut strip of representational ECG data, determine if ECG events meet escalation, notification (emergent or urgent) criteria	215
Notification of patient and physician when criteria met including involvement of Supervising Monitoring Technician as secondary reviewer in event adjudication and physician/patient notification process	13
Preparation and transmission of urgent report when criteria are met	3
Review and analyze ECG data of the past 24 hours, identify abnormalities, prepare and transmit daily report	51
Prepare final summary report upon completion of monitoring period and transmit to physician	8
Total Monitoring Time	**290**

In addition to the monitoring activities shown above, from the responses it is typical for a certified technician to provide additional QA activities over the course of the prescription period as shown in Table 2 below.

Table 2. Volume Weighted Average Total ED Tech Time for Quality Assurance Activities

Quality Assurance / Over Read by 2nd Certified technologist	Vol Wgt AVG Total Time
Review of daily representational ECG data	15
Review of issue alerts	3
Review of report representation and prepared report	5
Total QA Time	**24**

Based on these findings, total certified electrodiagnostic technician time over the course of the monitoring period is 314 minutes (Table 3).

Table 3. Volume Weighted Average Total ED Tech Time in Minutes Per Patient Across the Up to 30 Day Monitoring Period

Activity Category	**Vol Wgt AVG Total Time**
Monitoring	**290**
Quality Assurance / Over Read by 2nd Certified Technologist	**24**
Total ED Technologist Time	**314**

Non-Certified Technologist

A number of other activities provided by non-certified technicians, clinical assistants or others occur on a per patient basis across the MCT prescription timeframe. Table 4 presents the volume weighted total time per activity that occurs over the monitoring period for a patient. Total time for these other activities cumulates to ~62 minutes.

Table 4. Volume Weighted Average Total Non-Certified Technician Time for Other Patient Activities Over the Up to 30 day Monitoring Period

Descrition	Vol Wgt AVG Total Time
Complete pre-procedure phone calls and prescription	
Contact patient to obtain clinical information, arrange for device to be delivered to patient, schedule appointment for patient education and connection to monitor	2.51
Provide education/obtain consent	
Provide patient education and instruction for use of device and service including monitor set up and care, electrode placement and care, how to record symptomatic events, alerts and connections	9.94
Prepare, set up monitoring of patient	
Configure device for patient per physician order	12.13
Prepare device for shipping with education materials and supplies	6.41
Trouble Shooting / Maintenance	
Respond to patient questions by phone	12.95
Contact patient to address break/problem in service issues	1.55
Contact patient to address electrode artifact issues	0.35
Contact patient to address other device issues	2.06
Disconnect / Discharge Patient	
Contact patient for end of service call to coordinate discharge from monitoring service	9.89
Clean and service device unit for next use	3.83
Total Time Other Patient Activities	**61.59**

Disposable Medical Supplies

We also asked the IDTFs to provide the typical quantity and a description of the single use, medical supplies that are necessary to provide MCT to an individual patient over the course of the monitoring period. A variety of items were included in the responses and ranged from items that are clearly disposable (e.g., alcohol pads) to items that appear to be equipment accessories (e.g., cellular phone) or indirect expenses (e.g., equipment packaging). We reviewed all of the submitted items and focused on those items that were common across the 5 IDTFs and that fit the direct cost supply concept. We then crosswalk those common, direct supply items to existing CMS PE supply input codes. Table 5 below lists the supply item, CMS supply code where applicable, and average quantity as per the IDTF response.

Table 5. Direct Supply Items Consumed During the Up to 30 Day Monitoring Period

Common Direct Supply Items	Potential CMS Crosswalk	Potential CMS Code	Average Quantity
Electrode, ECG (single)	electrode, ECG (single)	SD053	69
Patch	New	New	5
Skin prep pack or adhesive remover and alchohol pads	skin prep barrier wipes, swab-pad, alcohol, adhesive remover, pad (acetone)	SM029, SJ053, SG006	3
Patient education booklets	patient education booklet	SK062	2
Battery or Rechargable Battery	battery, AA	SK095	1

Of the 5 IDTFs, 3 use a patch and, on average across these IDTFs, the patient receives 5 total patches. One of the IDTFs that uses a patch also provides the patient with electrodes[8] while the remaining 2 companies provide only electrodes. When electrodes are provided, the average quantity is 69. All of the IDTFs provide at least one patient education booklet or patient guide. Three of the IDTFs provide some form of skin prep kit or adhesive remover and/or alcohol wipe with an average quantity of the kit at 2.5 and larger quantities if providing single alcohol wipes/adhesive remover rather than a kit.

While some of the IDTFs list batteries as a supply item, three of the IDTFs use a rechargeable battery and submitted USB charging cords as a supply item instead. Similarly, a single-use leadwire adaptor was also listed as a supply. The USB charging cords and leadwire adaptor are expenses incurred by the IDTF for direct patient use, however we have not included them in Table 5 above as it is possible they could be classified as equipment accessories. Likewise, shipping costs incurred by the IDTF are not reflected here. Consequently, our findings may underrepresent supply costs incurred by the IDTFs.

Conclusion

Information on the resource inputs necessary to provide external MCT over an up to 30 day period from 5 IDTFs indicate that total electrodiagnostic technologist time per patient is, on average, 314 minutes over the course of the monitoring period. Total time spent providing other direct patient activities related to the clinical service over the monitoring period is ~62 minutes. The average wear time of the MCT device is 20 days. A number of supply expenses are incurred by the IDTFs including a patch and/or, electrodes, materials to prepare the skin, patient education items and batteries or a rechargeable battery with USB charging cords.

[8] We understand that some IDTFs have multiple options for patients to support what is best for the individual. For example, if a patch causes skin irritation, smaller electrodes might not.

Appendix A

As a point of reference, Table A1 below provides Medicare fee for service volume data for MCT (93229) at the NPI level. At the time of this report, 2017 is the most recent year of NPI level data available. The below table reflects the top NPIs billing Medicare in 2017 and includes entities that participated in this initiative and as well as ones that were not part of the questionnaire process.

Table A1. 2017 Medicare FFS Volume by NPI for Code 93229

NPI	Name	Provider Type	HCPCS 93229 Service Count	Share of Total HCPCS 93229 Volume
1427320399	Cardionet, Llc.	IDTF	60,593	29%
1255367843	Lifewatch Services, Inc	IDTF	48,796	23%
1063414258	Preventice Services, Llc	IDTF	32,095	15%
1407273873	Medi-Lynx Cardiac Monitoring, Llc	IDTF	17,943	9%
1871964296	Medtronic Monitoring Inc	IDTF	7,476	4%
1497160717	Medicomp Inc	IDTF	3,203	2%
1255761664	Rmx Monitoring Llc.	IDTF	2,280	1%
1366877508	Versa Cardio	IDTF	2,147	1%
1962451203	A-1 Heart Monitoring, Llc	IDTF	1,521	1%
1205840204	Telerhythmics, Llc	IDTF	1,312	1%
Cumulative Volume of IDTFs Participating in this Initiative			164,910	79%
Total 93229 Volume*			209,168	100%

Medicare Fee for Service Provider Utilization and Payment Data Physician and Other Supplier Public Use File (PUF), 2017.
BioTelemetry is the umbrella for which both the former CardioNet & LifeWatch reside.
Low volume providers are not included in PUF totals to meet confidentiality and privacy requirements.

THE MORAN COMPANY

Prepared For: Powers, Pyles, Sutter, and Verville, P.C.
Date: 08/17/20
Preliminary results for external discussion prior to issuance of final report.
HCPCS 93229
Total ED Tech Time

Table 1. Average Total ED Tech Time for MCT Monitoring Activities

Intra Service Period - Monitoring. Typically the certified EDT Tech
Activation of device and confirm baseline ECG transmission has been accepted into monitoring center
Review and analyze recorded ECG data and/or triggered event data, cut strip of representational ECG data, determine if ECG events meet escalation, notification (emergent or urgent) criteria
Notification of patient and physician when criteria met including involvement of Supervising Monitoring Technician as secondary reviewer in event adjudication and physician/patient notification process
Preparation and transmit of urgent report when criteria are met
Review and analyze ECG data of the past 24 hours, identify abnormalities, prepare and transmit daily repo
Prepare final summary report upon completion of monitoring period and transmit to physician

Total Monitoring Time

Table 2. Average Total ED Tech Time for Quality Assurance Activities

Quality Assurance / Over Read by 2nd Certified technologist
Review of daily representational ECG data
Review of issue alerts
Review of report representation and prepared report

Total QA Time

314

Vol Wgt AVG	
1	
215	
13	
3	
51	281
8	

290

Vol Wgt AVG
15
3
5

24

THE MORAN

Prepared For: Power
Date: 08/17/20
Preliminary results for
HCPCS 93229
Total Time Other Ac

Potential CMS Code
CA005 or CA007
CA011
CA013 and/or CA014
CA021
CA021
CA024, CA037, CA038

COMPANY

s, Pyles, Sutter, and Verville, P.C.

external discussion prior to issuance of final report.

tivity

Complete pre-procedure phone calls and prescription
Contact patient to obtain clinical information, arrange for device to be delivered to patient, schedule appointment for patient education and connection to monitor
Provide education/obtain consent
Provide patient education and instruction for use of device and service including monitor set up and care, electrode placement and care, how to record symptomatic events, alerts and connections
Prepare, set up monitoring of patient
Configure device for patient per physician order
Prepare device for shipping with education materials and supplies
Trouble Shooting / Maintenance
Respond to patient questions by phone
Contact patient to address break/problem in service issues
Contact patient to address electrode artifact issues
Contact patient to address other device issues
Quality Assurance / Over Read by 2nd Certified technologist
See ED Tech Time Tab
Disconnect / Discharge Patient
Contact patient for end of service call to coordinate discharge from monitoring service and arrange for de
Clean and service device unit for next use

Vol Wgt AVG
2.51
9.94
12.13
6.41
12.95
1.55
0.35
2.06
9.89
3.83

RCSPG
Remote Cardiac Services Provider Group

August 17, 2020

RCSPG REPORT ON MOBILE CARDIAC TELEMETRY PRACTICE EXPENSES

The Remote Cardiac Services Provider Group undertook to gather practice expense costs of furnishing mobile cardiac telemetry (MCT) services as described by CPT Code 93229. The RCSPG is an organization whose members are Medicare-enrolled independent diagnostic testing facilities (IDTF) that provide and bill Medicare for remote cardiac monitoring services including MCT. The information provided below is to inform the American College of Cardiology and the Heart Rhythm Society as they prepare to make recommendations on practice expenses of MCT to the AMA's Relative Value Update Committee at its October 2020 meeting.

We identified three RCSPG members that perform MCT and two non-members that also perform the service and who agreed to participate in the process. Participating companies were BioTel, Rhythmedix, MediComp, Preventice, and MediLynx.

The RCSPG contracted with The Moran Company to develop a questionnaire on clinical labor time and supply items which we submitted to ACC and HRS for review before finalizing. The questionnaire used the clinical tasks in the RUC PE spreadsheet to the extent applicable. In addition, a list of clinical tasks specific to MCT and not adequately described in the RUC spreadsheet was developed based on company operations and workflow.

IDTFs returned their data directly to the Moran Company to ensure confidentiality of proprietary company information. Attached to this Report are the aggregated data on spreadsheets prepared by The Moran

Company. These are preliminary. The Moran Company's formal report will be provided by the end of the week.

We attach excerpts from a company Operations/Training Manual per your request. In addition, we include, again, the workflow document from BioTel that provides a detailed description of MCT monitoring.

We would be pleased to review the information with you in a conference call and answer any questions you might have.

Overview

All five companies completed the questionnaire. One company provides 59% of the total services reported by the 5 companies and another company provides at least 29% of total services. Thus, two of the five furnish almost 90% with the three remaining companies providing approximately 10% of services. The total number of tests provided by the IDTFs who completed the questionnaire is estimated to be over 500,000. Given this variation in testing volume, our consensus is that the volume-weighted average is more accurate and better defines the "typical" service.

Summary of Clinical Staff Time

As provided in more detail in the Moran preliminary spreadsheets (attached), clinical staff includes electrodiagnostic technicians (L037A) and medical/technical assistants (L026A).

- Total time for electrodiagnostic technicians, using a weighted average, is 314 minutes. This time falls within the CA21 for time not directly related to physician work time. The increase in

technician time from the last time this code was reviewed in 2008 is largely due to improvements in technology and algorithms which result in more frequent detection of potential events requiring technician adjudication.

- Total time for medical/technical assistants, using a weighted average, is 62 minutes.

Equipment Minutes of Use

- The average number of days of monitoring, using a weighted average, is 20. Based on this, we recommend equipment minutes of use for the telemetry system (EQ340) of 28,800 minutes (1440 x 20).

Summary of Supply Items

- **Patch:** Three of the IDTFs (including the dominant provider) use a patch instead of electrodes. The average number of patches provided to the patient is five for the three companies that use them. Those that report using electrodes use an average of 69 per patient/test.
    - We believe the patch is more commonly used than electrodes and recommend that this be added as a new supply item. We will provide invoices.

- **Patient Education Book:** All of the IDTFs provide a patient education book
    - We recommend maintaining this item as a supply
- **Batteries:** Three IDTFs provide a rechargeable battery and charging cords. For one IDTF, the battery is embedded in the
-

sensor and not removable. One IDTF uses two batteries (type not specified).

  - Given the above, we recommend removing the AA batteries from supply items. The rechargeable batteries are re-used and thus are more appropriately categorized as equipment accessories.

- **Skin Prep Packs:** Three of the IDTFS provide a skin prep pack or alcohol wipe and adhesive remover. We believe this is now typical. The average number of skin prep packs per test is 2.5.

  - We recommend adding skin prep barrier wipes (SM029) and adhesive remover pad (acetone) SG006 or creating a new supply code for the kit.

0MCT Process *(High Level)*

- Prescription is submitted via online portal or fax. *(reference documents: Salesforce Fax Enrollments SOP, Access User Guide MCT pg. 14)*
- Insurance Verification determines if coverage is active and services is covered. *(reference documents: MCOT Medicare Verification Process, Medicare Insurance Tagging, Approved doc site – Insurance Verification)*
- Activation of device. *(reference documents: Pegs Folder & YouTube Videos Folder)*

- **Monitoring Technician Syllabus**

Monitoring Technician Training Duration: 7 - 9 weeks
ECG 101 Course
4 weeks
CRAT Preparation Course
1 week
Software Training Course
MSA: 4 weeks
Holter: 2 weeks
Ramp up-12 weeks of reviewing expected weekly QA and productivity goals. Although this is not related to tech time it does give the opportunity to identify early on any deficits or challenges related to QA/productivity and provide re-training if necessary.

Monitoring Technician Role (MT 1) - To apply learned skills from ECG training and to analyze real time ECG data received into our monitoring software. All ECG data must be processed in a timely manner. The core responsibility of the Monitoring Technician is to interpret ECG data at a minimum of 96% accuracy and to identify when an event requires immediate attention by a Senior Monitoring Technician (SMT), or Supervisor.
Quizzes, Mid-Term and Final Exam - Upon the completion of each ECG section the trainees are quizzed on comprehension and ECG interpretation. A mid-term and final exam will be given half- way through and at the conclusion of ECG 101 training and Software training.
Testing Scores - An 85% or above is the required passing score on ECG Phase 1, ECG Phase 2, and Software in order to proceed in the program. Quiz scores are weighted in with the mid-term and finals to determine the overall score in each phase.
Course Details

Provided Materials
ECG 101 Course Book – (One of eight training volumes attached to this document)
Note Pad/Book
Calipers & Calculator
Strip practice packets/Homework

ECG Layout
Basic Anatomy & Physiology
Electrical Conduction System
Waveform, Measurement and Rate Calculation
ECG Rhythm Analysis and Interpretation

- **Technicians begin reviewing strips:**

Event Processing Procedure:

1. MT 1 signs into MSA and opens the Event Queue.
2. MT 1 selects the oldest event in the Event Queue.
3. MT 1 will analyze and process the event.

IF	THEN
If the recorded event is the Baseline for the Enrollment period, the 1st recorded event of the day or a PIE	• Interpret the raw data • Review the Notification Criteria for the patient
If the recorded event is the Baseline for the Enrollment period, the 1st recorded event of the day or a PIE and does not meet the Notification Criteria	• Cut a 6 second strip that best represents the raw data, interpret and post
If the recorded event is the Baseline for the Enrollment period, the 1st recorded event of the day or a PIE and does meet the Notification Criteria	• Cut a 6 second strip that best represents the raw data, interpret and post • Escalate the event according to the "Escalation Procedure"
If the recorded event is the Baseline for the Enrollment period, the 1st recorded event of the day or a PIE and contains an arrythmia that demonstrates a sudden increase or decrease in the heart rate	• Cut the onset and the offset of the arrhythmia, interpret and post
If the recorded event is the Baseline for the Enrollment period, the 1st recorded event of the day or a PIE and does not show the onset and offset of that arrhythmia	• Send a CRT Fetch request to the monitor for 4, 8 or 12 minutes of additional data and cut, interpret and post.
If the recorded event is a triggered event and meets Notification Criteria	• Cut a 6 second strip that best represents the raw data, interpret and post • Escalate the event according to the "Escalation Procedure"
If the recorded event is a triggered event and contains an arrhythmia that demonstrates a sudden increase or decrease in the heart rate	• Cut the onset and the offset of the arrhythmia and interpret and post appropriately
If the recorded event is a triggered event and does not show the onset and offset of that arrhythmia	• Send a CRT Fetch request to the monitor for 4, 8 or 12 minutes of additional data and cut, interpret and post
If the recorded event is a triggered event and it does not meet Notification Criteria	• Follow MSA rules for processing triggered events that do not meet Notification criteria • Interpret the raw data
If the recorded event is a triggered event and it does not meet Notification Criteria but represents a change in rhythm, rate, duration, ectopy from previous data collected for that day	• Cut a 6 second strip that best represents the raw data, interpret and post

- Senior Monitoring Technicians-Notifications determine if an arrhythmia requires notification to physician and/or patient. *(reference documents: Unified Notification Order Form and Combined Criteria Chart, MSA Urgent and Emergent Notification Process, MSA Urgent and Emergent Business Hours Notification Process, 24- hour notification process, Business hours notification process, Delayed event process)*

Notification Procedure:

1. SMT signs into MSA and opens the Issue Tracker
2. SMT selects the oldest pending notification in the Issue Tracker
3. SMT will review the escalated event for accuracy

IF	**THEN**
The event was escalated inappropriately	• SMT will downgrade notification to a finding review for the MT 1 to review and correct interpretation
The event was escalated appropriately	• SMT will review the Notification Criteria to determine if the event is **"**Urgent" or "Emergent**"** and review notification instructions
The event meets **"Urgent"** notification criteria	• SMT will post/fax "urgent" report. • SMT will call the notifying physician.
The attempt to notify is successful	• The SMT will document the date, time and who was notified of the "Urgent" event on the ECG strip and in the issue tracker.
The 1st attempt to notify is unsuccessful	• The SMT will make a 2nd attempt to notify.
The 2nd attempt is unsuccessful	• The SMT will document verbal notification unsuccessful on the ECG strip and in the issue tracker. • The SMT will email the AE of the unsuccessful notification.

IF	THEN
The event meets “Emergent” notification criteria	• SMT will post/fax “Emergent” report • SMT will make three attempts to call the patient and advise to seek medical attention. If unable to reach the patient the SMT will send a text message to the monitor requesting a call to the Monitoring Center. • SMT will call the notifying physician to report “emergent” notification and update patient status, if applicable.
The attempt to notify is successful	• The SMT will document the date, time and who was notified of the “Emergent event on the ECG strip and in the issue tracker.
The 2nd attempt is unsuccessful SMT will document	• The SMT will document verbal notification unsuccessful on the ECG strip and in the issue tracker. • The SMT will email the AE of the unsuccessful notification
The patient returns the SMT’s call after the **“Emergent”** notification has been reported to the notifying physician	• SMT will document record of conversation in MSA. • SMT will attempt to reach the notifying physician to update patient status and document accordingly

- Senior Monitoring Technicians-Reports review all representative ECG data; perform editing of daily and EOS reports; conduct quality assurance of reports and issue QA alerts when applicable; manually request data from the device for report representation and prepare requested reports submitted via email.

Report Processing Procedure:

1. SMT signs into MSA and opens the report task tab
2. SMT selects the oldest pending report
3. SMT reviews the report for:
    a. Daily representative data
    b. HR trend graph
    c. AF burden graph
    d. Ectopy burden graphs
    e. Symptomatic events
    f. Auto triggered events

IF	THEN
The report is accurate	• The SMT will post/fax report
Representative ECG data is interpreted incorrectly	• The SMT will correct ECG interpretation; post/fax report and submit QA alert
Onset/offset is not represented on the report	• The SMT will manually request the onset/offset from the device and will post/fax report
High/low HR spikes are seen on HR trend graph	• The SMT will manually request data to validate high/low HR spikes and will post/fax report
A PVC is not represented on the report	• The SMT will review prior events, select representative PVC for the report and will post/fax report
Symptomatic events have not been represented	• The SMT will select the most significant six second strip to represent on the report and will post/fax report

- During the monitoring period a patient can call Patient Services with questions or trouble shooting if they have device issues. *(reference documents: Flow charts folder, Handling Patient Services Complaints, Handling Escalated Patient Services Complaints)*
- During the monitoring period we will also contact a patient if they have a Break in Service. *(reference document: BIS Process)*
- Service is billed through Auto biller with some exceptions that may require manual billing. *(reference documents: MCOT Billing Report SOP, Approved Doc Site – Reimbursement Billing Folder)*

[redacted]

[redacted] Operating [redacted] Procedures

Cardiac Monitoring Center (CMC)

[redacted]

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1.3 Opening the Workflow & Workflow Layout

If needed, you can have both CMC Florida and CMC California open at the same time. To do this all you need to do is minimize one window and then double click on the [redacted] logo again and enter the other domains username and password. You can then alternate between the two using the [redacted] logos at the bottom of your screen.



Once logged in you will see the workflow screen below. The beige color advises you that you are in [redacted]



The green colored background will advise you that you are in the CMC3 California workflow.


[redacted]

Layout of the workflow page


[redacted]

The tree on the left and the tabs at the top allow you to search by specific criteria. You can search by patients, active procedures, physicians, or facility.



The left side of the workflow is the Inbound data (unviewed data coming in).



[redacted] Operating Procedures

Procedures can be opened either by double clicking on them or highlighting them and then clicking on "Open Selected". The data can also be sorted by preference, by clicking on the header at the top of each column.

Double click the procedure or highlight and click "Open Selected"

Sort by clicking on any column header


[redacted]

The right side of the workflow is the outbound data (data that has already been triaged for notifications and ready to go into reports for the customer). Further triaging may be necessary.


[redacted]

Chapter 2: Triage

2.1 Triaging Inbound:

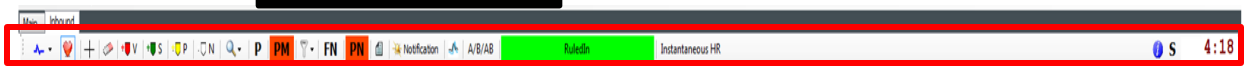
To get started with triage, click on the "Inbound" icon. This will take you to the new triaging process, as the old way consisted of working directly from the inbound section of the workflow.

[redacted]

Be aware of the countdown in the upper right corner. If the page is not advanced within 5 minutes, you will be kicked from the triage workflow. The toolbar only includes the items you will need at the time of triage.

[redacted]

Triage Toolbar



Channel set up-Currently only allows you to invert the recording

Toggle marked/inserted beats

Selection Tool

Beat Eraser

Add or change to Ventricular beat

Add or change to SV beat

Add or change to Paced beat

Noise beat(s)

Magnify or enlarge recording by %

P Pediatric Flasher- flashes when the patient is listed as pediatric protocol

PM Pacemaker Flasher- flashes when patient was enrolled with a pacemaker

Signal Filters- allows you to clean up artifact with filters

FN Facility Flasher- flashes when there is specific notification criteria for this facility

PN Patient Specific Flasher- flashes when there is specific notification criteria for this patient and/or Arrhythmias previously notified on

Notification Criteria- Allows you to view the notification criteria for this site

Notification Marks a recording as a notification- aka bell it

Superimpose- Allows you to grab rhythm and move it around to check regularity

A/B/AB Toggles channel A and channel B on or off

RuledIn All recording are automatically ruled in by default-To rule out-simply click on it to change it to RuledOut

Notification Marks a recording as a notification- aka bell it

Instantaneous HR Toggles the Instantaneous HR

Click to enter Symptoms, Location, and Activity from audio diary

S Symptoms Flasher- flashes when there are symptoms to be examined. You must click on the blinking "S" Flasher to acknowledge you have listened to the audio diary or viewed the symptom(s) listed, before the system will let you go to the next set of data.

4:53 Timer

1 Strip #

The goal of triaging is to identify all arrhythmias and /or symptoms that meet the notification criteria, enter all audio diaries containing symptoms from patient, rule out recording that meet the rule out criteria, and keep the non-critical recording that should be presented to the customer.

Navigating between recording sets:

- Pressing the letter “N” or right clicking on the mouse and selecting “Next” will take you to the next set of recordings
- Pressing the letter “B” or right clicking on the mouse and selecting “Back” will take you back to the previous set of recordings (If you utilize the Back function, you must triage the recordings on the current page before you go back, otherwise it will count against you if you miss anything. This function can be useful if the timer is getting low and you need a few more moments to review the recordings in question further. Select “Next” then select “Back”)
- Pressing the letter “C” or right clicking on the mouse and selecting “Close” will close out the triage session. To open triage again, you must click elsewhere first, then back on triage.

Layout of Triage Screen:

Each recording contains: Patient Name, DOB, Age of Patient, the status of each recording, symptoms manually entered by the patient, flasher information, and the strip # of this data set. I. All recordings are presented to you in the “Ruled In” state. It is your responsibility to change these based on our current Rule-Out Criteria. Please be aware that the triage system was designed to perform best on a larger screen with a portrait view, so it will be necessary to scroll ALL THE WAY DOWN TO VIEW ALL RECORDINGS, if you do not have this setup.



Chapter 3: Notification Criteria

Each customer/facility/doctor's office will have their own notification criteria that we are required to follow. The site specific criteria can be found in each and every procedure. As described in the previous section, select the criteria icon in the toolbar located above the ECG recording to view the criteria.



Over time [redacted] has updated the notification criteria form. It is important to note that most sites do not have the same criteria. Always confirm the criteria before creating a notification report. Below are two examples, one for pre-September 20th, 2018 and one post September 20th, 2018.

3.1Notification Contacts/Criteria: (Pre-September 20th, 2018)

[redacted]

Notification Contacts/Criteria

[redacted]

Page 2 of 3

Internal Use Only
PaceArt _____
Beacon _____
CT _____

Please FAX this two-page form to: (855) 24[redacted]

Contact Page: Provides the person of contact and route of contact when a notification is warranted, along with hours of operation and any special instructions.

Date: _____ Completed by: _____

Client: _____

Address: _____

Normal Business Hours

Please list your normal business hours with time zone (e.g. M-F 8am-5pm, Check time zone box & Sat/Sun)
Time Zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific ☐ Alaska ☐ Hawaii
Weekends: Open: ☐ Saturday ☐ Sunday **Closed:** ☐ Saturday ☐ Sunday

_____

Contact person and/or department _____

Direct Phone number _____ Alternate Number _____

FAX Number _____

Is it is acceptable for Medicomp to leave a message as the sole way of informing you that one or more of the Notification Arrhythmia listed below has occurred? YES ☐ NO ☐

If "NO", please specify any additional, relevant contacts (Name, area code, and phone number):

1. Name/Department _____
   Direct Phone Number _____
2. Name/Department _____
   Direct Phone Number _____

After Hours

Same contact information as Normal Business Hours? YES ☐ NO ☐

If After Hours contact information differs from Normal Business Hours, please complete the following:

Contact person and/or department _____

Direct Phone number _____ Alternate number _____

Additional instructions _____

_____

[redacted]

Standard Notification Criteria: (Pre-September 20th, 2018)

Notification Criteria & Contacts

[redacted]

Page 3 of 3

Client: _____

(^) Sustained Arrhythmia are defined as a duration of 30 seconds or greater. Triage actions will not be taken if we have been notified on a patient by patient basis that certain arrhythmias are chronic for that patient. All arrhythmias marked with an asterisk (*) will be triaged until we have followed the patient with one or two follow-up transmissions. If the arrhythmia/symptom occurs after business hours and the follow-up is normal, you will be notified the next business day.

	Notification Arrhythmia	Parameters
1.	Sustained^ Supraventricular Tachycardia (SVT in which the P wave has changed Morphology or is Absent)*	HR > 150
2.	Sustained^ Atrial Fibrillation w/RVR*	HR > 150
3.	Sustained^ Sinus Tachycardia, non-exercise related*	HR > 180
4.	Sustained^ New onset of Atrial Fibrillation*; Notification will be made next business day if the diagnosis is Atrial Fibrillation.	Any rate
5.	Sustained^ Marked Bradycardia, IVR or A-fib with SVR*	HR < 36
6.	SA Block 3:1, Sinus Arrest, pause of uncertain origin	> 3.0 sec
7.	Second degree AV block type 2, high grade AVB; or Complete Heart Block	All episodes
8.	Ventricular Standstill	All episodes
9.	Ventricular Tachycardia/Wide QRS Tachycardia (all types) of	**> 6 beats**
10.	Sustained^ Exercise Related Sinus Tachycardia*	> 220-age
11.	Ventricular Escape Rhythm/Accelerated IVR	> 6 beats
12.	Ventricular Fibrillation or Torsades de Pointes	All episodes
	SYMPTOMS	
1.	Syncope/Blackouts – any episode *	YES
2.	Chest pain/Angina – associated with ischemic changes in ECG and/or sustained for 2 minutes in duration*	YES
3.	Seizure – any episode*	YES
4.	Severe shortness of breath, unprovoked or with ECG changes*	YES
5.	Pacemaker failure	YES

Authorized Signature _____ Date: _____

Name (please print) _____

[redacted]

3.2 Current Notification Criteria Form (Post-September 20th, 2018)p1

[redacted]

Notification Criteria for Cardiac Event/MCT Procedures

Please review this form carefully. The information contained in this document defines the parameters that Medicomp, Inc. will use to notify you of significant findings seen during an Event/MCT procedure. The guidelines listed below will be implemented across all patients enrolled with your facility.

It is our policy to take the following actions when physician notification is warranted:

1. Notify the facility of the patient's name and the reason for contact as specified on this Notification Criteria form.
2. [redacted] maintains documentation stating the name of the person contacted, phone number contacted, date and time of contact, reason for notification, and mode of message delivery (e.g. phone, email, fax).
3. All reports will be published to [redacted] for printing and/or viewing. If requested by an ER facility, a preliminary report can be faxed.
4. If alternate contact information is not provided and leaving a voicemail is unacceptable [redacted] will make three notification attempts. If unsuccessful after third attempt, notification will be made the next business day.
5. Activate EMS if warranted, as defined on page 3.

Note: Notification Criteria forms must be signed by the physician that represents your facility and faxed or emailed directly to [redacted] at the fax number or email address below as soon as possible. Medicomp must be informed immediately of any updates or changes in contact information. Failure to do so may result in a delay in notification of critical dysrhythmias.

[redacted]

Current Notification Contact Page (Post-September 20th, 2018)p2

Internal Use Only
PaceArt _____
Beacon _____
Icon _____

Cardiac Event/MCT Monitoring

Notification Contacts/Criteria [redacted]

Please Email [redacted]

Date: _____ **Facility:** _____

Contact: _____ **Address:** _____

NORMAL BUSINESS HOURS

Please list your normal business hours below with time zone (e.g. M-F 8am-5pm, Sat?

M-F _____ Saturday_____ Sunday _____

Time Zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific ☐ Alaska ☐ Hawaii ☐ Other:_____

[redacted] will attempt to contact the after hour's person of contact if your facility is closed on a holiday. If we cannot make contact after 3 attempts, we will notify Next Business Day. Please list any holidays in which your facility will be open.

Contact person and/or department: _____

Contact #: _____ **Alternate #:** _____ **Fax #:** _____
(Area code & phone #)

Is it acceptable fo[redacted]eave a message during **Business Hours** as the sole way of informing you that one or more of the Notification Arrhythmias listed on page 3 have occurred? **YES** ☐ **NO** ☐

If "NO", please specify any additional, relevant contacts (Name, area code & phone number):

1. Name/Department: _____
   Direct Phone Number: _____
2. Name/Department: _____
   Direct Phone Number: _____

AFTER HOURS

Is it acceptable fo[redacted]o leave a message during **After Hours** as the sole way of informing you that one or more of the Notification Arrhythmias listed on page 3 have occurred? **Yes** ☐ **NO** ☐

If after Hours contact information differs from Normal Business Hours, please complete the following:

Contact person and/or department: _____

Direct Phone Number: _____ Alternative Number: _____

Additional Instructions: _____

[redacted]

Contact Page: Provides the person of contact and route of contact when a notification is warranted, along with hours of operation and any special instructions.

Current Notification Criteria Form (Post-September 20th, 2018)p3

Facility: _____ Site ID: _____ [redacted]

Cardiac Event/MCT Notification Criteria: Adult & Pediatric

Activation of Emergency Protocol: If severe or life-threatening conditions are seen or the patient is highly symptomatic, it [redacted] policy to contact the patient first, instruct them to seek emergency medical attention, dispatch EMS if necessary, and then no[redacted] physician as instructed below. Activation of the Emergency Protocol is warranted by the parameters below. "Highly symptomatic" refers to the following symptoms: nausea, acute SOB, acute chest pain/pressure, diaphoresis, numbness of the neck or jaw, radiation of pain, numbness to an extremity or unable to speak. **PLEASE INDICATE BELOW WHETHER YOU WANT TO BE NOTIFIED AH (After Hours) OR NBD (Next Business Day) WHEN WE SEND A PATIENT TO THE EMERGENCY DEPARTMENT.**

EMERGENCY

	Activation of Emergency Protocol cannot be modified NOTIFICATION ARRHYTHMIAS REQUIRING ACTIVATION OF MEDICOMP'S Emergency Protocol	Notify After Hours or Next Business Day?
1.	Pauses ≥ 6 sec	AH ☐ NBD☐
2.	Complete Heart Block	AH ☐ NBD☐
3.	Ventricular Tachycardia/ Wide Complex Tachycardia (all types) ≥ 30 sec	AH ☐ NBD☐
4.	Idioventricular Rhythm or Ventricular Escape Rhythm, HR ≤ 40 bpm ≥ 30 sec	AH ☐ NBD☐
5.	Torsades de Pointes, Ventricular Fibrillation, Ventricular Flutter	AH ☐ NBD☐
6.	Acute Shortness of Breath or Acute Chest Pain/Pressure, unprovoked or with ECG changes	AH ☐ NBD☐
7.	Highly-symptomatic patients regardless of arrhythmia	AH ☐ NBD☐
8.	Severe/Life Threatening Arrhythmia(s) that do not subside after one or two follow ups	AH ☐ NBD☐
9.	Pacemaker failure	AH ☐ NBD☐

All arrhythmias marked with an asterisk (*) will be triaged until we have followed the patient with one or two follow-up transmissions (depending on the severity of symptoms) at intervals between 5 and 20 minutes. If these arrhythmias/symptoms occur after business hours and the follow-up ECG is normal, you will be notified the next business day if you have not agreed to be notified by voicemail or selected AH (After Hours) below.

^ Sustained ≥ 30 seconds. Note: A standalone, 15-second auto-capture recording also qualifies for notification.

STANDARD

	URGENT NOTIFICATION ARRHYTHMIAS	Parameters	Notify After Hours or Next Business Day?
1.	(^) Sustained (*) Supraventricular Tachycardia PEDIATRIC CRITERIA ≥ 180 bpm	HR ≥ 150	AH ☐ NBD☐
2.	(^) Sustained (*) Atrial Fibrillation w/RVR	HR ≥ 150	AH ☐ NBD☐
3.	(^) Sustained (*) Sinus Tachycardia, non-exercise related	HR ≥ 180	AH ☐ NBD☐
4.	(^) Sustained (*) First Observance of Atrial Fibrillation. First observance of Afib will be made next business day if found after hours and the diagnosis is Afib	Any rate	AH ☐ NBD☐
5.	(^) Sustained (*) Marked Bradycardia, IVR or Afib with SVR, Second Degree AVB Type I Wenckebach PEDIATRIC CRITERIA < 60bpm	HR ≤ 36	AH ☐ NBD☐
6.	Second degree AV block type 2, High grade AVB 3:1 or higher, Second degree AV block 2:1 not in the presence of Wenckebach	All episodes	AH ☐ NBD☐
7.	Ventricular Standstill, Asystole, or Pauses	≥ 3 sec	AH ☐ NBD☐
8.	Ventricular Tachycardia/Wide Complex Tachycardia (all types)	> 6 beats	AH ☐ NBD☐
9.	(^) Sustained (*)Exercise Related Sinus Tachycardia	> 220-age	AH ☐ NBD☐
10.	Ventricular Escape Rhythm/Accelerated IVR	> 6 beats	AH ☐ NBD☐
11.	(*) Syncope/Blackouts	Any	AH ☐ NBD☐
12.	(*) Seizure	Any	AH ☐ NBD☐

Authorized Physician's Printed Name: _____

Authorized Signature: _____ Date: _____

[redacted]

3.3 Just Fainted Policy

With the steady transition to wireless cardiac monitors, [redacted] electrocardiographers frequently encounter **"Just Fainted"** entered as a symptom by the Patient. The Just Fainted recording is identified when triaging recordings.

Figure 1: Screen shot identifying a Symptom as Just Fainted. Also, identifying Symptom icon

[redacted]

The following policy and procedure are applicable for all Mobile Cardiac Telemetry (MCT) and Wireless Event (WE) procedures.

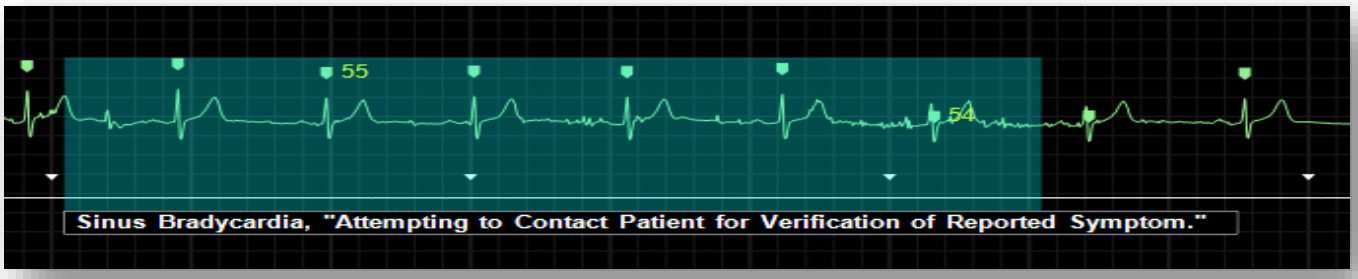
- **Call the Patient to verify if he/she has fainted. The Symptom Button may have been pressed accidentally.**
- **If the Patient fainted, start the Notification Process. Transfer the Notification Report and call the Site immediately.**
- **If the Patient did not faint, change the Symptom of Just Fainted to No Symptoms.**

What If I Can't Reach the Patient?

If the CCT/ EMT-P/ CMC Specialist cannot reach the Patient, proceed forward with the Notification Process. **The CMC staff may wait up to one (1) hour or the end of the shift whichever comes first for a Reply from Patient. Do not hand off this task to the oncoming shift. The Notification must be completed prior to your departure.** You are accountable for this Patient.

Old policy instructions required us to enter special notes in the Notes section of the report. Since the note section will no longer be available for Classic reports and is not available for MCTs, please follow the new policy that follows. If you are unable to reach the Patient the strip selections from the recording that contained the Just Fainted symptom must indicate the following at the end of the strip label:
"Attempting to Contact Patient for Verification of Reported Symptom."

Figure 2: Example of required comment at the end of the strip label



been unable to reach the Patient.

[redacted] will continue to try and reach the Patient for a total of three (3) times over the time period described above.

Plan to proactively notify. If there is a short time between the sites end of the business day hours, notify right away rather than delay the notification call until the next business day. Be proactive.

What Do I Do When the Patient Returns the Call?

After the Patient returns the call, update the report. The purpose of the Amended Report is to inform the physician if fainting was confirmed or denied by the Patient.

- Type in one of the following statements at the end of the strip labels (overwrite the previous comment of Attempting to Contact Patient to Verify Symptom of Just fainted if applicable):

  Amended Report: Contacted Patient and Confirmed Patient Fainted

  or

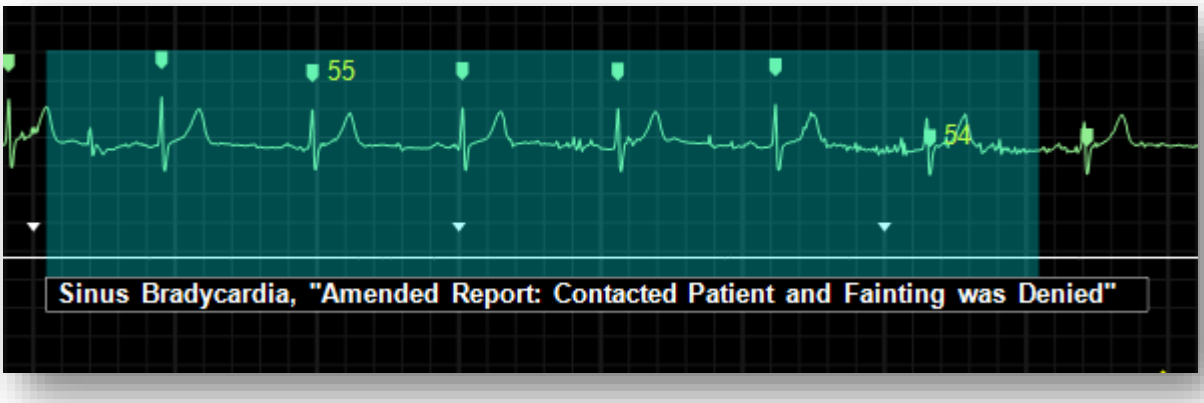
  Amended Report: Contacted Patient and Fainting was Denied

- Leave the Amended Report marked as a Notification 

- Transfer the Amended Report

- **A follow-up verbal Notification must be made to the Site reporting the Amended Report**

Figure 3: Example of Contacted Patient and Fainting was denied



This portion of the page was left Blank intentionally.

Please note:

The Patient ALWAYS comes first. Use your best judgement. Document your actions or decision if you deviate from the standard policy. Always follow the notification criteria.

In the case where a report of Just Fainted occurs during late night or early morning hours, the CCT / EMT-P may use his/her best judgement regarding whether to call the patient in the middle of the night.. You may determine that it is best to wait until the morning to contact the Patient.

Clearly communicate directions for the AM Patient Verification to the oncoming shift.

Clearly document your actions/ decision.

Remember, if it wasn't documented, it wasn't done.

Friendly Reminder: If the Consistency Contract is NOT followed, the report will be reviewed as a Missed Notification.



EFFICIENCY TOOL

The use of these preformatted updates provides consistency throughout all CMCs and Shifts and enhances Medicomp's professionalism.

Here are some examples of the canned sentences.

- **Attempting to Contact Patient for Verification of Reported Symptom Just Fainted**
- **Attempting to Contact Patient for Verification of Symptom Selected**
- **Attempting to Contact Patient for Verification of Reported Symptom**

Amended Canned Comments:

- **Amended Report: Contacted Patient who Confirmed He/She Fainted**

  -Or-
- **Amended Report: Contacted Patient who Denied Fainting**

Here is a preformatted comment for most recent data requests resulting in a Notification Report.

No Notification Arrhythmia present. Report sent due to physician request and represents the most recent Patient data.

Here is a preformatted comment for Unknown Duration of Arrhythmia. Offset Only.

- **Onset of Ventricular Run NOT captured. Duration of Run is at least 9 Beats.**
- **Onset NOT captured. Offset only.**
- **Duration of Arrhythmia is NOT captured. The rhythm strip represents Offset Only.**

Here is a preformatted comment for MCT procedures where one channel is removed due to Artifact.

- **Second Channel Removed due to Artifact**

Here is a preformatted comment for verifying Activity.

- **Verified activity with Patient. Patient was walking to class.**
- **Verified activity with Patient. Patient was in gym class and was _____ .**
- **Verified activity with Patient. Patient was at rest.**
- **Verified activity with Patient. Patient was exercising and was _____ .**
- **Waiting Callback to Confirm Activities Associated with Elevated Heart Rate**
- **Awaiting Patient Callback to Confirm Activity**

Here is a preformatted comment for Accounts requiring Notification details to be documented in the body of the Final Analysis (Notes Section) of the Notification Report.

- **Pending verbal notification.**
- **Pending verbal notification. Verbal notification complete. Dr. _____ notified at _____.**
- **Notified _____ at _____.**

[redacted]

- **The Person notified**
- **The Number we reached the person notified**
- **The Date/Time the Notification was made**

- **Notified (Insert Person Notified Name Here) at (Insert Phone Number Here) on (Insert Date and Time) [Your Initials]**

3.4 Sinus Tachycardia > 180 Policy

[redacted] electrocardiographers frequently encounter and identify the rhythm **Sinus Tachycardia Greater ≥ 180 bpm.**

If the patient has not selected and reported any symptoms, the CCT/ EMT-P/ CMC Specialist must adhere to the following protocol.

Call the Patient to determine activity at the time of the recording. The Patient may report physical activity or describe that he/she was **At Rest**.

If the Patient reports that he/she was **NOT** performing an activity that would cause an increased heart rate, initiate the Notification following the Site Notification Criteria for Sinus Tachycardia ≥ 180 bpm.

If the Patient reports an activity that is associated with an expected increased heart rate, change the Symptom, Location, Activity (SLA) Tab in the Beacon recording to reflect the information obtained from the Patient. Examples include Racing Heart; Shoveling Snow; Yard; or Pounding Heart, Exercising, and /or Gym. **IMPORTANT-PLEASE NOTE**: This rhythm could still meet standard notification criteria by having a sustained heart rate <220-age, so keep this in mind! *Example: 35 y/o pt and the rhythm is Sinus Tachycardia at a rate of 187 (exercise related); we would still notify if the criteria stated that we notify for Exercise Related Sinus Tachycardia >220-age.*

What If I Can't Reach the Patient?

If the CMC Specialist cannot reach the Patient, proceed forward with the Notification Process. **The CMC staff may wait up to two (2) hours or the end of the shift whichever comes first for a Reply from the Patient. Do not hand off this task to the oncoming shift. The Notification must be completed prior to your departure. You are accountable for this Patient.**

If unable to reach the Patient, the comment below should be added to the end of the strip label:

"Attempting to Contact Patient for Verification of Activities During Selected Times."

Figure 1: Screenshot of required comment at end of strip label-if unable to reach patient


[redacted]

When notifying the Site, indicate that [redacted] has reached out to the Patient to identify his/her activities; but has been unable to reach the Patient. Medicomp will continue to try and reach the Patient for a total of three (3) calls.

What Do I Do When the Patient Returns the Call?

After the Patient returns the call and the activities are obtained, update the existing Notification Report indicating the symptom/ activity. Amend the report by following the steps below:

- Add a canned comment to the end of the strip label(s): **"Amended Report: Patient indicates that his/her activity during the elevated heart rate was (fill-in-the-blank.) (see other examples on next page)**
- Leave the Amended Report marked as a Notification. 

- Transfer the Amended Report
- A follow-up verbal Notification must be made to the Site reporting the Amended Report and Patient activities.

Figure 2: Example of required comment at the end of the strip label when a patient calls back



Please note:

The Patient ALWAYS comes first. Use your best judgement. Document your actions or decision if you deviate from the standard policy.

In the case where the rhythm occurs during late night or early morning hours, the CCT/ EMT-P may use his/her best judgement. You may determine that it is best to wait until the morning to contact the Patient.

Clearly communicate directions for the AM Patient Verification to the oncoming shift.

Clearly document your actions/ decision.

Remember: if it wasn't documented; it wasn't done.



EFFICIENCY TOOL

The use of these preformatted updates provides consistency throughout all CMCs and Shifts and enhances Medicomp's professionalism.

Here are some examples of the canned sentences.

- **Attempting to Contact Patient for Verification of Activities during Selected Times**
- **Attempting to Contact Patient or Guardian for Verification of Activities during Selected Times**

Amended Canned Comments:

- **Amended Report: Patient indicates that his/her activity during the elevated heart rate was (fill-in-the-blank.)**
- **Amended Report: Patient's mother/father reports that activity during the elevated heart rate was (fill-in-the-blank.)**

Here is a preformatted comment for most recent data requests resulting in a Notification Report.

No Notification Arrhythmia present. Report sent due to physician request and represents the most recent Patient data.

Here is a preformatted comment for Unknown Duration of Arrhythmia. Offset Only.

- **Onset of Ventricular Run NOT captured. Duration of Run is at least 9 Beats.**
- **Onset NOT captured. Offset only.**
- **Duration of Arrhythmia is NOT captured. The rhythm strip represents Offset Only.**

Here is a preformatted comment for MCT procedures where one channel is removed due to Artifact.

- **Second Channel Removed due to Artifact**

Here is a preformatted comment for verifying Activity.

- **Verified activity with Patient. Patient was walking to class.**
- **Verified activity with Patient. Patient was in gym class and was _____ .**
- **Verified activity with Patient. Patient was at rest.**
- **Verified activity with Patient. Patient was exercising and was _____ .**
- **Waiting Callback to Confirm Activities Associated with Elevated Heart Rate**
- **Awaiting Patient Callback to Confirm Activity**

Here is a preformatted comment for Accounts requiring Notification details to be documented in the body of the Final Analysis (Notes Section) of the Notification Report.

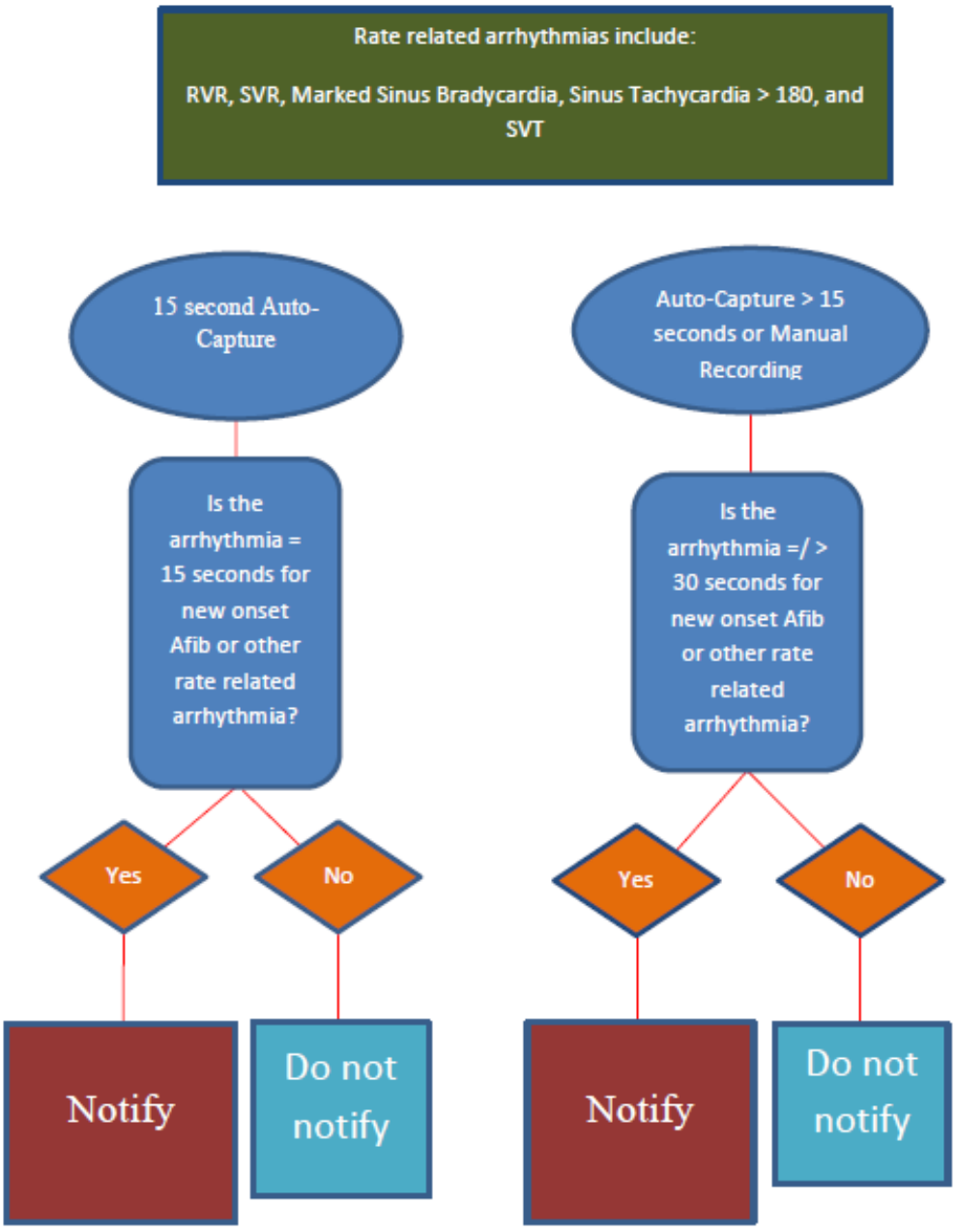
- **Pending verbal notification.**
- **Pending verbal notification. Verbal notification complete. Dr. _____ notified at _____.**
- **Notified _____ at _____.**

[redacted]

- **Notified (Insert Person Notified Name Here) at (Insert Phone Number Here) on (Insert Date and Time) [Your Initials]**

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3.5 Identifying new onset of Afib and other rate related arrhythmias for Notifications



Control date: 20180208wb Always Follow the Site's Notification Criteria. See Also- Written document titled,, "Identifying new onset of Afib and other rate related arrhythmias for Notification "

Identifying new onset of Afib and other rate related arrhythmias for Notification

Rate related arrhythmias include:

RVR, SVR, Marked Sinus Bradycardia, Sinus Tachycardia > 180, and SVT

- **15 second Auto-Capture**

  * Notify if the arrhythmia is = 15 seconds for new onset Afib or other rate related arrhythmia

  * Do not notify if the arrhythmia is < 15 seconds for new onset Afib or other rate related arrhythmia

< 15 seconds of Afib should be identified as "SV Ectopic Run–Consider PAF"

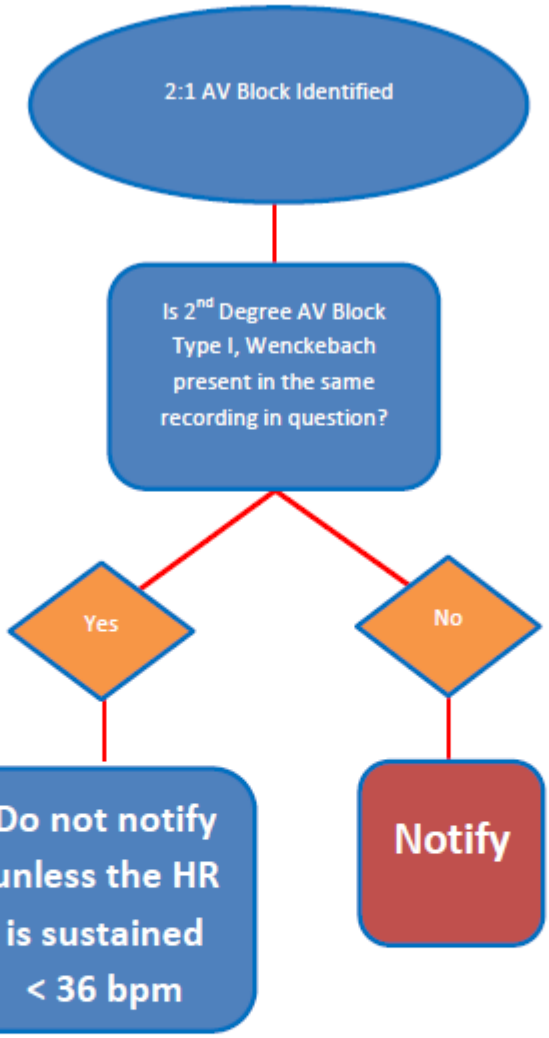
- **For All Other Auto-Capture Length (ex 30 sec/ 45 sec) and All Manual Recordings**

  * Notify if the arrhythmia is =/ > 30 seconds for new onset Afib or other rate related arrhythmia

  * Do not notify if the arrhythmia is < 30 seconds for new onset Afib or other rate related arrhythmia

Always follow the Site's Notification Criteria!

3.6 Identifying 2:1 AV Block for Notifications



When notifying on 2:1 and 2nd Degree AV Block Type II cannot be proven because the entire recording is 2:1,(you cannot check whether the back-to-back PR intervals are the same in 2 consecutive PQRS Complexes) Label the strip selections 2:1 AV Block, Cannot Rule Out Second Degree AV Block Type II

Control date:20180208wb Always Follow Site's Notification Criteria. See Also- Written document titled,, "Notifying on 2:1"

Notifying on 2:1

2:1 AV Block Identified

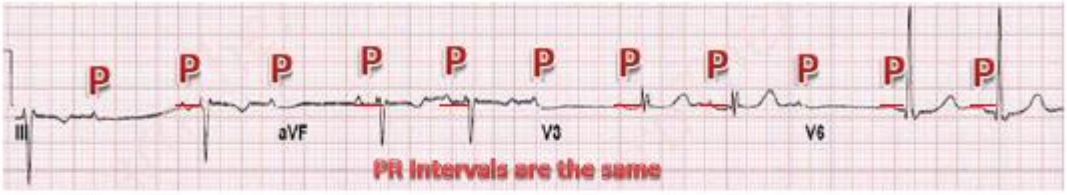
- **Do not notify if Second Degree AV Block Type I, Wenckebach is present in the same recording**
  Unless the heart rate is sustained at a rate < 36 bpm
- **Notify on all other instances of 2:1**

When notifying on 2:1 and a 2nd Degree AV Block Type II cannot be proven due to the entire recording is 2:1,(meaning you cannot check whether the back-to-back PR intervals are the same or not in 2 consecutive PQRS complexes) Label the strip selections 2:1 AV Block, Cannot Rule Out Second Degree AV Block Type II

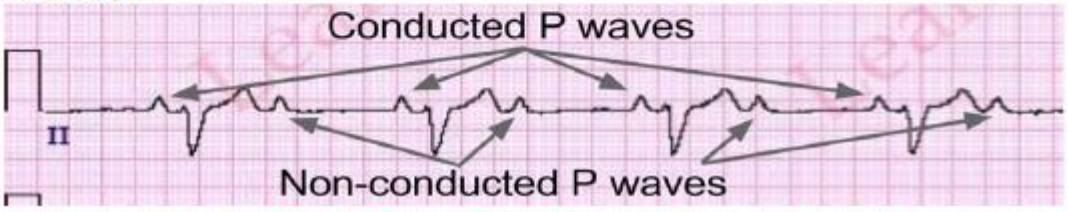
Example of when not to notify: 2:1 with Wenckebach



Example of when to notify: 2:1 w/ 2nd Degree AVB



Example of when to notify: 2:1 with no consecutive PQRS complexes to measure PR Interval (In the case of only seeing 2:1 throughout recording, err on side of caution and notify whether the QRS is wide or narrow)



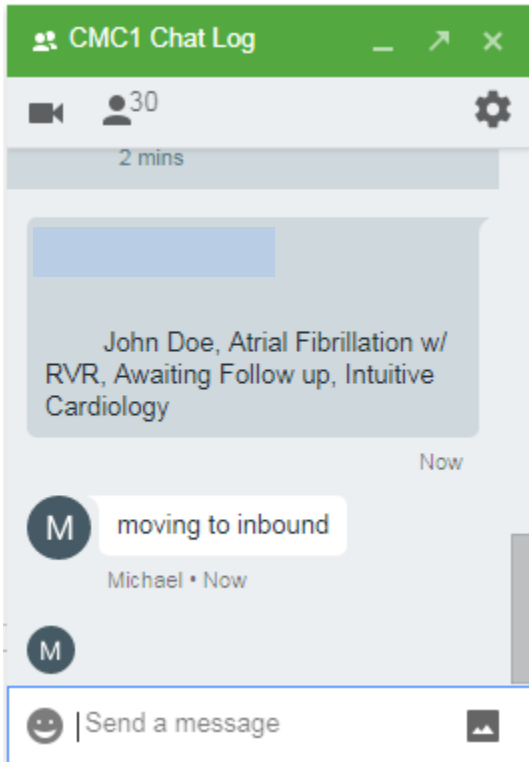
Control date: 20180208wb Always Follow the Site's Notification Criteria. See flow chart for more details.

3.7 Documenting Notifications

When arrhythmia(s) and/or symptom(s) are identified as a notification, the team member that identified the notification is responsible for notifying the Notification Team for that shift. Currently, all arrhythmia notifications will be handled by CMC Florida and CMC California, but it is still the responsibility of the CCT triaging or working in Outbound to make the team aware of the notification that needs to be addressed. This is simply done by utilizing the Team [redacted]

- At the start of each shift, you should log into the group chat and advise that you're starting your shift. This will help Shift Leads decide how to best organize all team members for that shift.
- When a notification is identified you are required to bell the notification, and then enter the notification details into the CMC1 Chat Log (Group Chat). The format should be: Patient's name, Notification reason and if it requires a call to the patient for symptoms/activities, Site name, and Urgency (Urgent, awaiting follow-up, etc). Example:CMC1, John Doe, Atrial Fibrillation with RVR, Awaiting Follow-up, Intuitive Cardiology)
- Keep in mind there may come a time that you will need to create the report and make the notification if instructed to do so.
- If located at CMC3 San Francisco CA, you will not be utilizing the CMC1 Chat box, please see your Shift Lead for further training.

Example of the CMC1 Chat Log (Google Chat Box)



- By providing the site you will be advising the notification team whether the call can be grouped with another call to the same site, and whether it's really a notification worthy arrhythmia for that site.
- By providing the need for a call for symptoms/activities, it will allow the other people the chance to make the sheet and phone call to the Pt rather than waiting for the notification team to call these when critical arrhythmias may also be pending calls.
- By providing the urgency (Urgent, awaiting follow-up, etc), it lets the notification team know that other calls may need to take a back seat to this one.

It's not G-Chat, It's a Patient
Documenting Acknowledgement of Notifications & Inbound-Outbound Presence

In our mission to manage each patient properly, we want to be sure that with so many chats going on at once, we identify the responses appropriately. Most people are already on the right track but it will be important to follow this going forward for our safety as well as each patient.

When moving into Inbound or Outbound, it has been well documented by each participant. At times, it has been noticed that there is simply a response of "k" or other poor acknowledgements. When patients are entered for notifications, most team members are replying "Thanks, I got XXXXX" which is great, but this has also been seen responded to with "k". Please remember that this is a Medical Office setting and proper documentation is very important. If a notification is missed or a patient is not properly handled, this would not be seen as proper documentation of receiving the hand-off of a notification. Also, please remember that when you are signing in and typing "Inbound" in the chat and your directive is to manage it as a group, the team is relying on your full attention, this time should be dedicated to triaging and not participating in other activities (ie: making reports, responding to emails, texting, etc). Think of this just as if you were in a hospital setting and everyone is coming in as a trauma, you wouldn't divert to other tasks before figuring out where the bleed is coming from. That's why we call it triaging and the team is relying on everyone to equally contribute and get it down collectively so they can all move back to outbound. If you choose to perform other tasks, please reserve them to your break-time or during outbound where the rest of the teams productivity is not affected.

*If your team does not handle it this way as a collective moving back and forth, this may not apply, but please be sure that you understand the directive for the shift from your shift lead.

Going forward, all Inbound and Outbound movement should continue to be documented with "Inbound" or "Outbound" Abbreviations such as "I" or "O" of "k" will not be seen as acceptable responses.

Also when you are handling notifications, the response should identify which patient you are accepting and taking ownership of. Again, "K" or "Got it" will not be acceptable. Naming the patient to acknowledge each one will provide reliable communication and research-able documentation. Here is an example of an acceptable response.


[redacted]

Remember... It's not a G-Chat... It's a Patient. CS

Chapter 5: Creating a Patient Report (Individually from the OB workflow)

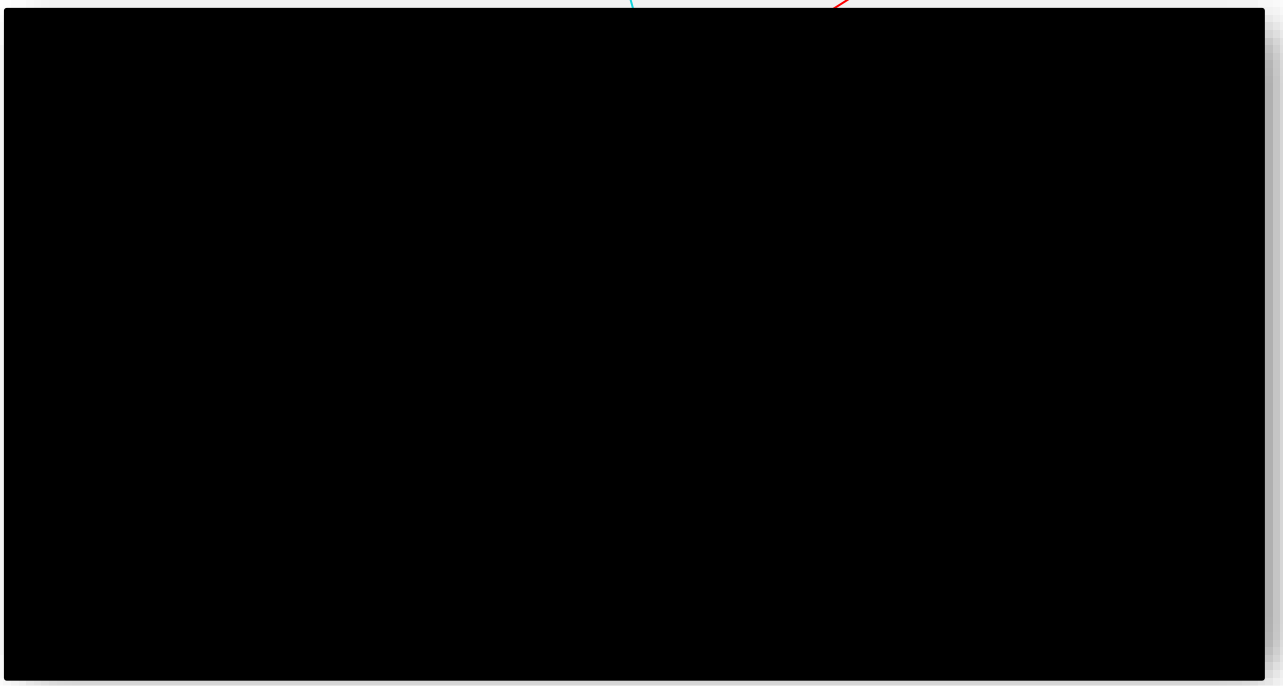
1. Select a Patient Procedure from the Outbound Queue on the right side of the workflow page



2. Once again triage the Patient Recordings using the Triage Criteria to De Bulk the report. Keep at least one NSR, one Sinus Bradycardia, and one Sinus Tachycardia strip selection for each day. Include the underlying rhythm for at least one of each rhythm type for each day.
3. Click on the First Recording that you want to use in your report.
4. Use the signal filters to clean up the recording if needed
5. Click on the ECG area of the recording that you want to be the center of your strip. Yellow brackets will appear at the start and end of the strip selection.



6. Right click on the strip where the yellow brackets now appear and start typing in the label using the predictive text- to help us keep consistent with our labeling. Hit the in enter key to grab the selected strip (the strip will now be highlighted in green). Then click “Save”.
7. After selecting all the strips that you want to include in your report, look in the tree for the unsent report and click on it to open the report. It will be a white report (without the blue arrow) located at the bottom of the recording tree.
8. Verify that your report is correct (heart rate is on the strip, the recording is cleaned up, and the label is correct), then Double click in the “Notes:” box to complete your clinical findings. Sign the report with your name and credentials by clicking on the “Sign Report” tab. Then click OK!

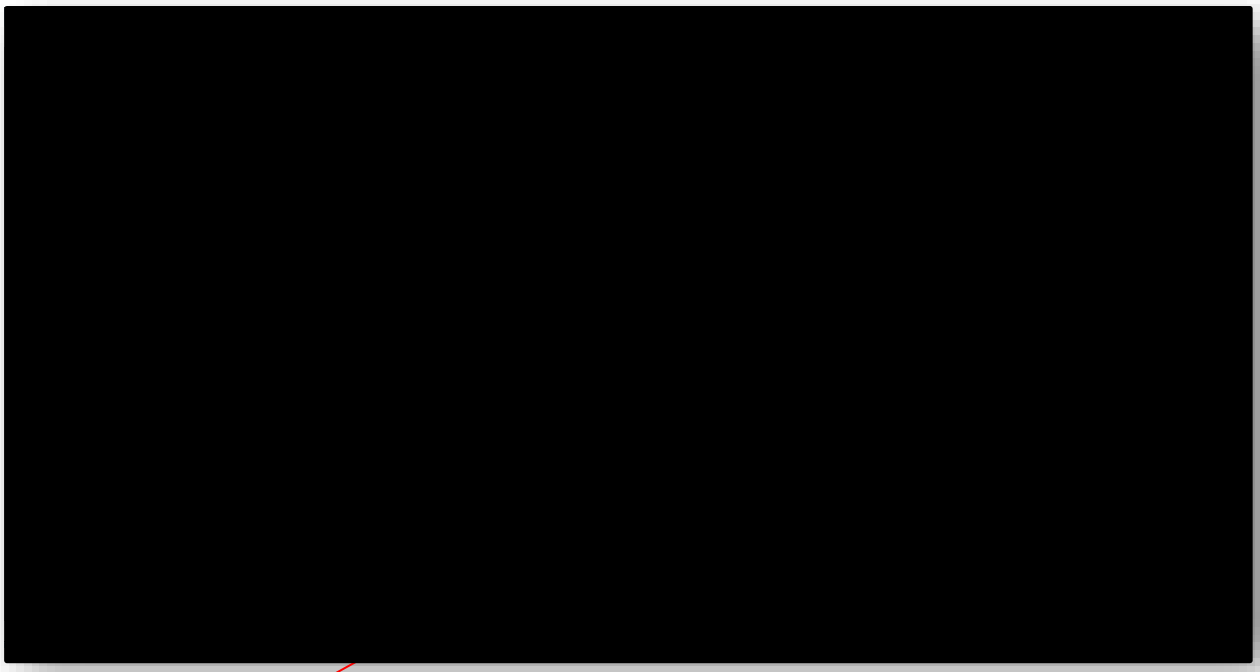


9. To send the report, click the “Transfer report” tab and wait for the report to transfer. The report has been transferred when the system notifies you in the lower area of your screen- in red indicating the report is sent. The report is now complete. Close the patient procedure.



Chapter 6: Baseline Report Creation

1. Open workflow


[redacted]

2. Clicking on a header will sort the column alphabetically (Pt Name, Date, Comments, Device, or Facility) Report types are listed under the column “Comments”.

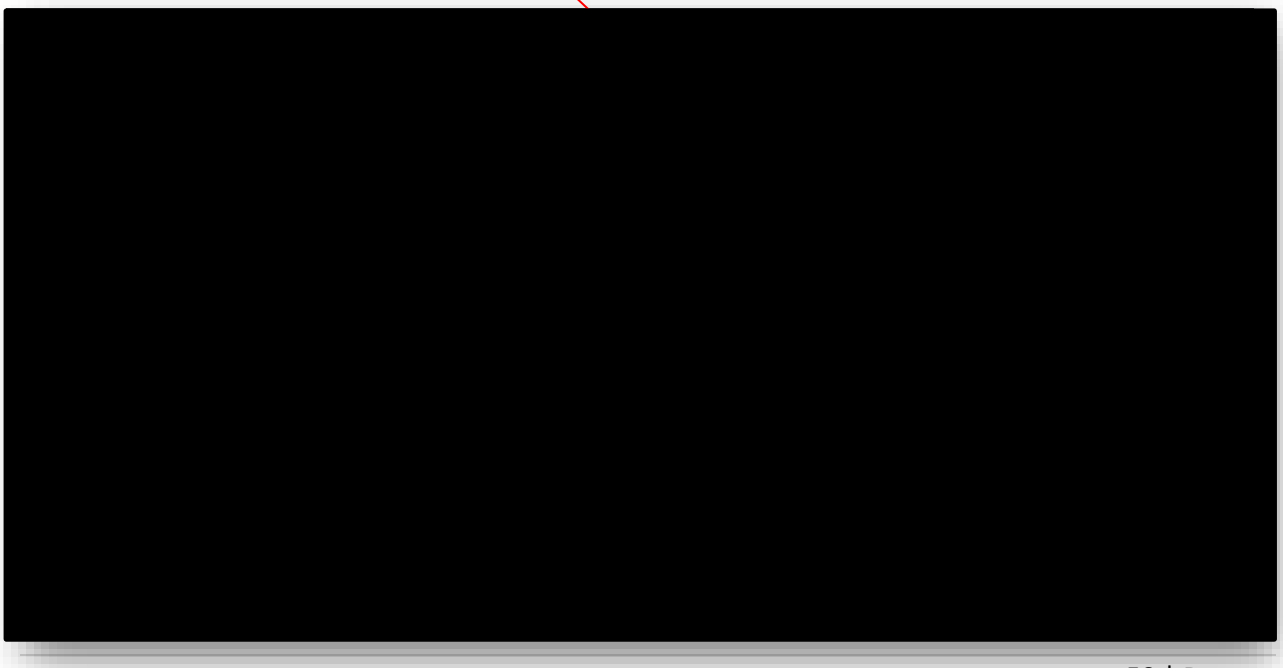

[redacted]

3. Double click the patient procedure to open it.

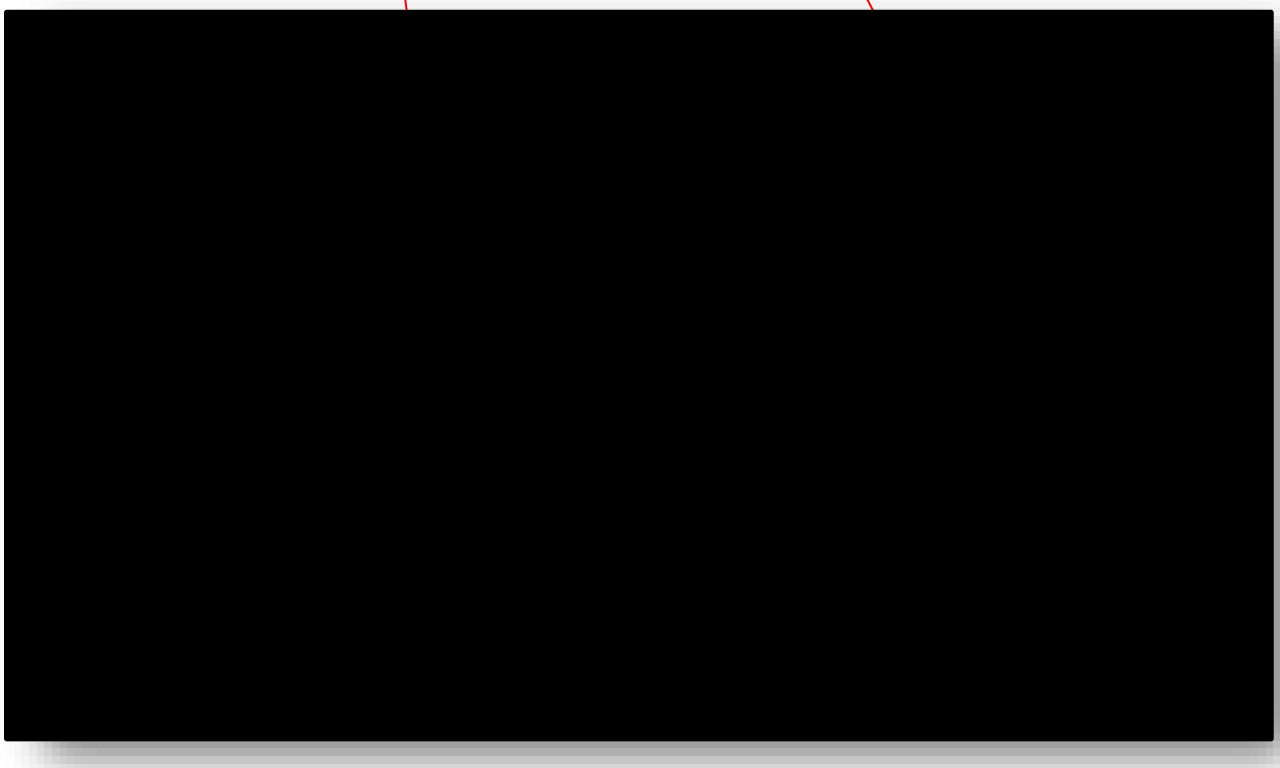
4. Look for a manual recording marked as Baseline in the Symptom field.



5. At any time, when working in Outbound and you see that these are the first transmissions for the patient and there are no recordings listed with the Symptom of Baseline, look for a manual recording and re-label it to read Baseline (if no Manual is found, use an Auto-Capture recording). To re-label it click on the "SLA" button in the edit tools and add appropriate verbiage (Do not overwrite any listed symptoms. You can add Baseline to the listed Symptom). Click OK to continue.



6. Then follow the strip selection process and label your findings (Please note: All baseline recording must include the underlying rhythm on the strip label). If the report is not already populated in the left tree under the recordings, then create the report by either pressing F7 or navigating to the "Procedure" tab and clicking on the "New Report" tab, then select "Interim report".



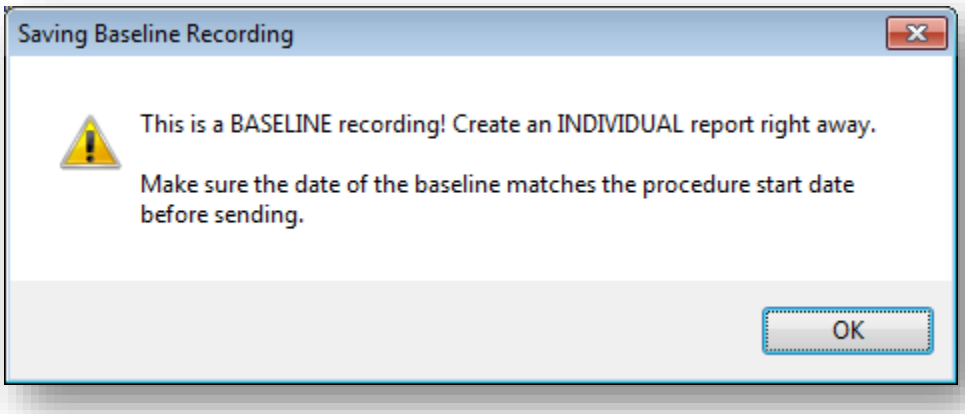
7. Verify that your report is correct (heart rate is on the strip, the recording is cleaned up, and the label is correct), then Double click in the "Notes:" box to complete your clinical findings. Sign the report with your name and credentials by clicking on the "Sign Report" tab. Then click OK!



8. To send the report, click the “Transfer report” tab and wait for the report to transfer. The report has been transferred when the system notifies you in the lower area of your screen- in red indicating the report is sent. The report is now complete. Close the patient procedure



9. It is important to note, the procedure start date is required to be the same as the first initial recording presented in the reports (even if an older recording comes in at a later time- on a later report, the earliest date of any recording presented is required to match the procedure start date).
10. When creating Baseline reports for Classic Reports, it is normal to get a pop up that advises you to make sure the date of the baseline matches the procedure start date before sending. Please take a moment to make sure the dates match. The pop up below will not occur for Customizable Reports (aka Dream Reports), as you cannot create reports for Dream Reports- unless it is a notification report. Dream Reports are auto-populated based on the parameters set in the Beacon System by Customer preferences.



11. It is also possible that you may get a pop up that asks, “Do you want to change the procedure start date to match the baseline date?” Always click “Yes”, but go back to the procedures tab and the look for the earliest recording to make sure it matches. This pop up box is usually seen in home hookups, as the enrollment date is usually earlier than the initial recordings.

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Received: 5 July 2017 | Revised: 12 September 2017 | Accepted: 13 September 2017

DOI: 10.1111/jce.13342

ORIGINAL ARTICLE

WILEY

Diagnostic yield of asymptomatic arrhythmias detected by mobile cardiac outpatient telemetry and autotrigger looping event cardiac monitors

Wayne M. Derkac MD[1] | Jeffrey R. Finkelmeier BS[1] | Daniel J. Horgan BBA[1] | Mathew D. Hutchinson MD[2]

[1]BioTelemetry, Malvern, PA, USA

[2]Division of Cardiovascular Medicine, Sarver Heart Center, University of Arizona College of Medicine Tucson, Tucson, AZ, USA

Correspondence
Wayne M. Derkac, MD, BioTelemetry, 1000 Cedar Hollow Road, Malvern, PA 19355-2300, USA.
Email: wayne.derkac@biotelinc.com

W.M. Derkac and J.R. Finkelmeier report stock ownership in BioTelemetry and are named on a patent pending relevant to this technology.

Abstract

Introduction: Asymptomatic arrhythmias can have important therapeutic implications in certain patient populations, for example, atrial fibrillation in patients with prior ischemic stroke. We sought to compare the diagnostic yield of two commercially available monitoring systems with automated arrhythmia detection algorithms.

Methods: We queried a large, proprietary database containing rhythm data for patients receiving ambulatory EKG monitoring (BioTelemetry, Malvern, PA, USA). We compared all patients prescribed mobile cardiac outpatient telemetry (MCOT™, Braemar Manufacturing, LLC, Eagan, MN, USA) versus autotrigger looping event recorder (AT-LER) devices over a consecutive 8-month period. Data from both device types were analyzed for diagnostic yields in detecting asymptomatic (device-triggered) arrhythmias consisting of atrial fibrillation (of any detected duration), bradycardia (ventricular rate ≤ 40 bpm), ventricular pause (≥ 3 seconds), supraventricular tachycardia (≥ 6 consecutive supraventricular beats), and ventricular tachycardia (≥ 4 consecutive premature ventricular contractions). The mean time to first diagnosis of each arrhythmia for each device was determined. Physician-designated diagnostic codes for patients prescribed each device were also determined from the database.

Results: The MCOT™ device had significantly higher diagnostic yields of all evaluated asymptomatic arrhythmias than the AT-LER. The MCOT™ device also produced an earlier mean time to diagnosis for all evaluated asymptomatic arrhythmias. These findings were noted despite a shorter average prescription length for MCOT™ monitored patients.

Conclusions: In patients with conventional diagnostic monitoring indications, MCOT™ had significantly higher diagnostic yields for five asymptomatic arrhythmias compared to the AT-LER.

KEYWORDS

atrial fibrillation, autotrigger looping monitor, mobile cardiac outpatient telemetry

1 | INTRODUCTION

Early long-term external cardiac monitoring devices were able to detect only symptomatic arrhythmias, with patient input required to initiate recording of these events. Recognition of the clinical importance of asymptomatic arrhythmias promoted the development of monitoring devices with automatic (i.e., autotrigger) arrhythmia detection capabilities. Despite the widespread use of mobile cardiac outpatient telemetry (MCOT™) and autotrigger looping event recorders (AT-LERs) without wireless connectivity capability (AT-LER) to detect asymptomatic cardiac arrhythmias, little information is available comparing their diagnostic yields. While both the MCOT™ and AT-LER devices share autotrigger capabilities, the diagnostic algorithms used by the devices are different. In this study we sought to compare the diagnostic accuracy of the MCOT and the AT-LER devices to detect asymptomatic (i.e., autotrigger) events using a large proprietary monitoring database.

2 | METHODS

The study protocol was reviewed by the institutional review board at the University of Arizona College of Medicine and determined not to

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constitute human research. We queried the BioTelemetry database retrospectively for the 8-month period (January 1, 2016—August 31, 2016) to evaluate data for every MCOT™ and AT-LER device with analyzable data during this timeframe. The 8-month database sample time window was chosen as a representative sample of recent patients from our entire database with no selection restrictions applied. All information lacked specific patient-related data other than age and gender; we stratified the resulting cohort based on these factors as both are associated with arrhythmia occurrence.

The MCOT™ device consists of a sensor with three leads providing two EKG channels for analysis by the monitor, which is a cell phone-sized device communicating wirelessly with the sensor. The monitor contains embedded EKG analysis algorithms that analyze every heartbeat received from the sensor. The EKG signal is analyzed for threshold triggers related to rate, rhythm irregularity, QRS morphology, and p-wave analysis. When trigger thresholds are met, the monitor wirelessly sends representative arrhythmia diagnostic strips to an independent diagnostic testing facility (IDTF), which is staffed continuously, for further adjudication by monitoring center-trained technicians who also generate daily and end of service summary reports for final physician approval. If the arrhythmia characteristics meet notification criteria established for that patient, then the designated physician, and in emergency situations the patient/family, is notified. The device is prescribed for up to 30 days and has unlimited memory capacity due to its wireless connectivity. Specific timeframe data can be searched during the monitoring period and EKG strips for any time period can be examined. This device type also provides atrial fibrillation burden, heart rate trend data calculations, and can send unlimited patient-triggered events.

The AT-LER device has single or two EKG channel functionality and uses a rate and rhythm regularity detection algorithm to automatically trigger for arrhythmias. The device has finite memory storage for autotriggered events, comprising a total of five recordings of 90 seconds each (60 seconds predetection and 30 seconds postdetection). The device reserves memory to receive a patient-initiated event as a sixth stored event. The device lacks wireless connectivity capability and the patient is required to transmit events via landline telephone. Technicians review each patient data transmission subsequently generating reports for physician review and final interpretation. Failure to transmit data in a timely fashion can result in failing to retain future, newer events due to the limited memory capacity of the device. Since this device category captures only specific arrhythmia events, it lacks the capability to provide additional information on triggered events and also lacks the ability to search for EKG tracings during specific timeframes. This device type cannot determine arrhythmia offsets and as a result atrial fibrillation burden cannot be calculated. Notifications are also called to physicians when qualifying events are received by the IDTF based on arrhythmia criteria established for each patient with this device. Events can also be triggered by patient initiation but limited memory in the AT-LER device may restrict the number of events that can be recorded.

For each device type, analysis of diagnostic yield, mean time to first diagnosis, patient age and patient gender, and patient diagnostic codes were determined for the diagnoses of asymptomatic (device-triggered) atrial fibrillation (any duration), bradycardia (ventricular rate $\leq$ 40 bpm), ventricular pause ($\geq$ 3 seconds), supraventricular tachycardia ($\geq$ 6 consecutive supraventricular beats), and ventricular tachycardia ($\geq$ 4 consecutive premature ventricular contractions). These arrhythmias were chosen as each device detects these arrhythmias based on triggers in the device algorithm for the parameters noted. The top 10 primary diagnostic codes chosen by physicians who ordered each device were determined from the database. Arrhythmia diagnoses were made by the embedded algorithms in each device type with subsequent independent confirmation or rejection by independent diagnostic testing facility trained technicians with ultimate adjudication made by independent physicians. The Cochran-Mantel–Haenszel procedure[1] was used to represent weighted average statistical comparisons of device performance for each decade of age and for each gender. P-values and 95% confidence intervals of each ratio of events across all demographic groups were calculated.

3 | RESULTS

From the 8-month analysis period, data from 69,977 patients prescribed MCOT™ and 8,513 patients prescribed AT-LERs without wireless capability were examined. MCOT™ patients consisted of 43.1% males and 56.9% females, while the AT-LER device patients were composed of 38.0% males and 62.0% females. The same top 10 primary diagnostic codes are represented in differing proportions between device groups with the same 10 codes comprising 89% of MCOT™ patients and 87.8% of AT-LER patients (Tables 1 and 2). Prescription length averaged 19.9 days (median 20 days) for patients monitored by MCOT™ and averaged 27.4 days (median 30 days) for patients monitored by an AT-LER device. Of note is that, starting with the second decade of life, the mean age for male and female patients within each decade of age varies between devices by no more than 1 year.

MCOT™ patients had significantly higher diagnostic yields for all five asymptomatic arrhythmias examined compared to the AT-LER despite a 7.5 day shorter average prescription length for MCOT™ patients. Examination of these diagnostic yields of each device for each arrhythmia reveals that MCOT™ has a 128% higher diagnostic yield for AF, a 54% higher diagnostic yield for bradycardia, a 17% higher diagnostic yield for ventricular pause, an 80% higher diagnostic yield for supraventricular tachycardia, and a 222.2% higher diagnostic yield for ventricular tachycardia than the AT-LER (Table 3).

The mean time to diagnosis for each asymptomatic arrhythmia evaluated was shorter for patients monitored with MCOT™ compared to patients monitored with an AT-LER device. The MCOT™ device needed 1.9 fewer days to detect AF, 1.0 day less to detect bradycardia, 6.7 fewer days to detect ventricular pauses, 2.5 fewer days to detect supraventricular tachycardia, and 3.8 fewer days to detect ventricular tachycardia than the AT-LER (Table 3).

4 | DISCUSSION

The main findings of our study include:

TABLE 1 Mobile cardiac outpatient telemetry (MCOT) patient diagnostic codes (top 10)

Device category	Diagnosis ID	Diagnosis	n	Diagnosis percent of total
MCOT	R00.2	Palpitations	26,555	37.9%
MCOT	R55	Syncope and collapse	9,999	14.3%
MCOT	I48.0	Paroxysmal atrial fibrillation	9,939	14.2%
MCOT	I48.91	Unspecified atrial fibrillation	5,160	7.4%
MCOT	R42	Dizziness and giddiness	3,018	4.3%
MCOT	R00.1	Bradycardia, unspecified	2,032	2.9%
MCOT	I47.1	Supraventricular tachycardia	1,777	2.5%
MCOT	I48.1	Persistent atrial fibrillation	1,308	1.9%
MCOT	G45.9	Transient cerebral ischemic attack, unspecified	1,279	1.8%
MCOT	R00.0	Tachycardia, unspecified	1,271	1.8%

TABLE 2 Autotrigger looping event recorder (AT-LER) patient diagnostic codes (top 10)

Device category	Diagnosis ID	Diagnosis	n	Diagnosis percent of total
AT-LER	R00.2	Palpitations	4,236	49.8%
AT-LER	R55	Syncope and collapse	1,106	13.0%
AT-LER	I48.0	Paroxysmal atrial fibrillation	578	6.8%
AT-LER	R42	Dizziness and giddiness	356	4.2%
AT-LER	R00.0	Tachycardia, unspecified	302	3.5%
AT-LER	I48.91	Unspecified atrial fibrillation	277	3.3%
AT-LER	I47.1	Supraventricular tachycardia	267	3.1%
AT-LER	R00.1	Bradycardia, unspecified	152	1.8%
AT-LER	I48.1	Persistent atrial fibrillation	103	1.2%
AT-LER	G45.9	Transient cerebral ischemic attack, unspecified	97	1.1%

TABLE 3 Diagnostic yield of mobile cardiac outpatient telemetry (MCOT) and autotrigger looping event (AT-LER) cardiac monitors

Asymptomatic arrhythmia	MCOT/AT-LER diagnostic yield ratio	95% Confidence interval	P	Mean time to diagnosis (days)	
				MCOT	AT-LER
Atrial fibrillation	2.28	2.10–2.48	<0.001	6.2	8.1
Bradycardia	1.54	1.50–1.59	<0.001	5.0	6.0
Ventricular pause	1.17	1.02–1.34	0.026	5.4	12.1
Supraventricular tachycardia	1.80	1.67–1.94	<0.001	9.2	11.7
Ventricular tachycardia	23.2	18.2–29.6	<0.001	9.0	12.8

(1) Compared to AT-LER, MCOT™ had a significantly higher diagnostic yield for five clinically relevant asymptomatic arrhythmias.

(2) The mean time to arrhythmia diagnosis was significantly shorter with MCOT™ for all arrhythmia diagnoses.

In 2005, Reiffel and colleagues[2] performed a similar retrospective cohort study to determine the diagnostic performance of the newly developed AT-LER, compared to the standard monitoring devices of the day. This study demonstrated the benefit of both monitoring duration and the autotrigger algorithm to detect asymptomatic arrhythmias. Contemporary ambulatory monitoring devices with wireless connectivity are now widely used in clinical practice; however, their comparative diagnostic yield to the AT-LER device has heretofore been lacking. Our results suggest that the MCOT™ provides higher diagnostic yield with a shorter time to diagnosis compared to the AT-LER. Since the autotriggered arrhythmias in our trial are potentially clinically impactful, one might speculate that the increased diagnostic yield and shorter time to diagnosis may improve clinical outcomes in selected patients (e.g., patients with embolic stroke of undetermined source and asymptomatic atrial fibrillation). This concept merits further study. Other technologies present in the MCOT™ but not the AT-LER device (e.g., AF burden calculations and heart rate trend graphs) may enhance longitudinal management of arrhythmia patients including: AF thromboprophylaxis,[3] catheter ablation outcomes,[4] and assessing the efficacy of antiarrhythmic treatment.[5] These concepts merit further study.

From the study design, it is not possible to determine the relative contribution in diagnostic performance of the specific onboard detection algorithm versus the continuously attended telemetry feature inherent in the MCOT™ monitor. The MCOT™'s p-wave

analysis provides an added level of sophistication to the rate and rhythm-regularity functions of the AT-LER algorithm and may have contributed to the increased diagnostic yield. The lack of QRS morphology analysis by the AT-LER may be responsible for its lower ventricular tachycardia diagnostic yields. Since patients are required to use land-based telephone lines for communication of data with the AT-LER, the enhanced performance of the MCOT™ device in arrhythmia detection is, in part, likely associated with its wireless connectivity feature that obviates patient involvement in sending data to the monitoring center. Lack of patient compliance with landline transmissions with the AT-LER can lead to filling the memory capacity of the device with lack of capture of future arrhythmia episodes due to the limited memory capacity of this device. Near real-time technician oversight may also improve diagnostic yield for patients using MCOT™ and should be considered when weighing the increased monitoring cost compared to the AT-LER device.

All patients receiving these devices within an 8-month time interval were included if any ECG data were received; thus, the smaller cohort of patients with the AT-LER device reflects an 8:1 preference for the MCOT device by ordering providers. This utilization disparity was noted despite more limited MCOT™ coverage by commercial health insurance carriers compared to the AT-LER device. The increased cost considerations for the MCOT™ device must be weighed in the context of potential cost savings from its improved diagnostic yield and earlier arrhythmia diagnosis and treatment.

5 | LIMITATIONS

The choice of a specific monitoring technology was made by the ordering physician based on personal or patient-related preferences. Despite the bias inherent in nonrandomized designs, the large cohort included may mitigate the impact of selection bias to some degree.

The BioTelemetry database contains no information on patient comorbid conditions so the distribution of comorbidities between patients using the two devices is unknown. Patients under 40 years of age were underrepresented in our cohort, and thus our results may be less generalizable to this cohort.

While both devices have the capability of recording patient initiated events generated by patient interaction as the result of symptoms, we cannot exclude that knowledge of the autotrigger functionality may cause some patients to forgo patient initiation to record events. Since both devices have this autotrigger functionality, it is likely that the action by some patients to avoid patient initiation to record symptomatic events may lead to the possible inclusion of some symptomatic arrhythmias with those arrhythmias that we have defined as asymptomatic (device-triggered).

Transmission of data to the monitoring center may be adversely affected by limited wireless accessibility (MCOT™) and landline connection quality (AT-LER).

Despite meticulous review of EKG data by certified EKG technicians and over-reading physicians, the possibility of arrhythmia interpretation errors may exist. Technician participation is inherent in both the collection and interpretation of the primary monitoring data.

6 | CONCLUSION

In a large patient cohort with standard diagnostic indications for cardiac monitoring, MCOT™ demonstrated a higher diagnostic yield and a shorter time to arrhythmia diagnosis compared to AT-LERs. Wireless connectivity may serve to enhance asymptomatic arrhythmia detection with MCOT™ compared to nonwireless devices by improving patient compliance in data retrieval. This study serves to further inform the provider's decision in choosing a specific monitoring device for their patient.

ACKNOWLEDGMENT

The authors wish to thank Eugene R. Heyman, PhD, for statistical analysis of the data.

ORCID

Wayne M. Derkac MD http://orcid.org/0000-0001-8511-2631

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How to cite this article: Derkac WM, Finkelmeier JR, Horgan DJ, Hutchinson MD. Diagnostic yield of asymptomatic arrhythmias detected by mobile cardiac outpatient telemetry and autotrigger looping event cardiac monitors. *J Cardiovasc Electrophysiol*. 2017;00:1–4. https://doi.org/10.1111/jce.13342

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2020

Electrophysiologic Evaluation - REVISED

In October 2019, the RUC identified this service via the high-volume growth screen for services with Medicare utilization of 10,000 or more and have increased by at least 100% from 2013 through 2018. In January 2020, the RUC recommended this service be surveyed for April 2020. The code was surveyed individually, as it is not part of a specific family, because it is an add-on service that can be used with several different procedures - base codes or other add-on codes, diagnostic as well as therapeutic.

93621 ***Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 53 cardiologists and cardiac electrophysiologists and determined that a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 1.75, 20 minutes intra-service and total time) would appropriately account for the physician work required to perform this service and falls below the survey 25th percentile.

The RUC discussed the decrease in intra-service time from 30 to 20 minutes and the accordant increase in intensity. Because the recommended work RVU is not an increase, a compelling evidence argument is not necessary. However, because of the change in calculated intensity that results from a decrease in intra-service time without an entirely commensurate decrease in work RVU, the specialty societies provided compelling evidence that there has been a change in technique that has changed physician work.

Since 2001, when this code was last surveyed, there have been several changes in technique that have contributed to an increase in the intensity and decrease in the total time of the procedure. In particular, the typical access technique has evolved to the femoral vein to insert the catheter, as opposed to the jugular or subclavian vein. Previously, a superior vena cava (SVC) approach via internal jugular (IJ) or subclavian vein access was the preferred route to access the coronary sinus. Anatomically, this provides an ideal angle from which to cannulate the coronary sinus which sits at the inferior posteroseptal region of the right atrium, just above the tricuspid valve. This angle makes it possible to use a simple fixed curve catheter and ensures that the catheter position will remain stable throughout the procedure. The downside of the superior approach is that it requires an additional access site (the internal jugular or subclavian vein) that would otherwise not be needed. This carries a small but real risk of pneumothorax and the IJ /

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subclavian access site can be uncomfortable for patients during and after the procedure. For these reasons, most electrophysiologists have evolved their practice and now use a femoral vein approach to deploy the coronary sinus catheter.

The femoral approach avoids the need to prep and drape an additional access site since the other sheaths and catheters for EP studies are also placed from a femoral approach. However, a separate and additional sheath needs to be inserted into the femoral vein for placement of the coronary sinus catheter. Due to the need for multiple sheaths in the same femoral vein access region, care must be taken during venous access to space the access sites sufficiently to avoid interference between the catheters. In addition, a femoral venous approach introduces anatomical challenges for cannulating the coronary sinus and does not provide the natural stability of the catheter achieved from a subclavian approach. The primary anatomical obstacles are the height of the eustachian ridge/inferior vena cava junction and the abrupt reverse angle (usually greater than 135 degrees) that the catheter must traverse once it passes above the eustachian ridge in order to enter to coronary sinus ostium. With the advent of manually deflectable catheters, electrophysiologists are usually (but not always) able to cannulate the coronary sinus from a femoral approach despite the anatomical challenges. However, because the anatomy (eustachian ridge/IVC junction) intrinsically puts pressure on the catheter in a direction that pulls it away from the coronary sinus, the catheter is much less stable than it would be from a superior approach. As a result, it is typical for the coronary sinus catheter to become dislodged multiple times in a single case requiring the operator to reposition the catheter each time.

The RUC agreed that the minutes reduced from the change in access site are at the lower end of the intensity spectrum for the service, which naturally leads to an increase in calculated intensity that is compounded by the increased intensity of making the turn at the IVC/eustachian ridge and multiple re-positionings of the catheter.

Another difference from 2001 is that this service is typically added on to EP-studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Medicare reported together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures. The survey add-on code is most often reported with ablation code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.75, 180 minutes intra-service time) and diagnostic code 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* (work RVU = 5.23, 90 minutes intra-service time). Specifically, the data shows that approximately 80% of 93621 is reported with CPT code 93653. The placement of a catheter for pacing/recording in the left atrium and coronary sinus is more complex/intense in an ablation versus a diagnostic procedure. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization.

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Moreover, the RUC notes that while it is uncommon for an add-on code to be more intense than the underlying service, it does occur, and it is common in the electrophysiology space. A relevant example is trans-septal puncture CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) that may be performed with SVT ablation CPT code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.75, 180 minutes intra-service and 239 minutes total time). The ablation procedure intensity is 0.075 while the puncture is more intense at 0.093. An intensity of 0.088 from the RVU recommendation for CPT code 93621 fits this model and is a reasonable intensity rank order.

The RUC compared CPT code 93621 to the second highest key reference service and MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25, 30 minutes intra-service and total time) and noted the intra-service time is 10 minutes less for the survey code and all the survey respondents that selected the second key reference code rated the survey code as more intense and complex overall relative to the reference code.

The RUC also identified CPT code 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80, 20 minutes intra-service time and 22 minutes total time) for comparison purposes and noted that the comparator code has the same amount of intra-service time and intensity as the survey code.

For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service time and 1 minute immediate post-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison codes appropriately bracket the survey code. The RUC further noted that there are 12 RUC reviewed ZZZ codes with 20 minutes intra-service time and work values between 1.40 and 2.00.

The RUC concluded that, given changes in intensity and total time for the procedure, CPT code 93621 should be valued based on a direct work RVU crosswalk to CPT code 36483 with 20 minutes intra-service time as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 93621.**

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Practice Expense
CPT code 93621 is provided exclusively in the facility setting; thus, no direct practice expense inputs are recommended.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)	ZZZ	1.75

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93621 Tracking Number Original Specialty Recommended RVU: **2.10**
Presented Recommended RVU: **1.75**
Global Period: ZZZ Current Work RVU: **2.10** RUC Recommended RVU: **1.75**

CPT Descriptor: Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a separately reported cardiac electrophysiology procedure, a 37 year-old man with recurrent palpitations is indicated, for diagnostic purposes, for the recording of electrical activity from the left atrium and ventricle and to pace the left atrium.

[Note: This is an add-on code. Only consider the additional work for left atrial pacing and recording from coronary sinus or left atrium. Do not include any work that is included in base codes 93620, 93653 or 93654.]

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The patient is undergoing a separately reported cardiac electrophysiology procedure, and it is necessary to place a catheter in the coronary sinus to record left atrial activity. Femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2020					
Presenter(s):	Richard Wright, MD, Thad Waites, MD and Christpher Liu, MD, David Slotwiner, MD, Mark Schoenfeld, MD					
Specialty Society(ies):	American College of Cardiology; Heart & Rhythm Society					
CPT Code:	93621					
Sample Size:	1188	**Resp N:**	53			
Description of Sample:	random ACC electrophysiologist members and random HRS members					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	40.00	**75.00**	120.00	250.00	
Survey RVW:	1.45	2.50	**3.20**	5.00	20.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	12.00	**20.00**	35.00	200.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93621	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93609	ZZZ	4.99	**RUC Time**

CPT Descriptor Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99292	ZZZ	2.25	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	12,831

CPT Descriptor 1 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	65,235

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36483	ZZZ	1.75	**RUC Time**

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 33.9 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 11.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 93621	Top Key Reference CPT Code: 93609	2nd Key Reference CPT Code: **99292**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	90.00	30.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**90.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	28%	28%	22%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	22%	28%	50%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	50%	39%
Physical effort required	22%	44%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	28%	39%	33%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	83%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	50%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	17%	83%
Physical effort required	0%	17%	83%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

At the April 2020 virtual RUC meeting, the RUC recommended a value of 1.44, a crosswalk to CPT code 37253. The societies appealed that outcome after feeling limited by the virtual format, unable to adequately consult with one another or facilitate in the typical manner. That appeal was granted, and this SOR is a re-presentation of data from the April survey with reconfigured and enhanced recommendations the societies believe provide a satisfactory path forward.

In October 2019, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2013 through 2018, including CPT 93621 electrophysiologic evaluation.

For the April 2020 meeting, HRS and ACC randomly surveyed electrophysiologists, as designated by membership rolls. The survey was completed by physicians who have experience with the service. The key reference code is 93609 for intraventricular and/or intra-atrial mapping of tachycardia with catheter manipulation. It was selected by 33.9% of respondents. Nearly a third of these respondents indicate 93621 was virtually identical. The second reference code was 99292 for critical care evaluation. It was selected by 11.3% of respondents. All of these respondents indicated that 93621 was more intense/complex overall.

Since 2001, when this code was last surveyed, there have been a number of changes in technique that have contributed to change in intensity and total time of the procedure. In particular the typical access technique has evolved to the femoral vein to insert the catheter (as included in the updated description of service above), as opposed to the jugular or subclavian vein (as currently presented from the 2001 survey in the RUC database).

Compelling Evidence-Type Explanation for RVU Recommendation

Because the recommended work RVU is not an increase, a compelling evidence argument is not necessary. However, because of the change in calculated intensity that results from a decrease in intraservice time without an entirely commensurate decrease in work RVU, the societies make a compelling evidence-type presentation here. Specifically, there has been a change in technique that has changed physician work.

The technique used for coronary sinus catheter placement has evolved. Previously, a superior vena cava (SVC) approach via internal jugular (IJ) or subclavian vein access was the preferred route to access the coronary sinus. Anatomically, this provides an ideal angle from which to cannulate the coronary sinus which sits at the inferior posteroseptal region of the right atrium, just above the tricuspid valve. This angle makes it possible to use a simple fixed curve catheter and ensures that the catheter position will remain stable throughout the procedure. The downside of the superior approach is that it requires an additional access site (the internal jugular or subclavian vein) that would otherwise not be needed. This carries a small but real risk of pneumothorax and the IJ / subclavian access site can be uncomfortable for patients during and after the procedure. For these reasons, most electrophysiologists have evolved their practice and now use a femoral vein approach to deploy the coronary sinus catheter.

The femoral approach avoids the need to prep and drape an additional access site since the other sheaths and catheters for EP studies are also placed from a femoral approach. However, a separate and additional sheath does need to be inserted into the femoral vein for placement of the coronary sinus catheter. Due to the need for multiple sheaths in the same femoral vein access region, care must be taken during venous access to space the access sites sufficiently to avoid interference between the catheters. In addition, a femoral venous approach introduces anatomical challenges for cannulating the coronary sinus and does not provide the natural stability of the catheter achieved from a subclavian approach. The primary anatomical obstacles are the height of the eustachian ridge/inferior vena cava junction and the abrupt reverse angle (usually greater than 135 degrees) that the catheter must traverse once it passes above the eustachian ridge in order to enter to coronary sinus ostium. With the advent of manually deflectable catheters, electrophysiologists are usually (but not always) able to cannulate the coronary sinus from a femoral approach despite the anatomical challenges. However, because the anatomy (eustachian ridge/IVC junction) intrinsically puts pressure on the catheter in a direction that pulls it away from the coronary sinus, the catheter is much less stable than it would be from a superior approach. As a result, it is typical for the coronary sinus catheter to become dislodged multiple times in a single case requiring the operator to reposition the catheter each time.

We believe the minutes reduced from the change in access site are at the lower end of the intensity spectrum for the service, which naturally leads to an increase in calculated intensity that is compounded by the increased intensity of making the turn at the IVC/eustachian ridge and multiple re-positionings of the catheter.

Another difference from 2001 to now is that this service is typically added on to EP-studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Billed together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures, specifically the data shows that roughly 78% of 93621 is billed with 93653. This is another difference from the 2001 valuation. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization.

For comparison purposes, the societies identified RVW comparator code 37252 for intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention. This code has the same amount of intraservice time, 20 minutes and, correctly, a slightly lower IWPUT of 0.088 than results from our recommendation. The societies also identified two other comparator codes that bracket the recommendation: 36483 for endovenous ablation therapy at 1.75 RVW with a slightly higher intensity than the recommendation at 0.088. This code reflects a mostly 'technical' procedure. The second code, 36227 for selective catheter placement has an RVW of 2.09 and a higher intensity of 0.1393 IWPUT.

Finally, revisiting a topic that arose during the first presentation of this code, while it is uncommon for an add-on code to be more intense than the underlying service, it does occur and it is common in the electrophysiology space. A relevant example is trans-septal puncture (93462) that may be performed with SVT ablation (93653). The ablation procedure IWPUT is 0.075 while the puncture is more intense at 0.093. An IWPUT of 0.088 from the RVU recommended below fits this model, and is a reasonable IWPUT rank order to the expert panel.

Recommendation

Therefore, for code 93621 the societies **recommend a crosswalk to the RVW of 1.75 from code 36483 with 0 minutes preservice time, 20 minutes intraservice time from the survey median, and 0 minutes postservice time**.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93621

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ACC How often? Commonly

Specialty HRS How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 59784
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on double the Medicare data estimation reported in 2018.

Specialty Cardiac Electrophysiology Frequency 48000 Percentage 80.28 %

Specialty Cardiology Frequency 11794 Percentage 19.72 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 29,892 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Fee for service utilization from RUC database from 2018 for 93621.

Specialty Cardiac Electrophysiology Frequency 24000 Percentage 80.28 %

Specialty Cardiology Frequency 5892 Percentage 19.71 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93621

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Eletrophysiological services

TAB: 21

Source	CPT	Global	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	93609	ZZZ	Intraventricular and/or intra-atrial mapping of tachycardia	18	0.055			4.99			90	0	0	0			90			0					
2nd REF	99292	ZZZ	Critical care, evaluation and management of the critically ill	6	0.075			2.25			30	0	0	0			30			0					
CURRENT	93621	ZZZ	Comprehensive electrophysiologic evaluation		0.070			2.10			30						30			0					
SVY	93621	ZZZ	Comprehensive electrophysiologic evaluation	53	0.160	1.45	2.50	3.20	5.00	20.00	20	0	0	0	5	12	20	35	200	0	0	40	75	120	250
REC	93621	ZZZ	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple		0.088			1.75			20	0	0	0			20			0					
COMP	37252	ZZZ	Intravascular ultrasound (noncoronary vessel) during		0.088			1.80			22	1	0	0			20			1					
COMP	20931	ZZZ	Allograft, structural, for spine surgery only (List separately in		0.091			1.81			20	0	0	0			20			0					
COMP	15151	ZZZ	Tissue cultured skin autograft, trunk, arms, legs; additional 1		0.100			2.00			20	0	0	0			20			0					
COMP XWALK	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity,		0.088			1.75			20	0	0	0			20			0					
MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during		0.071			1.44			21	0	0	0			20			1					
MPC	36227	ZZZ	Selective catheter placement, external carotid artery,		0.1393			2.09			15	0	0	0			15			0					

SS Rec Summary

ISSUE: Excision of bone

TAB: 84

source	CPT	Global	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11
1st REF	11111	000	xyz	30	0.029			4.25			131	5	5	5			30			5				1	1.0				1			
2nd REF	22222	000	def	15	0.055			5.15			137	10	5	5			35			5					1.0				1	1		
CURRENT	55555	000	abc		0.053			5.00			133	17					27			8				1	1.0				1			
SVY	55555	000	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0				1			
REC	55555	000	abc		0.020			4.25			142	17	1	3			30			10				1	1.0				1			

August 25, 2020

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 21 Practice Expense

Dear Dr. Manaker:

Tab 21 on the October 2020 RUC agenda addresses one add-on code for electrophysiologic services. This add-on service is provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 21.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,

Richard Wright, MD
ACC RUC Advisor

Mark Schoenfeld, MD
HRS RUC Advisor