AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2023
January 2022 Meeting

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CMS Request/Relativity Assessment Identified Codes TAB

SARS-CoV-2-IA-Pfizer, Age 5-11, Third Dose and Age 6 months up to 5 years for CPT 2022

AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
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February 8, 2022

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

Subject: RUC Recommendations

Dear Administrator Brooks-LaSure,

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 2023* and to existing services identified by the RUC's Relativity Assessment Workgroup and CMS.

Enclosed are the RUC recommendations for all the CPT codes reviewed at the January 12-15, 2022, RUC meeting.

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

The RUC reviewed the Pfizer Tris-Sucrose age 5-11 third dose and age 6 months up to 5 years, separately in early February 2022, and are submitting those recommendations with this submission. All 23 COVID-19 immunization administration RUC recommendations to date are included with this submission.

CPT 2023 New and Revised Codes – *January 2022 RUC Submission*
The enclosed submission contains RUC recommendations, including those for new and revised CPT codes. **The RUC submits work value and/or practice expense inputs for 90 new/revised/related family CPT codes from the January 2022 meeting and submits one recommendation to contractor price and resurvey for the April 2022 RUC meeting.**

CPT 2023 New and Revised Codes – *Entire CPT 2023 Cycle*
The total number of coding changes for the entire *CPT 2023* cycle is 344, including 84 additions, 129 revisions, 96 deletions, and 35 codes that were identified as part of the family for review in relationship to the new/revised codes. Of the 248 new/revised/related family CPT codes, 13 services are not payable on the RBRVS or do not require physician work (eg, laboratory services and vaccines) and 42 are Category III codes, and accordingly, the RUC does not submit any recommendations on these codes.

The RUC submits work value and/or practice expense inputs for 193 new/revised/related family CPT codes for the 2023 Medicare Physician Payment Schedule.

Existing Services Identified by RUC and CMS for Review
In addition to the new/revised CPT code submission, the RUC submits recommendations for four services identified by the RUC or CMS as potentially misvalued and reviewed at the January 2022 RUC meeting. **The RUC recommendations are in addition to the 17 recommendations for existing services submitted to CMS following the RUC's April and October 2021 meetings, totaling 21 recommendations identified via the potentially misvalued services project for the 2023 Medicare Physician Payment Schedule.**

CPT 2022 New and Revised Codes
The RUC would like to remind CMS of the RUC recommendations that were submitted in January 2021 that were interim recommendations for 2022, resurveyed in April 2021 and subsequently submitted to CMS in May 2021.

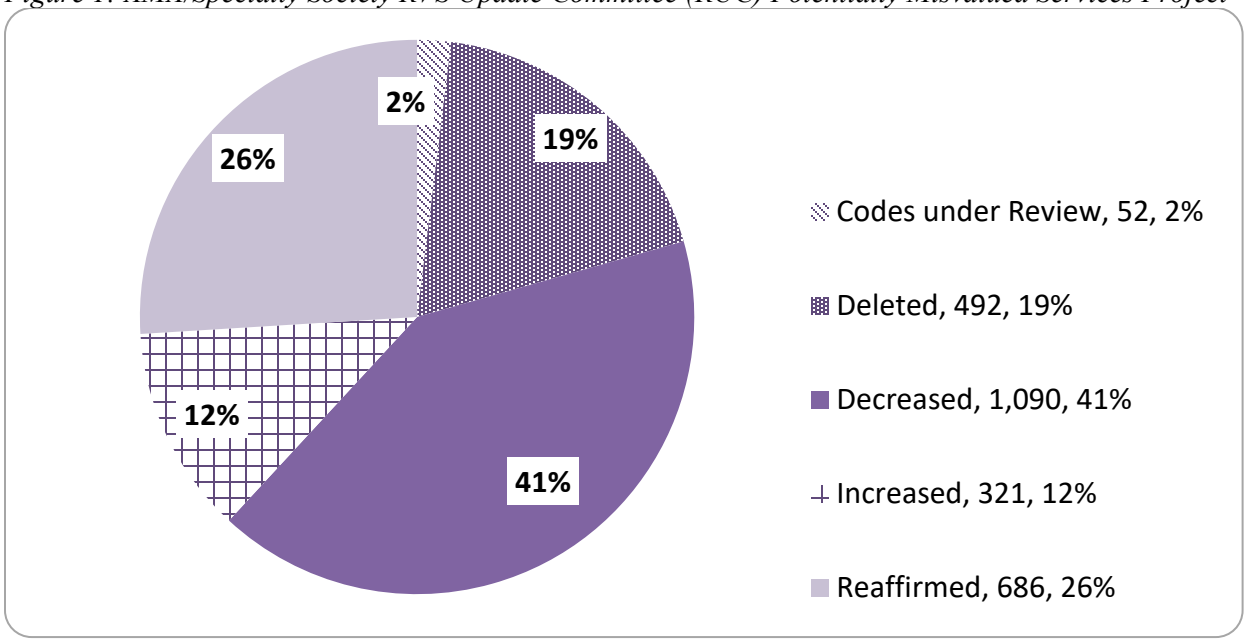
- Arthrodesis Decompression (22630, 22632, 22633, 22634, 63052, 63053)
- Drug Induced Sleep Endoscopy (DISE) (42975)
- Cardiac Ablation (93613, 93621, 93653, 93654, 93655, 93656, 93657, 93662)

Office and Hospital Visits Included in Codes with a Surgical Global Period
The RUC strongly believes that the changes in valuation of the office and hospital E/M visits be incorporated to the visits in the surgical global periods. Since CMS did not apply the office E/M visit increases to the visits bundled into global surgery payment, it is disadvantaging specific specialties. An example of the shortcomings of this policy decision became apparent during discussion of CPT code 67141 *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy* (RUC recommended work RVU = 2.53 and 2-99213 office visits) at the October 2020 RUC meeting. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes were being valued too low considering that office visits for the surgical global period were not going to be increased to the 2021 office E/M codes. Considering that the 99213 office visit is valued at 1.30 RVUs two 99213 office visits are valued higher than the 2.53 value of this code. Therefore, the CMS policy is disadvantageous to the eye surgeons and an example of shortcomings and rank order abnormalities the flawed policy creates. The Agency's position implies that the physician work for office visits is not the same when performed in a surgical global period, which is an inaccurate assumption.

The RUC recommends that CMS apply the office visit and hospital visit valuation changes uniformly across all services and specialties. CMS should not hold specific specialties to a different standard than others. The RUC urges CMS to apply the office visit and hospital visit changes to the office and hospital visits included in surgical global payment, as it has applied historically.

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes
Since 2006, the RUC has identified 2,641 potentially misvalued services through objective screening criteria and has completed review of 2,589 of these services. The RUC has recommended that 60% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services.

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



Source: American Medical Association

Potential Misreporting

Chemical Cauterization of Granulation Tissue (17250)
CPT code 17250 *Chemical cauterization of granulation tissue (ie, proud flesh)* was identified via the high volume growth screen with total Medicare utilization of 10,000 or more that increase by at least 100% from 2008 through 2013. The Relativity Assessment Workgroup reviewed CPT code 17250 and noted that the dominant Medicare provider is Family Medicine in the nursing facility and skilled nursing facility. The specialty societies indicated that the increase in CPT code 17250 reporting is due to this service's absence from the consolidated billing list of codes for nursing facilities. **The RUC would like to notify CMS that perhaps CPT code 17250 should be added to the consolidated billing list of codes for nursing facilities to curb the misreporting for work that is paid to the facility.**

Work Neutrality (CPT 2018) Home INR Monitoring (93792, 93793 & G0250)
In October 2019, the RUC identified this family as having more than a 10% increase (311%) in work RVUs for 2018 than what was projected. In January 2020, the Workgroup noted that CMS created G0250 to describe these services before 93792 and 93793 were developed. The Workgroup noted that 93792 and 93793 were new codes and an increase was expected as these services were not specifically described before. The Workgroup also noted that the RUC recommended that CMS delete G0250 for 2018. The Workgroup recommended reviewing in two years and continued to recommend that CMS delete the G code.

In January 2022, the Workgroup reviewed this family of services. The specialty societies indicated that these services were never projected as work neutral. CMS created the G codes to report home INR testing and interpretation when it issued a national coverage determination (NCD) covering home INR services. G0248 is the initial training of home INR with some supplies and equipment and staff time. G0249 is resupply for another month of home INR. G0250 is interpretation/management of one month of home INR, or **four** tests. When these G codes appeared on the RUC high volume growth screen, the societies approached CPT to create CPT codes that capture those three elements, but also capture the broader work of anticoagulation management for any INR test wherever it is obtained. G0248 is basically equal to 93792. CPT did not want to create an equivalent, PE-only re-supply code equivalent to G0249. In the new code construct, G0250 would be the same as **four** individual 93793s. In addition, 93793 could be reported if a patient went to a lab to get an INR test or had one done in the clinician's office, although it is not reportable the same day as an E/M. A revised neutrality calculation in the spreadsheet demonstrated that if source utilization of G0250 is multiplied by 4, as was the original intent of the societies, budget neutrality was within 3% in 2018. The specialty societies continue to request that CMS delete G0248, G0249 and G0250, and note that these services will soon become obsolete. Fewer patients have the associated mechanical valves and warfarin use will diminish as a management option. **The RUC recommends that CMS delete G0248, G0249 and G0250.**

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

High Cost Disposable Supplies
The RUC calls on CMS to separately identify and pay for high cost disposable supplies. The RUC makes this recommendation to address the outsized impact that high cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high costs supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense

pool and the practice expense for all other services. **The RUC recommends that CMS separately identify and pay for high cost disposable supplies priced more than $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

As described in the specific recommendations, new high cost supply inputs include the procedure specific catheters for CPT codes 386X1 and the 386X2 and the radio frequency wand needed to deliver the radio frequency to the nasal valve in CPT code 37X01. The RUC noted the high cost of these new supply inputs and reiterates its previous request to CMS separately identify and pay for high cost disposable supplies using appropriate HCPCS codes.

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for *CPT 2023*.
- RUC Recommendation Summary of Existing Codes Identified by CMS or the Relativity Assessment Workgroup.
- RUC Recommendation Progress and Status Reports for 2,641 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File – A list of the physician time data for each of the CPT codes reviewed at the January 2022 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions – The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table – The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- BETOS Assignment Table – The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.
- Utilization Data Crosswalk – A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2023 conversion factor increase.

- New Technology List and Timeline – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 755 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 – This includes changes in work RVUs and time by incorporating the increase of office visits and hospital visits in the surgical global periods.

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

Sincerely,

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

Enclosures

cc: RUC Participants
Perry Alexion, MD
Larry Chan
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Ryan Howe
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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2023

RESOURCE MATERIALS
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CPT 2023 RUC and HCPAC Recommendations

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
0016M	YYY	R	Feb 2022	13	Admin MAAA – Oncology (Bladder) – Revise 0016M		CLFS						☐		☐
0163T	YYY	D	Sep 2021	12	Total Disc Arthroplasty		January 2022	05					☐		☐
0312T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0313T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0314T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0315T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0316T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0317T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0402T	YYY	R	Sep 2021	61	Category III - Transepithelial Corneal Collagen Crosslinking		Cat III						☐		☐
0464T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0465T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0469T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0470T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0471T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0472T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0473T	YYY	D	Feb 2022	39	Category III – Sundown		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
0474T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0475T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0476T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0477T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0478T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0479T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0480T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0481T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0483T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0484T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0485T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0486T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0487T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0488T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0489T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0490T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0491T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0492T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0493T	YYY	D	Feb 2022	39	Category III – Sundown		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
0494T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0495T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0496T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0497T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0498T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0499T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0500T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0501T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0502T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0503T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0504T	YYY	D	Feb 2022	39	Category III – Sundown		Cat III						☐		☐
0514T	YYY	D	Sep 2021	62	Category III - Intraoperative Visual Axis Identification		Deleted						☐		☐
0591T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching Services		Cat III						☐		☐
0591T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching Guideline Revision		Cat III						☐		☐
0592T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching Guideline Revision		Cat III						☐		☐
0592T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching 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
0593T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching Services		Cat III						☐		☐
0593T	YYY	R	Sep 2021	71	Category III - Health and Well-Being Coaching Guideline Revision		Cat III						☐		☐
0702T	YYY	D	Sep 2021	43	Cognitive Behavioral Therapy Monitoring		January 2022	12					☐		☐
0703T	YYY	D	Sep 2021	43	Cognitive Behavioral Therapy Monitoring		January 2022	12					☐		☐
0X00T	YYY	N	Feb 2022	34	Category III – Perianal Tissue Injection		Cat III						☐		☐
0X04T	YYY	N	Sep 2021	64	Category III - Quantitative CT Tissue Characterization		Cat III						☐		☐
0X05T	YYY	N	Sep 2021	64	Category III - Quantitative CT Tissue Characterization		Cat III						☐		☐
0X06T	YYY	R	Feb 2022	40	Category III – Remote Therapeutic Activity– Revise 0X06T, 0X07T		Cat III						☐		☐
0X07T	YYY	R	Feb 2022	40	Category III – Remote Therapeutic Activity– Revise 0X06T, 0X07T		Cat III						☐		☐
0X10T	YYY	N	Sep 2021	80	Category III - Xenograft Scaffold for Osteochondral Regeneration		Cat III						☐		☐
0X11T	YYY	N	Sep 2021	54	Category III - Audio Detected Coronary Artery Disease Risk Score		Cat III						☐		☐
0X12T	YYY	N	Feb 2022	28	Category III – Absolute Quantification Myocardial Blood Flow (AQMBF)		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
0X13T	YYY	N	Feb 2022	30	Category III – Bioprosthetic Venous Value Category III – Bioprosthetic Venous Value		Cat III						☐		☐
0X14T	YYY	N	Sep 2021	68	Category III - Laser Trabeculotomy with Optical Coherence Tomography		Cat III						☐		☐
0X18T	YYY	N	Sep 2021	45	Category III - Coronary Therapeutic Services and Procedures		Cat III						☐		☐
0X19T	YYY	N	Sep 2021	74	Category III - Cranial Intraoperative Radiation Therapy		Cat III						☐		☐
0X27T	YYY	N	Sep 2021	67	Category III - Vestibular Implant Services		Cat III						☐		☐
0X28T	YYY	N	Sep 2021	67	Category III - Vestibular Implant Services		Cat III						☐		☐
0X29T	YYY	N	Sep 2021	70	Category III - AI Facial Phenotypic Analysis		Cat III						☐		☐
0X31T	YYY	N	Sep 2021	67	Category III - Vestibular Implant Services		Cat III						☐		☐
0X32T	YYY	N	Sep 2021	67	Category III - Vestibular Implant Services		Cat III						☐		☐
0X33T	YYY	N	Sep 2021	67	Category III - Vestibular Implant Services		Cat III						☐		☐
0X35T	YYY	N	Feb 2022	31	Category III – Cardiac Functional Radioablation		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
0X38T	YYY	N	Feb 2022	26	Category III – Magnetic Field Induction Malignant Prostate Tissue		Cat III						☐		☐
0X39T	YYY	N	Feb 2022	26	Category III – Magnetic Field Induction Malignant Prostate Tissue		Cat III						☐		☐
0X41T	YYY	N	Feb 2022	27	Category III – Automated Insulin Titration		Cat III						☐		☐
0X42T	YYY	N	Feb 2022	27	Category III – Automated Insulin Titration		Cat III						☐		☐
0X82T	YYY	N	Sep 2021	65	Category III - Quantitative Magnetic Resonance Cholangiopancreatography (MRCP)		Cat III						☐		☐
0X83T	YYY	N	Sep 2021	65	Category III - Quantitative Magnetic Resonance Cholangiopancreatography (MRCP)		Cat III						☐		☐
0X84T	YYY	N	Sep 2021	75	Category III - Colonic Lavage		Cat III						☐		☐
0X85T	YYY	N	Sep 2021	72	Category III - Intramuscular Drug Administration by Electroporation		Cat III						☐		☐
0X86T	YYY	N	Sep 2021	63	Category III - Percutaneous Electrical Nerve Field Stimulation		Cat III						☐		☐
0X89T	YYY	N	Sep 2021	59	Category III - Posterior Vertebral Joint Replacement		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
0X94T	YYY	N	Sep 2021	58	Category III - Autologous Adipose-Derived Regenerative Cell Therapy for Partial Thickness Rotator Cuff Tear		Cat III						☐		☐
0X95T	YYY	N	Sep 2021	58	Category III - Autologous Adipose-Derived Regenerative Cell Therapy for Partial Thickness Rotator Cuff Tear		Cat III						☐		☐
0X96T	YYY	N	Sep 2021	76	Category III - Transperineal Laser Ablation		Cat III						☐		☐
157X1	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C1	April 2021	09	ACS, ASCRS, SAGES	8.50	8.00		☑		☐
15850	XXX	D	Sep 2021	25	Removal of Sutures or Staples		January 2022	04					☑		☐
15851	000	R	Sep 2021	25	Removal of Sutures or Staples	W1	January 2022	04	ACS, ASCRS, ASSH	1.20	1.10		☑		☐
158X1	ZZZ	N	Sep 2021	25	Removal of Sutures or Staples	W2	January 2022	04	ACS, ASCRS, SAGES				☑	PE Only	☐
158X2	ZZZ	N	Sep 2021	25	Removal of Sutures or Staples	W3	January 2022	04	ACS, ASCRS, SAGES				☑	PE Only	☐
20700	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			1.50	1.50	Yes	☑		☐
20701	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			1.13	1.13	Yes	☑		☐
20702	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			2.50	2.50	Yes	☑		☐
20703	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			1.80	1.80	Yes	☑		☐
20704	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			2.60	2.60	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
20705	ZZZ	R	Sep 2021	15	Drug Delivery Code Revisions		Editorial			2.15	2.15	Yes	☑		☐
20802	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			42.62	42.62	Yes	☑		☐
20805	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			51.46	51.46	Yes	☑		☐
20808	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			63.09	63.09	Yes	☑		☐
20816	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			31.95	31.95	Yes	☑		☐
20822	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			26.66	26.66	Yes	☑		☐
20824	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			31.95	31.95	Yes	☑		☐
20827	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			27.48	27.48	Yes	☑		☐
20838	090	R	Sep 2021	18	Replantation Paranthetical Revisions		Editorial			42.88	42.88	Yes	☑		☐
22630	090	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			22.09	22.09	Yes	☑		☐
22632	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			5.22	5.22	Yes	☑		☐
22633	090	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			27.75	27.75	Yes	☑		☐
22634	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			8.16	8.16	Yes	☑		☐

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22857	090	R	Sep 2021	12	Total Disc Arthroplasty	T1	January 2022	05	AANS, CNS, AAOS, ISASS, NASS NASS ISASS NASS AAOS ISASS NASS AAOS ISASS NASS	27.13	27.13	Yes	☑	Resurvey for April 2022, Interim Recommendation – No Change	☐
228XX	ZZZ	N	Sep 2021	12	Total Disc Arthroplasty	T2	January 2022	05	AANS, CNS, AAOS, ISASS, NASS NASS ISASS NASS AAOS ISASS NASS AAOS ISASS NASS				☑	Resurvey for April 2022, Interim Recommendation, Contractor Price	☐
30468	000	F	Sep 2021	26	Energy Based Repair of Nasal Valve Collapse	X1	January 2022	07	AAO-HNS	2.80	2.80	Yes	☑	Affirmed January 2020 RUC Recommendation	☐
338X3	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A1	October 2021	04	ACC, SCAI	14.00	14.00		☑		☑
338X4	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A2	October 2021	04	ACC, SCAI	18.00	18.00		☑		☑
338X5	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A3	October 2021	04	ACC, SCAI	17.33	17.33		☑		☑
338X6	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A4	October 2021	04	ACC, SCAI	20.00	20.00		☑		☑

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338X7	ZZZ	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A5	October 2021	04	ACC, SCAI	7.27	7.27		☑		☑
368X1	000	N	Sep 2021	23	Percutaneous Arteriovenous Fistula Creation	V1	January 2022	06	ACR, RPA, SIR, SVS	7.50	7.50		☑		☑
368X2	000	N	Sep 2021	23	Percutaneous Arteriovenous Fistula Creation	V2	January 2022	06	ACR, RPA, SIR, SVS	9.60	9.60		☑		☑
37X01	000	N	Sep 2021	26	Energy Based Repair of Nasal Valve Collapse	X2	January 2022	07	AAO-HNS	2.70	2.70		☑		☐
43197	YYY	R	Feb 2022	EC-C	Parenthetical Revision to Esophagoscopy		Editorial			1.52	1.52	Yes	☑		☐
43198	YYY	R	Feb 2022	EC-C	Parenthetical Revision to Esophagoscopy		Editorial			1.82	1.82	Yes	☑		☐
43235	YYY	R	Feb 2022	EC-C	Parenthetical Revision to Esophagoscopy		Editorial			2.09	2.09	Yes	☑		☐
43235	000	F	Feb 2021	16	Endoscopic Bariatric Device Procedures	B1	April 2021	08	ACG, AGA, ASGE, SAGES	2.09	2.09	Yes	☑		☐
43X21	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B2	April 2021	08	ACG, AGA, ASGE, SAGES	3.40	3.11		☑		☑
43X22	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B3	April 2021	08	ACG, AGA, ASGE, SAGES	2.80	2.80		☑		☑
49560	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49561	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49565	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49566	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49568	ZZZ	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐

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
49570	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49572	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49580	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49582	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49585	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49587	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49590	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49652	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49653	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49654	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49655	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49656	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49657	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		April 2021	09					☑		☐
49X01	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C2	April 2021	09	ACS, ASCRS, SAGES	6.27	6.27		☑		☐
49X02	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C3	April 2021	09	ACS, ASCRS, SAGES	9.00	9.00		☑		☐
49X03	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C4	April 2021	09	ACS, ASCRS, SAGES	10.80	10.80		☑		☐
49X04	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C5	April 2021	09	ACS, ASCRS, SAGES	16.65	14.00		☑		☐

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49X05	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C6	April 2021	09	ACS, ASCRS, SAGES	17.00	14.88		☑		☐
49X06	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C7	April 2021	09	ACS, ASCRS, SAGES	24.24	20.00		☑		☐
49X07	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C8	April 2021	09	ACS, ASCRS, SAGES	7.75	7.75		☑		☐
49X08	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C9	April 2021	09	ACS, ASCRS, SAGES	10.79	10.79		☑		☐
49X09	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C10	April 2021	09	ACS, ASCRS, SAGES	12.00	12.00		☑		☐
49X10	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C11	April 2021	09	ACS, ASCRS, SAGES	18.50	16.50		☑		☐
49X11	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C12	April 2021	09	ACS, ASCRS, SAGES	18.53	16.97		☑		☐
49X12	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C13	April 2021	09	ACS, ASCRS, SAGES	25.00	24.00		☑		☐
49X13	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C14	April 2021	09	ACS, ASCRS, SAGES	15.50	14.24		☑		☐
49X14	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C15	April 2021	09	ACS, ASCRS, SAGES	20.25	18.00		☑		☐
49X15	ZZZ	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C16	April 2021	09	ACS, ASCRS, SAGES	5.00	5.00		☑		☐
50080	090	R	Sep 2021	22	Percutaneous Nephrolithotomy - Revise 50080-50081	U1	January 2022	08	AUA	16.00	13.50		☑		☐
50081	090	R	Sep 2021	22	Percutaneous Nephrolithotomy - Revise 50080-50081	U2	January 2022	08	AUA	22.00	22.00		☑		☐
55821	090	F	Sep 2021	27	Lapaorscopic Simple Prostatectomy	Y1	January 2022	09	AUA	15.18	15.18		☑		☐

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55831	090	F	Sep 2021	27	Lapaorscopic Simple Prostatectomy	Y2	January 2022	09	AUA	15.60	15.60		☑		☐
55866	090	F	Sep 2021	27	Lapaorscopic Simple Prostatectomy	Y3	January 2022	09	AUA	25.18	22.46		☑		☐
558XX	090	N	Sep 2021	27	Lapaorscopic Simple Prostatectomy	Y4	January 2022	09	AUA	22.00	19.53		☑		☐
63035	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			3.15	3.15	Yes	☑		☐
63044	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			0.00	0.00	Yes	☑		☐
63048	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			3.47	3.47	Yes	☑		☐
63053	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			3.19	3.19	Yes	☑		☐
63057	ZZZ	R	Sep 2021	EC-A	Lumbar Spine Paranthetical and Code Descriptor Revisions		Editorial			5.25	5.25	Yes	☑		☐
64400	000	F	May 2021	14	Somatic Nerve Injections	M1	October 2021	05	AAN, AAPM, AAPM&R, ASA, SIS	1.00	1.00		☑		☐
64405	000	F	May 2021	14	Somatic Nerve Injections	M2	October 2021	05	AAN, AAPM, AAPM&R, ASA, NANS, SIS	0.94	0.94	Yes	☑		☐
64408	000	F	May 2021	14	Somatic Nerve Injections	M3	October 2021	05	ASA, NANS, SIS	0.90	0.90		☑		☐
64415	000	R	May 2021	14	Somatic Nerve Injections	M4	October 2021	05	ASA, ASIPP	1.50	1.50		☑		☐
64416	000	R	May 2021	14	Somatic Nerve Injections	M5	October 2021	05	ASA, ASIPP	1.80	1.80		☑		☐

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
64417	000	R	May 2021	14	Somatic Nerve Injections	M6	October 2021	05	ASA, ASIPP	1.31	1.31		☑		☐
64418	000	F	May 2021	14	Somatic Nerve Injections	M7	October 2021	05	ASA, NANS, SIS	1.10	1.10	Yes	☑		☐
64420	000	F	May 2021	14	Somatic Nerve Injections	M8	October 2021	05	AAPM, AAPM&R, ASA NANS, SIS	1.18	1.18		☑		☐
64421	ZZZ	F	May 2021	14	Somatic Nerve Injections	M9	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	0.60	0.60		☑		☐
64425	000	F	May 2021	14	Somatic Nerve Injections	M10	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	1.19	1.19		☑		☐
64430	000	F	May 2021	14	Somatic Nerve Injections	M11	October 2021	05	ASA, NANS, SIS	1.15	1.15		☑		☐
64435	000	F	May 2021	14	Somatic Nerve Injections	M12	October 2021	05	ASA, NANS, SIS	0.75	0.75	Yes	☑		☐
64445	000	R	May 2021	14	Somatic Nerve Injections	M13	October 2021	05	AAPM, AAPM&R, ASA, ASIPP	1.39	1.39		☑		☐
64446	000	R	May 2021	14	Somatic Nerve Injections	M14	October 2021	05	ASA, ASIPP	1.75	1.75		☑		☐
64447	000	R	May 2021	14	Somatic Nerve Injections	M15	October 2021	05	ASA, ASIPP	1.34	1.34		☑		☐
64448	000	R	May 2021	14	Somatic Nerve Injections	M16	October 2021	05	ASA, ASIPP	1.68	1.68		☑		☐
64449	000	F	May 2021	14	Somatic Nerve Injections	M17	October 2021	05	ASA, NANS, SIS	1.55	1.55		☑		☐
64450	000	F	May 2021	14	Somatic Nerve Injections	M18	October 2021	05	AAPM, AAPM&R, APMA, ASA, NANS, SIS	0.75	0.75	Yes	☑		☐
64451	000	F	May 2021	14	Somatic Nerve Injections	M19	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	1.52	1.52	Yes	☑		☐

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64454	000	F	May 2021	14	Somatic Nerve Injections	M20	October 2021	05	AAPM, AAPM&R, ASA, ASA,NANS, SIS	1.52	1.52	Yes	☑		☐
64455	000	F	May 2021	14	Somatic Nerve Injections	M21	October 2021	05	APMA, NANS, SIS	0.75	0.75	Yes	☑		☐
64490	000	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.82	1.82	Yes	☑		☐
64491	ZZZ	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.16	1.16	Yes	☑		☐
64492	ZZZ	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.16	1.16	Yes	☑		☐
64493	000	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.52	1.52	Yes	☑		☐
64494	ZZZ	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.00	1.00	Yes	☑		☐
64495	ZZZ	R	Sep 2021	21	64490-64495 Guideline Revisions		Editorial			1.00	1.00	Yes	☑		☐
69714	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N1	January 2022	10	AAOHNS	8.00	8.00		☑		☐
69715	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		January 2022	10					☑		☐
69716	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N2	January 2022	10	AAOHNS	9.03	9.03		☑		☐
69717	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N4	January 2022	10	AAOHNS	8.48	8.48		☑		☐
69718	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		January 2022	10					☑		☐
69719	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N5	January 2022	10	AAOHNS	9.46	9.46		☑		☐
69726	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N7	January 2022	10	AAOHNS	7.50	7.50		☑		☐

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69727	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N8	January 2022	10	AAOHNS	7.38	7.38		☑		☐
69XX0	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N3	January 2022	10	AAOHNS	9.97	9.97		☑		☐
69XX1	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N6	January 2022	10	AAOHNS	10.25	10.25		☑		☐
69XX2	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N9	January 2022	10	AAOHNS	8.50	8.50		☑		☐
76881	XXX	F	Sep 2021	32	Neuromuscular Ultrasound	Z1	January 2022	11	AAN, AANEM, AAPM&R, ACR, ACRh, APMA	0.90	0.90		☑		☐
76882	XXX	R	Sep 2021	32	Neuromuscular Ultrasound	Z2	January 2022	11	AAN, AANEM, AAPM&R, ACR, ACRh, APMA	0.69	0.69		☑		☐
76942	XXX	R	May 2021	14	Somatic Nerve Injections	M22	October 2021	05	AAPM, AAPM&R, ACR, SIR, SIS AAPM&R	0.67	0.67	Yes	☑		☐
76XX0	XXX	N	Sep 2021	32	Neuromuscular Ultrasound	Z3	January 2022	11	AAN, AANEM, AAPM&R, ACR, ACRh	1.21	1.21		☑		☑
77002	ZZZ	R	May 2021	14	Somatic Nerve Injections	M23	October 2021	05	AAPM, AAPM&R, ACR, SIR, SIS AAPM&R	0.54	0.54	Yes	☑		☐
77003	ZZZ	R	May 2021	14	Somatic Nerve Injections	M24	October 2021	05	ACR, SIR, SIS	0.60	0.60	Yes	☑		☐
81445	XXX	R	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐
81450	XXX	R	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐
81455	XXX	R	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐

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814X1	XXX	N	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐
814X2	XXX	N	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐
814X3	XXX	N	Sep 2021	39	GPS-Neoplasm 81445-81455		CLFS						☐		☐
814XX	XXX	N	Sep 2021	38	GSP-Inherited Bone Marrow Failure Syndrome (IBMFS)		CLFS						☐		☐
84XXX	XXX	N	Sep 2021	42	Thiopurine Methyltranserase (TPMT) Enzyme Activity		CLFS						☐		☐
8X000	XXX	N	Sep 2021	41	GSP-Drug Metabolism		CLFS						☐		☐
90587	XXX	R	Sep 2021	49	Dengue Vaccine 2 - Dose Schedule		Vaccine						☐		☐
905XX	XXX	N	Sep 2021	49	Dengue Vaccine 2 - Dose Schedule		Vaccine						☐		☐
90739	XXX	R	Sep 2021	46	Hepatitis B Vaccine (HepB) - Revise 90739		Vaccine						☐		☐
90785	ZZZ	R	Sep 2021	EC-B	Psychiatry Paranthetical Revision		Editorial			0.33	0.33	Yes	☑		☐
92065	XXX	R	Feb 2021	35	Orthoptic Training	D1	April 2021	10	AAO, AOA	0.71	0.71		☑		☑
920XX	XXX	N	Feb 2021	35	Orthoptic Training	D2	April 2021	10	AAO, AOA				☑	PE Only	☑
92229	YYY	R	Feb 2022	25	Retinal Imaging – Revise 92229		Editorial			0.00	0.00	Yes	☑		☐
92284	XXX	R	May 2021	EC-M	Dark Adaptation Examination		Editorial			0.24	0.24	Yes	☑		☐
93563	ZZZ	F	May 2021	36	Pulmonary Angiography	P1	October 2021	08	ACC, SCAI	1.11	1.11	Yes	☑		☐
93564	ZZZ	F	May 2021	36	Pulmonary Angiography	P2	October 2021	08	ACC, SCAI	1.13	1.13	Yes	☑		☐
93565	ZZZ	F	May 2021	36	Pulmonary Angiography	P3	October 2021	08	ACC, SCAI	0.86	0.86	Yes	☑		☐
93566	ZZZ	F	May 2021	36	Pulmonary Angiography	P4	October 2021	08	ACC, SCAI	0.86	0.86	Yes	☑		☐

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93567	ZZZ	F	May 2021	36	Pulmonary Angiography	P5	October 2021	08	ACC, SCAI	0.97	0.97	Yes	☑		☐
93568	ZZZ	R	May 2021	36	Pulmonary Angiography	P6	October 2021	08	ACC, SCAI	0.88	0.88	Yes	☑		☐
93656	YYY	R	Feb 2022	EC-B	Parenthetical Revision (Cardio) – 93656 & 93662		Editorial			19.77	19.77	Yes	☑		☐
93662	YYY	R	Feb 2022	EC-B	Parenthetical Revision (Cardio) – 93656 & 93662		Editorial			1.44	1.44	Yes	☑		☐
93XX0	ZZZ	N	May 2021	36	Pulmonary Angiography	P7	October 2021	08	ACC, SCAI	1.05	1.05		☑		☑
93XX1	ZZZ	N	May 2021	36	Pulmonary Angiography	P8	October 2021	08	ACC, SCAI	1.75	1.75		☑		☑
93XX2	ZZZ	N	May 2021	36	Pulmonary Angiography	P9	October 2021	08	ACC, SCAI	1.84	1.84		☑		☑
93XX3	ZZZ	N	May 2021	36	Pulmonary Angiography	P10	October 2021	08	ACC, SCAI	1.92	1.92		☑		☑
959XX	XXX	N	May 2021	27	Quantitative Pupillometry Services	Q1	October 2021	09	AAO, AAP	0.25	0.25		☑		☑
96158	XXX	R	Sep 2021	EC-D	Health Behavior Assessment and Intervention Paranthetical Revision		Editorial			1.45	1.45	Yes	☑		☐
96159	ZZZ	R	Sep 2021	EC-D	Health Behavior Assessment and Intervention Paranthetical Revision		Editorial			0.50	0.50	Yes	☑		☐
96X70	XXX	N	Feb 2021	39	Caregiver Behavior Management Training	E1	April 2021	11	AACAP, AND, APA (Psychology)	0.50	0.43		☑		☐
96X71	ZZZ	N	Feb 2021	39	Caregiver Behavior Management Training	E2	April 2021	11	AACAP, AND, APA (Psychology)	0.17	0.12		☑		☐

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
97150	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening		Editorial			0.29	0.29	Yes	☑		☐
97545	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening		Editorial			0.00	0.00	Yes	☑		☐
97546	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening		Editorial			0.00	0.00	Yes	☑		☐
98975	XXX	R	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA1	January 2022	12	AAP, ANA	0.00	0.00	Yes	☑	PE Only, Affirmed January 2021 RUC Recommendation	☑
98976	XXX	F	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA2	January 2022	12	AAP, ANA	0.00	0.00	Yes	☑	PE Only, Affirmed January 2021 RUC Recommendation	☑
98977	XXX	F	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA3	January 2022	12	AAP, ANA	0.00	0.00	Yes	☑	PE Only, Affirmed January 2021 RUC Recommendation	☑
98980	XXX	F	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA5	January 2022	12	AAP, ANA	0.62	0.62	Yes	☑	Affirmed January 2021 RUC recommendation	☑
98981	ZZZ	F	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA6	January 2022	12	AAP, ANA	0.61	0.61	Yes	☑	Affirmed January 2021 RUC recommendation	☑
989X6	XXX	N	Sep 2021	43	Cognitive Behavioral Therapy Monitoring	AA4	January 2022	12	APA (Psychiatric), APA (Psychological)				☑	PE Only, Contractor Price	☑
99217	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐

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
99218	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99219	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99220	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99221	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F1	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	1.92	1.63		☑		☐
99222	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F2	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	2.61	2.60		☑		☐

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
99223	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F3	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	3.86	3.50		☑		☐
99224	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99225	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99226	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		January 2022	13					☑		☐
99231	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F4	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	1.00	1.00		☑		☐

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
99232	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F5	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	1.59	1.59		☑		☐
99233	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F6	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	2.40	2.40		☑		☐
99234	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F7	January 2022	13	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS	2.56	2.00		☑		☐

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
99235	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F8	January 2022	13	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS	3.24	3.24	Yes	☑		☐
99236	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F9	January 2022	13	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS	4.30	4.30		☑		☐
99238	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F10	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	1.50	1.50		☑		☐

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
99239	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F11	January 2022	13	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS	2.15	2.15		☑		☐
99241	XXX	D	Feb 2021	07	Outpatient Consultations		October 2021	14					☑		☐
99242	XXX	R	Feb 2021	07	Outpatient Consultations	G1	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	1.08	1.08		☑		☐

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
99243	XXX	R	Feb 2021	07	Outpatient Consultations	G2	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	1.80	1.80		☑		☐
99244	XXX	R	Feb 2021	07	Outpatient Consultations	G3	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	2.80	2.69		☑		☐

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
99245	XXX	R	Feb 2021	07	Outpatient Consultations	G4	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	3.75	3.75		☑		☐
99251	XXX	D	Feb 2021	07	Inpatient Consultations		January 2022	14					☑		☐
99252	XXX	R	Feb 2021	07	Inpatient Consultations	G5	January 2022	14	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS	1.50	1.50	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
99253	XXX	R	Feb 2021	07	Inpatient Consultations	G6	January 2022	14	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS	2.00	2.00		☑		☐
99254	XXX	R	Feb 2021	07	Inpatient Consultations	G7	January 2022	14	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS	3.00	2.72		☑		☐

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
99255	XXX	R	Feb 2021	07	Inpatient Consultations	G8	January 2022	14	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS	4.00	3.86		☑		☐
99281	XXX	R	Feb 2021	08	Emergency Department Services	H1	April 2021	12	AAP, ACEP, ANA	0.25	0.25		☑		☐
99282	XXX	R	Feb 2021	08	Emergency Department Services	H2	April 2021	12	AAP, ACEP, ANA	0.93	0.93	Yes	☑		☐
99283	XXX	R	Feb 2021	08	Emergency Department Services	H3	April 2021	12	AAP, ACEP, ANA	1.60	1.60	Yes	☑		☐
99284	XXX	R	Feb 2021	08	Emergency Department Services	H4	April 2021	12	AAP, ACEP, ANA	2.74	2.60		☑		☐
99285	XXX	R	Feb 2021	08	Emergency Department Services	H5	April 2021	12	AAP, ACEP, ANA	4.00	4.00	Yes	☑		☐
99304	XXX	R	Feb 2021	09	Nursing Facility Services	I1	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.60	1.50		☑		☐
99305	XXX	R	Feb 2021	09	Nursing Facility Services	I2	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.50	2.50		☑		☐
99306	XXX	R	Feb 2021	09	Nursing Facility Services	I3	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	3.50	3.50		☑		☐

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
99307	XXX	R	Feb 2021	09	Nursing Facility Services	I4	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	0.70	0.70		☑		☐
99308	XXX	R	Feb 2021	09	Nursing Facility Services	I5	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.30	1.30		☑		☐
99309	XXX	R	Feb 2021	09	Nursing Facility Services	I6	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.92	1.92		☑		☐
99310	XXX	R	Feb 2021	09	Nursing Facility Services	I7	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.80	2.80		☑		☐
99315	XXX	F	Feb 2021	09	Nursing Facility Discharge Day Management Services	I8	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA	1.50	1.50		☑		☐
99316	XXX	F	Feb 2021	09	Nursing Facility Discharge Day Management Services	I9	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA	2.50	2.50		☑		☐
99318	XXX	D	Feb 2021	09	Nursing Facility Discharge Day Management Services		October 2021	11					☑		☐
99324	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99325	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99326	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99327	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99328	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐

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
99334	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99335	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99336	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99337	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99339	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99340	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99341	XXX	R	Feb 2021	10	Home and Residence Services	J1	October 2021	13	AAHPM, AGS, ANA, APMA	1.50	1.00		☑		☐
99342	XXX	R	Feb 2021	10	Home and Residence Services	J2	October 2021	13	AAHPM, AGS, ANA, APMA	2.00	1.65		☑		☐
99343	XXX	D	Feb 2021	10	Home and Residence Services		October 2021	13					☑		☐
99344	XXX	R	Feb 2021	10	Home and Residence Services	J3	October 2021	13	AAHPM, AGS, ANA	3.50	2.87		☑		☐
99345	XXX	R	Feb 2021	10	Home and Residence Services	J4	October 2021	13	AAHPM, AGS, ANA	4.00	3.88		☑		☐
99347	XXX	R	Feb 2021	10	Home and Residence Services	J5	October 2021	13	AAHPM, AGS, ANA, APMA	1.30	0.90		☑		☐
99348	XXX	R	Feb 2021	10	Home and Residence Services	J6	October 2021	13	AAHPM, AGS, ANA, APMA	1.92	1.50		☑		☐
99349	XXX	R	Feb 2021	10	Home and Residence Services	J7	October 2021	13	AAHPM, AGS, ANA	2.70	2.44		☑		☐
99350	XXX	R	Feb 2021	10	Home and Residence Services	J8	October 2021	13	AAHPM, AGS, ANA	3.55	3.60		☑		☐
99354	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		January 2022	15					☑		☐
99355	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		January 2022	15					☑		☐

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
99356	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		January 2022	15					☑		☐
99357	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		January 2022	15					☑		☐
99358	XXX	F	Feb 2021	11	Prolonged Services - Without Direct Patient	K1	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	1.80	1.80		☑		☐
99359	ZZZ	F	Feb 2021	11	Prolonged Services - Without Direct Patient	K2	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	1.00	0.75		☑		☐
993X0	ZZZ	N	Feb 2021	11	Prolonged Services - On the Date of an E/M	K6	January 2022	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, SHM, STS	0.81	0.81		☑		☐
99415	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE	K3	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS	0.00	0.00		☑	PE Only	☐
99416	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE	K4	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS	0.00	0.00		☑	PE Only	☐

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
99417	ZZZ	R	Feb 2021	11	Prolonged Services - On the Date of an E/M	K5	January 2022	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	0.61	0.61		☑		☐
99446	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.35	0.35	Yes	☑		☐
99447	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.70	0.70	Yes	☑		☐
99448	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			1.05	1.05	Yes	☑		☐
99449	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			1.40	1.40	Yes	☑		☐
99451	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.70	0.70	Yes	☑		☐
99464	YYY	R	Feb 2022	6	Delivery Room 99464, 99465 Parenthetical Revisions		Editorial			1.50	1.50	Yes	☑		☐
99465	YYY	R	Feb 2022	6	Delivery Room 99464, 99465 Parenthetical Revisions		Editorial			2.93	2.93	Yes	☑		☐
99483	XXX	R	Feb 2021	11	Cognitive Assessment and Care Plan Services	L1	April 2021	16	AAN, ACP, AGS	3.80	3.50		☑		☐
G2170	YYY	D	Sep 2021	23	Percutaneous Arteriovenous Fistula Creation		January 2022	06					☑		☐
G2171	YYY	D	Sep 2021	23	Percutaneous Arteriovenous Fistula Creation		January 2022	06					☑		☐

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
X012T	YYY	N	Feb 2022	29	Category III – Biomechanical CT with Vertebral Fracture Assessment		Cat III						☐		☐
X015T	YYY	N	Feb 2022	31	Category III – Cardiac Functional Radioablation		Cat III						☐		☐
X017T	YYY	N	Feb 2022	31	Category III – Cardiac Functional Radioablation		Cat III						☐		☐

RUC Recommendations for CMS Requests & Relativity Assessment Identified Code - January 2022

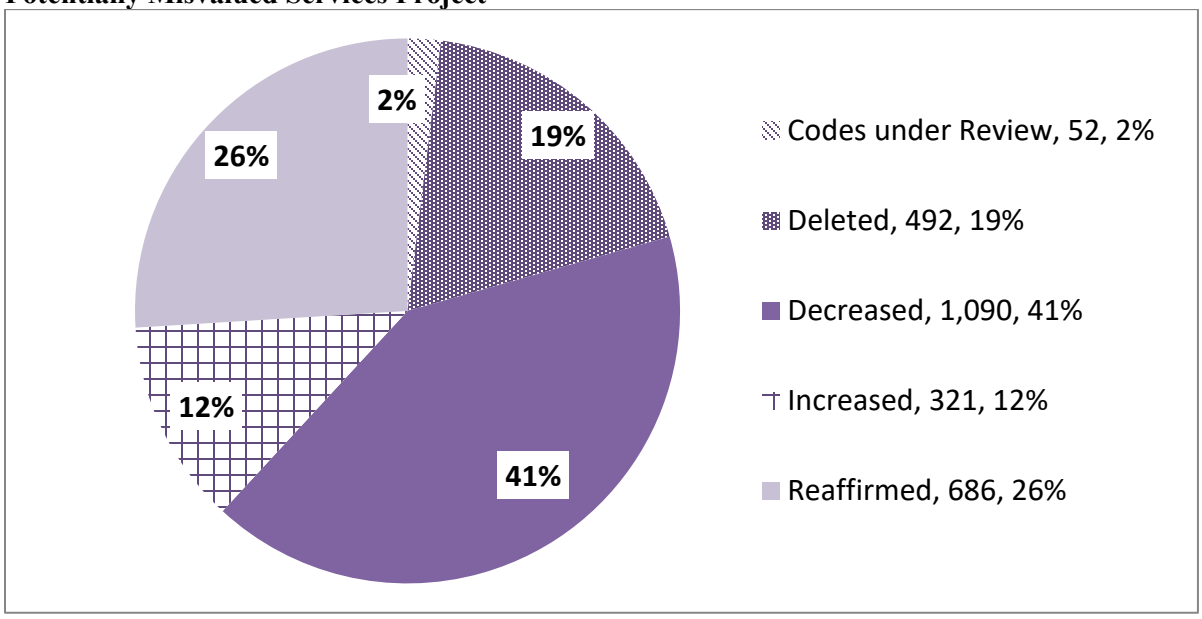
CPT Code	Long Descriptor	Issue	Tab	RUC Recommendation	CMS Request - Final Rule for 2022	Site of Service Anomaly
49436	Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	Delayed Creation of Exit Site from Embedded Catheter	16	PE Inputs	X	
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	Lumbar Laminotomy with Decompression	17	15.95		X
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Lumbar Laminotomy with Decompression	17	13.18		X
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)	Lumbar Laminotomy with Decompression	17	4.00		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 over 2,600 services through over 20 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining 2,641 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,582 services, redistributing $5 billion annually. Here are the outcomes for the committee's review of 2,641 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 755 services. In September 2010, the re-review cycle began and since then the RUC has recommended 54 services to be re-examined. The remaining services are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 279 services every April after three years of Medicare claims data is available for each service.

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

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

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

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

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

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

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

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

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

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

In 2018, the RUC also performed a site-of-service anomaly screen based on the review of three years of data (2015, 2016 and 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 these recommendation for the 2021 and 2023 Medicare Physician Payment Schedules.

In 2019, the RUC lowered the threshold for site-of-service anomalies based on the review of three years of data (2016, 2017 and 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 38 services to include the family of services. The RUC referred two codes to the CPT Editorial Panel for revision, CPT deleted 13 services and the RUC submitted 23 recommendations for the 2021-2023 Medicare Physician Payment Schedule.

In 2020, the RUC identified one code with Medicare data from 2017-2019e 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 submitted this recommendation for the 2021 Medicare Physician Payment Schedule.

High Volume Growth

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

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

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

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

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

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

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

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

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

CMS Fastest Growing

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

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

High IWPUT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to

the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate. The RUC completed review of services under this screen.

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

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

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

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

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

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

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

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

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

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

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

CMS/Other
Utilization over 500,000
In April 2011, the RUC identified 410 codes with a source of "CMS/Other." CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The RUC removed one service from the screen. The CPT® Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules and one service for the 2023 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

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

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

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

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

Utilization over 20,000
In October 2019, the RUC lowered the threshold for this screen of CMS/Other source codes with 2018e Medicare utilization over 20,000, which resulted in nine services and expanded to 16 to include the family of services. The RUC removed one code from the screen and referred one to the CPT Editorial Panel for revision. The CPT Editorial Panel deleted five codes. The RUC submitted recommendations for nine services for the 2021-2023 Medicare Physician Payment Schedules.

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

Bundled CPT® Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-Operative Visits

010-Day Global Codes

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

In October 2019, the identified five 010-day global period services more than one office visit based on 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 additional data is available.

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

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

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

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

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

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

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

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

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

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

Final Rule for 2020
In the Final Rule for 2020, the public and CMS nominated 10 services as potentially misvalued, which was expanded to 14 services as part of the family. The RUC submitted recommendations for 13 services for the 2021 and 2023 Medicare Physician Payment Schedules. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate. The RUC has completed review of the services under this screen.

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

Final Rule for 2022
In the Final Rule for 2022, CMS received public nomination on one code as potentially misvalued. The RUC reviewed and submitted a recommendation for the 2023 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

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

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

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

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,641**
Codes Completed	**2,589**
Work and PE Maintained	686
Work Increased	321
Work Decreased	910
Direct Practice Expense Revised (beyond work changes)	180
Deleted from CPT®	492
Codes Under Review	**52**
Referred to CPT® Editorial Panel or CPT Assistant	22
RUC to Review for *CPT 2024*	8
RUC to review future review after additional data obtained	22

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

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

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

2020 Medicare Utilization: 28,442

2022 Work RVU: 7.00
2022 NF PE RVU: 0.00
2022 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:**

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

2020 Medicare Utilization: 83,159

2022 Work RVU: 10.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 12

Referred to CPT

Result: Increase

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

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

2020 Medicare Utilization: 55,792

2022 Work RVU: 15.00
2022 NF PE RVU: 0.00
2022 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:**

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

2020 Medicare Utilization: 1,018,758

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 5 base units

Referred to CPT September 2016

Result: Maintain

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

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 **2020 Medicare Utilization:** 95,019

2022 Work RVU: 6.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

2020 Medicare Utilization: 910,064

2022 Work RVU: 4.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 4 base units

Referred to CPT September 2016

Result: Decrease

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

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

2020 Medicare Utilization: 384,162

2022 Work RVU: 3.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 3 base units

Referred to CPT September 2016

Result: Decrease

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

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

2020 Medicare Utilization: 426,571

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 5 base units

Referred to CPT September 2016

Result: Maintain

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

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?** Yes

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

First Identified: October 2020

2020 Medicare Utilization: 93,333

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Maintain

Referred to CPT

Result: Remove from screen

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 54,832

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2020 Medicare Utilization:** 46,739

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

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 **2020 Medicare Utilization:** 14,455

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2020 Medicare Utilization:** 21,562

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

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

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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** October 2016 **2020 Medicare Utilization:** 257,223

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

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

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

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 4.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 4.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 4.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 4.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 5.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,903

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2020 Medicare Utilization:** 6,252

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

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 **2020 Medicare Utilization:** 47,885

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 29,474

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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: 000 **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES **First Identified:** November 2019 **2020 Medicare Utilization:** 17

2022 Work RVU: 1.14
2022 NF PE RVU: 53.00
2022 Fac PE RVU: 0.49

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

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

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

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

2022 Work RVU: 1.34
2022 NF PE RVU: 1.57
2022 Fac PE RVU: 0.55

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

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

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

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

2022 Work RVU: 1.91
2022 NF PE RVU: 49.22
2022 Fac PE RVU: 0.78

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

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 **2020 Medicare Utilization:** 3,674

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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

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

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

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

First Identified: October 2020 **2020 Medicare Utilization:** 22,480

2022 Work RVU: 0.40
2022 NF PE RVU: 1.78
2022 Fac PE RVU: NA

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Remove from Screen

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

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

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

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

First Identified: January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** October 2020 **Result:** Contractor Price

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

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 **2020 Medicare Utilization:** 317

2022 Work RVU: 0.80
2022 NF PE RVU: 0.60
2022 Fac PE RVU: 0.35

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

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

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 **2020 Medicare Utilization:** 118,014

2022 Work RVU: 1.46
2022 NF PE RVU: 2.48
2022 Fac PE RVU: 0.54

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

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

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 **2020 Medicare Utilization:** 27,167

2022 Work RVU: 1.00
2022 NF PE RVU: 0.68
2022 Fac PE RVU: 0.38

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

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 **2020 Medicare Utilization:** 465

2022 Work RVU: 1.81
2022 NF PE RVU: 7.01
2022 Fac PE RVU: 0.66

RUC Recommendation: 1.81 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 21

2022 Work RVU: 1.18
2022 NF PE RVU: 3.63
2022 Fac PE RVU: 0.39

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 3,625

2022 Work RVU: 2.26
2022 NF PE RVU: 11.09
2022 Fac PE RVU: 0.77

RUC Recommendation: 2.43 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 46

2022 Work RVU: 1.65
2022 NF PE RVU: 6.17
2022 Fac PE RVU: 0.54

RUC Recommendation: 1.65

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

Result: Decrease

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 **2020 Medicare Utilization:** 74

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price

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

Result: Contractor Price

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 **2020 Medicare Utilization:** 73

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price

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

Result: Contractor Price

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 **2020 Medicare Utilization:** 13,427

2022 Work RVU: 1.03
2022 NF PE RVU: 1.87
2022 Fac PE RVU: 0.45

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 7,896

2022 Work RVU: 2.75
2022 NF PE RVU: 16.91
2022 Fac PE RVU: 0.94

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 **2020 Medicare Utilization:** 31,603

2022 Work RVU: 0.91
2022 NF PE RVU: 2.45
2022 Fac PE RVU: 0.52

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

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

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 **2020 Medicare Utilization:** 301,942

2022 Work RVU: 1.22
2022 NF PE RVU: 2.35
2022 Fac PE RVU: 1.74

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

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

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 **2020 Medicare Utilization:** 112,597

2022 Work RVU: 2.45
2022 NF PE RVU: 3.55
2022 Fac PE RVU: 2.63

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

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

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 **2020 Medicare Utilization:** 35,873

2022 Work RVU: 1.22
2022 NF PE RVU: 3.12
2022 Fac PE RVU: 1.70

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 **2020 Medicare Utilization:** 8,361

2022 Work RVU: 2.30
2022 NF PE RVU: 5.08
2022 Fac PE RVU: 2.46

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,874,785

2022 Work RVU: 1.01
2022 NF PE RVU: 2.74
2022 Fac PE RVU: 0.63

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 **2020 Medicare Utilization:** 511,436

2022 Work RVU: 2.70
2022 NF PE RVU: 3.81
2022 Fac PE RVU: 1.40

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 **2020 Medicare Utilization:** 103,711

2022 Work RVU: 4.10
2022 NF PE RVU: 4.44
2022 Fac PE RVU: 1.85

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 **2020 Medicare Utilization:** 562,568

2022 Work RVU: 0.50
2022 NF PE RVU: 0.62
2022 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 **2020 Medicare Utilization:** 297,110

2022 Work RVU: 1.03
2022 NF PE RVU: 0.95
2022 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 **2020 Medicare Utilization:** 79,890

2022 Work RVU: 1.80
2022 NF PE RVU: 1.43
2022 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 **2020 Medicare Utilization:** 717,784

2022 Work RVU: 0.35
2022 NF PE RVU: 1.77
2022 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 **2020 Medicare Utilization:** 1,666,621

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

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 **2020 Medicare Utilization:** 292,269

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:** 2,845,400

2022 Work RVU: 0.66
2022 NF PE RVU: 2.32
2022 Fac PE RVU: 0.37

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 **2020 Medicare Utilization:** 1,260,155

2022 Work RVU: 0.38
2022 NF PE RVU: 1.10
2022 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 **2020 Medicare Utilization:** 318,040

2022 Work RVU: 0.83
2022 NF PE RVU: 2.87
2022 Fac PE RVU: 0.45

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

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

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 **2020 Medicare Utilization:** 86,591

2022 Work RVU: 0.45
2022 NF PE RVU: 1.27
2022 Fac PE RVU: 0.25

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

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

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 **2020 Medicare Utilization:** 34,138

2022 Work RVU: 1.01
2022 NF PE RVU: 3.57
2022 Fac PE RVU: 0.54

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

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

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 **2020 Medicare Utilization:** 7,813

2022 Work RVU: 0.54
2022 NF PE RVU: 1.53
2022 Fac PE RVU: 0.30

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

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

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

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 **2020 Medicare Utilization:** 82,507

2022 Work RVU: 0.60
2022 NF PE RVU: 2.39
2022 Fac PE RVU: 0.33

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

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

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

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 **2020 Medicare Utilization:** 175,815

2022 Work RVU: 0.90
2022 NF PE RVU: 2.67
2022 Fac PE RVU: 0.50

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

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

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 **2020 Medicare Utilization:** 97,980

2022 Work RVU: 1.05
2022 NF PE RVU: 2.98
2022 Fac PE RVU: 0.59

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 **2020 Medicare Utilization:** 14,452

2022 Work RVU: 1.25
2022 NF PE RVU: 3.19
2022 Fac PE RVU: 0.69

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 **2020 Medicare Utilization:** 86,124

2022 Work RVU: 0.80
2022 NF PE RVU: 2.33
2022 Fac PE RVU: 0.24

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 **2020 Medicare Utilization:** 89,198

2022 Work RVU: 0.96
2022 NF PE RVU: 2.63
2022 Fac PE RVU: 0.39

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 **2020 Medicare Utilization:** 46,559

2022 Work RVU: 1.20
2022 NF PE RVU: 2.90
2022 Fac PE RVU: 0.53

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 **2020 Medicare Utilization:** 14,490

2022 Work RVU: 1.46
2022 NF PE RVU: 2.88
2022 Fac PE RVU: 0.49

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 **2020 Medicare Utilization:** 55,330

2022 Work RVU: 0.80
2022 NF PE RVU: 2.60
2022 Fac PE RVU: 0.44

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 **2020 Medicare Utilization:** 81,049

2022 Work RVU: 1.10
2022 NF PE RVU: 2.90
2022 Fac PE RVU: 0.61

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

2020 Medicare Utilization: 37,360

2022 Work RVU: 1.30
2022 NF PE RVU: 3.23
2022 Fac PE RVU: 0.73

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

2020 Medicare Utilization: 6,566

2022 Work RVU: 1.68
2022 NF PE RVU: 3.56
2022 Fac PE RVU: 0.94

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

2020 Medicare Utilization: 618,801

2022 Work RVU: 0.17
2022 NF PE RVU: 0.23
2022 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

2020 Medicare Utilization: 1,664,611

2022 Work RVU: 0.32
2022 NF PE RVU: 0.60
2022 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 **2020 Medicare Utilization:** 5,311,737

2022 Work RVU: 0.54
2022 NF PE RVU: 0.72
2022 Fac PE RVU: 0.12

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

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

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 **2020 Medicare Utilization:** 325,804

2022 Work RVU: 1.05
2022 NF PE RVU: 2.29
2022 Fac PE RVU: 0.43

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

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

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 **2020 Medicare Utilization:** 168,490

2022 Work RVU: 1.58
2022 NF PE RVU: 3.06
2022 Fac PE RVU: 1.27

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 51,856

2022 Work RVU: 1.25
2022 NF PE RVU: 2.32
2022 Fac PE RVU: 0.42

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

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

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 **2020 Medicare Utilization:** 220,328

2022 Work RVU: 0.52
2022 NF PE RVU: 1.11
2022 Fac PE RVU: 0.29

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

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

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 **2020 Medicare Utilization:** 58,874

2022 Work RVU: 0.80
2022 NF PE RVU: 1.20
2022 Fac PE RVU: 0.45

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

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

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 **2020 Medicare Utilization:** 28,049

2022 Work RVU: 1.10
2022 NF PE RVU: 1.52
2022 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, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)**

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 **2020 Medicare Utilization:** 9,550

2022 Work RVU: 1.14
2022 NF PE RVU: 1.65
2022 Fac PE RVU: 0.51

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 **2020 Medicare Utilization:** 3,025

2022 Work RVU: 1.34
2022 NF PE RVU: 1.78
2022 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 **2020 Medicare Utilization:** 1,684

2022 Work RVU: 1.91
2022 NF PE RVU: 1.99
2022 Fac PE RVU: 0.81

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 **2020 Medicare Utilization:** 157,000

2022 Work RVU: 0.84
2022 NF PE RVU: 1.79
2022 Fac PE RVU: 0.32

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 **2020 Medicare Utilization:** 128,921

2022 Work RVU: 1.14
2022 NF PE RVU: 2.01
2022 Fac PE RVU: 0.38

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 **2020 Medicare Utilization:** 20,692

2022 Work RVU: 1.44
2022 NF PE RVU: 2.20
2022 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 **2020 Medicare Utilization:** 5,583

2022 Work RVU: 1.97
2022 NF PE RVU: 2.92
2022 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 **2020 Medicare Utilization:** 1,045

2022 Work RVU: 2.39
2022 NF PE RVU: 3.31
2022 Fac PE RVU: 0.59

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 **2020 Medicare Utilization:** 365

2022 Work RVU: 2.90
2022 NF PE RVU: 3.48
2022 Fac PE RVU: 0.84

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 **2020 Medicare Utilization:** 78,196

2022 Work RVU: 1.07
2022 NF PE RVU: 2.07
2022 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 **2020 Medicare Utilization:** 47,045

2022 Work RVU: 1.22
2022 NF PE RVU: 2.03
2022 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 **2020 Medicare Utilization:** 6,518

2022 Work RVU: 1.57
2022 NF PE RVU: 2.40
2022 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 **2020 Medicare Utilization:** 3,210

2022 Work RVU: 1.98
2022 NF PE RVU: 2.76
2022 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 **2020 Medicare Utilization:** 612

2022 Work RVU: 2.68
2022 NF PE RVU: 3.36
2022 Fac PE RVU: 0.61

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 **2020 Medicare Utilization:** 69

2022 Work RVU: 3.18
2022 NF PE RVU: NA
2022 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 **2020 Medicare Utilization:** 26

2022 Work RVU: 3.61
2022 NF PE RVU: NA
2022 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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 54,321

2022 Work RVU: 2.00
2022 NF PE RVU: 5.65
2022 Fac PE RVU: 2.17

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, APMA **First Identified:** October 2009 **2020 Medicare Utilization:** 281,588

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

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Maintain

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

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 28,378

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

RUC Recommendation: 2.97 **Referred to CPT** **Result:** Maintain

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

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 5,035

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

RUC Recommendation: 3.60 **Referred to CPT** **Result:** Increase

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

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 1,011

2022 Work RVU: 4.23
2022 NF PE RVU: 7.87
2022 Fac PE RVU: 3.24

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 516

2022 Work RVU: 5.00
2022 NF PE RVU: 8.46
2022 Fac PE RVU: 3.64

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 18,761

2022 Work RVU: 2.10
2022 NF PE RVU: 5.58
2022 Fac PE RVU: 1.86

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 55,427

2022 Work RVU: 2.79
2022 NF PE RVU: 6.16
2022 Fac PE RVU: 2.60

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 2,652

2022 Work RVU: 3.19
2022 NF PE RVU: 7.77
2022 Fac PE RVU: 2.62

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 373

2022 Work RVU: 3.75
2022 NF PE RVU: 7.80
2022 Fac PE RVU: 3.58

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 86

2022 Work RVU: 4.30
2022 NF PE RVU: 9.72
2022 Fac PE RVU: 4.07

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 37

2022 Work RVU: 4.95
2022 NF PE RVU: 10.32
2022 Fac PE RVU: 4.31

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 50,484

2022 Work RVU: 2.33
2022 NF PE RVU: 5.88
2022 Fac PE RVU: 2.32

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 84,557

2022 Work RVU: 2.87
2022 NF PE RVU: 6.22
2022 Fac PE RVU: 2.60

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

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 12,470

2022 Work RVU: 3.17
2022 NF PE RVU: 7.33
2022 Fac PE RVU: 2.69

RUC Recommendation: 3.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 3,244

2022 Work RVU: 3.50
2022 NF PE RVU: 7.50
2022 Fac PE RVU: 2.35

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

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 349

2022 Work RVU: 4.50
2022 NF PE RVU: 9.82
2022 Fac PE RVU: 3.48

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 42

2022 Work RVU: 5.30
2022 NF PE RVU: 11.11
2022 Fac PE RVU: 5.06

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, APMA **First Identified:** February 2010 **2020 Medicare Utilization:** 26

2022 Work RVU: 6.00
2022 NF PE RVU: 11.25
2022 Fac PE RVU: 5.25

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 **2020 Medicare Utilization:** 4,629

2022 Work RVU: 3.00
2022 NF PE RVU: 6.85
2022 Fac PE RVU: 2.50

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 **2020 Medicare Utilization:** 80,932

2022 Work RVU: 3.50
2022 NF PE RVU: 8.00
2022 Fac PE RVU: 3.35

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 **2020 Medicare Utilization:** 20,759

2022 Work RVU: 1.24
2022 NF PE RVU: 2.05
2022 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 **2020 Medicare Utilization:** 10,142

2022 Work RVU: 3.23
2022 NF PE RVU: 7.02
2022 Fac PE RVU: 3.20

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 **2020 Medicare Utilization:** 175,826

2022 Work RVU: 4.00
2022 NF PE RVU: 8.29
2022 Fac PE RVU: 3.08

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 **2020 Medicare Utilization:** 27,066

2022 Work RVU: 1.44
2022 NF PE RVU: 2.14
2022 Fac PE RVU: 0.77

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 **2020 Medicare Utilization:** 31,462

2022 Work RVU: 3.73
2022 NF PE RVU: 7.44
2022 Fac PE RVU: 2.91

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 **2020 Medicare Utilization:** 243,613

2022 Work RVU: 4.78
2022 NF PE RVU: 8.77
2022 Fac PE RVU: 3.53

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 **2020 Medicare Utilization:** 14,077

2022 Work RVU: 2.19
2022 NF PE RVU: 2.54
2022 Fac PE RVU: 1.21

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 27,588

2022 Work RVU: 4.34
2022 NF PE RVU: 7.77
2022 Fac PE RVU: 3.27

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 **2020 Medicare Utilization:** 46,608

2022 Work RVU: 5.34
2022 NF PE RVU: 8.87
2022 Fac PE RVU: 3.84

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 **2020 Medicare Utilization:** 833

2022 Work RVU: 2.38
2022 NF PE RVU: 2.77
2022 Fac PE RVU: 1.28

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 **2020 Medicare Utilization:** 6,116

2022 Work RVU: 6.37
2022 NF PE RVU: 11.36
2022 Fac PE RVU: 7.30

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 **2020 Medicare Utilization:** 8,399

2022 Work RVU: 8.78
2022 NF PE RVU: 13.62
2022 Fac PE RVU: 8.83

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 15,715

2022 Work RVU: 7.22
2022 NF PE RVU: 12.49
2022 Fac PE RVU: 8.30

RUC Recommendation: 7.02 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 18,970

2022 Work RVU: 9.72
2022 NF PE RVU: 14.48
2022 Fac PE RVU: 9.67

RUC Recommendation: 9.52 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 57,382

2022 Work RVU: 8.60
2022 NF PE RVU: 12.68
2022 Fac PE RVU: 8.53

RUC Recommendation: 8.44 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 42,088

2022 Work RVU: 10.83
2022 NF PE RVU: 14.97
2022 Fac PE RVU: 10.10

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 **2020 Medicare Utilization:** 76,804

2022 Work RVU: 9.23
2022 NF PE RVU: 12.26
2022 Fac PE RVU: 9.07

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 **2020 Medicare Utilization:** 28,234

2022 Work RVU: 11.48
2022 NF PE RVU: 16.35
2022 Fac PE RVU: 11.02

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 36,421

2022 Work RVU: 12.65
2022 NF PE RVU: 17.51
2022 Fac PE RVU: 10.88

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 **2020 Medicare Utilization:** 42,550

2022 Work RVU: 3.73
2022 NF PE RVU: 1.96
2022 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 **2020 Medicare Utilization:** 23,819

2022 Work RVU: 3.65
2022 NF PE RVU: 6.10
2022 Fac PE RVU: 2.15

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 **2020 Medicare Utilization:** 31,129

2022 Work RVU: 4.58
2022 NF PE RVU: 6.58
2022 Fac PE RVU: 2.44

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:**

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 **2020 Medicare Utilization:** 12,169

2022 Work RVU: 9.90
2022 NF PE RVU: 14.08
2022 Fac PE RVU: 9.32

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:**

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 **2020 Medicare Utilization:** 7,976

2022 Work RVU: 10.15
2022 NF PE RVU: 13.29
2022 Fac PE RVU: 8.51

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:** 9,421

2022 Work RVU: 8.09
2022 NF PE RVU: 13.51
2022 Fac PE RVU: 8.63

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 **2020 Medicare Utilization:** 12,127

2022 Work RVU: 10.41
2022 NF PE RVU: 15.60
2022 Fac PE RVU: 11.45

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 **2020 Medicare Utilization:** 115,628

2022 Work RVU: 1.50
2022 NF PE RVU: 2.90
2022 Fac PE RVU: 0.74

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 **2020 Medicare Utilization:** 16,178

2022 Work RVU: 0.33
2022 NF PE RVU: 0.35
2022 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 **2020 Medicare Utilization:** 6,606

2022 Work RVU: 3.50
2022 NF PE RVU: 5.32
2022 Fac PE RVU: 1.67

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 **2020 Medicare Utilization:** 31,457

2022 Work RVU: 0.80
2022 NF PE RVU: 1.53
2022 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 **2020 Medicare Utilization:** 133,737

2022 Work RVU: 1.83
2022 NF PE RVU: 2.72
2022 Fac PE RVU: 0.71

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 **2020 Medicare Utilization:** 6,915

2022 Work RVU: 0.50
2022 NF PE RVU: 0.39
2022 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 **2020 Medicare Utilization:** 1,911

2022 Work RVU: 4.00
2022 NF PE RVU: 5.66
2022 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 **2020 Medicare Utilization:** 3,623

2022 Work RVU: 1.00
2022 NF PE RVU: 1.70
2022 Fac PE RVU: 0.47

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 268

2022 Work RVU: 10.21
2022 NF PE RVU: 14.93
2022 Fac PE RVU: 9.47

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 576

2022 Work RVU: 10.12
2022 NF PE RVU: 14.10
2022 Fac PE RVU: 9.73

RUC Recommendation: 9.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,656

2022 Work RVU: 10.70
2022 NF PE RVU: 13.77
2022 Fac PE RVU: 9.42

RUC Recommendation: 10.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,842

2022 Work RVU: 9.37
2022 NF PE RVU: 12.72
2022 Fac PE RVU: 8.61

RUC Recommendation: 9.24 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 1,544

2022 Work RVU: 13.50
2022 NF PE RVU: 27.61
2022 Fac PE RVU: 11.82

RUC Recommendation: 13.50 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2,073

2022 Work RVU: 14.38
2022 NF PE RVU: 16.69
2022 Fac PE RVU: 12.82

RUC Recommendation: Not part of family **Referred to CPT** September 2016 **Result:** Not Part of RAW

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 4,903

2022 Work RVU: 15.68
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.24

RUC Recommendation: 15.68 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 21,710

2022 Work RVU: 23.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.61

RUC Recommendation: 23.00 **Referred to CPT** September 2016 **Result:** Increase

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

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 **2020 Medicare Utilization:** 1,355

2022 Work RVU: 17.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.64

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 **2020 Medicare Utilization:** 5,804

2022 Work RVU: 19.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.04

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 **2020 Medicare Utilization:** 1,896

2022 Work RVU: 11.80
2022 NF PE RVU: 16.23
2022 Fac PE RVU: 11.09

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 **2020 Medicare Utilization:** 5,294

2022 Work RVU: 6.68
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.23

RUC Recommendation: 6.68. Flagged for RAW review April 2022.

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

Result: Increase

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 **2020 Medicare Utilization:** 2,564

2022 Work RVU: 6.73
2022 NF PE RVU: 9.56
2022 Fac PE RVU: 6.68

RUC Recommendation: 6.73

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

Result: Increase

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 **2020 Medicare Utilization:** 5,007

2022 Work RVU: 2.50
2022 NF PE RVU: 2.66
2022 Fac PE RVU: 1.40

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

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 **2020 Medicare Utilization:** 347

2022 Work RVU: 6.83
2022 NF PE RVU: 9.73
2022 Fac PE RVU: 6.81

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 **2020 Medicare Utilization:** 87

2022 Work RVU: 2.41
2022 NF PE RVU: 2.66
2022 Fac PE RVU: 1.39

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 **2020 Medicare Utilization:** 7,449

2022 Work RVU: 3.65
2022 NF PE RVU: 1.97
2022 Fac PE RVU: 1.97

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

157X1

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

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

RUC Recommendation: 8.00 **Referred to CPT** February 2021 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 69,275

2022 Work RVU: 6.81
2022 NF PE RVU: 10.86
2022 Fac PE RVU: 8.71

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, ACS, AAP **First Identified:** October 2009 **2020 Medicare Utilization:** 13,402

2022 Work RVU: 0.71
2022 NF PE RVU: 1.69
2022 Fac PE RVU: 0.78

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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, ACS, AAP **First Identified:** October 2009 **2020 Medicare Utilization:** 2,336

2022 Work RVU: 1.74
2022 NF PE RVU: 2.67
2022 Fac PE RVU: 1.26

RUC Recommendation: 1.85 **Referred to CPT** **Result:** Maintain

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

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, ACS, AAP **First Identified:** February 2010 **2020 Medicare Utilization:** 1,357

2022 Work RVU: 2.08
2022 NF PE RVU: 3.40
2022 Fac PE RVU: 1.40

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2012

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 **2020 Medicare Utilization:** 5,075,530

2022 Work RVU: 0.61
2022 NF PE RVU: 1.31
2022 Fac PE RVU: 0.93

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 16,342,065

2022 Work RVU: 0.04
2022 NF PE RVU: 0.16
2022 Fac PE RVU: 0.02

RUC Recommendation: 0.04 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 745,568

2022 Work RVU: 1.37
2022 NF PE RVU: 3.51
2022 Fac PE RVU: 1.35

RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,054

2022 Work RVU: 3.69
2022 NF PE RVU: 6.00
2022 Fac PE RVU: 3.94

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,396

2022 Work RVU: 4.79
2022 NF PE RVU: 7.80
2022 Fac PE RVU: 5.12

RUC Recommendation: 4.68 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 4,184

2022 Work RVU: 7.49
2022 NF PE RVU: 10.13
2022 Fac PE RVU: 6.88

RUC Recommendation: 6.37 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2,225,566

2022 Work RVU: 0.70
2022 NF PE RVU: 2.59
2022 Fac PE RVU: 1.17

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

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

2020 Medicare Utilization: 104,490

2022 Work RVU: 0.97
2022 NF PE RVU: 2.87
2022 Fac PE RVU: 1.31

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from screen

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

17250 **Chemical cauterization of granulation tissue (ie, proud flesh)**

Global: 000 **Issue:** Chemical Cauterization of Granulation Tissue **Screen:** High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAFP, ACS, APMA

First Identified: October 2015

2020 Medicare Utilization: 242,534

2022 Work RVU: 0.50
2022 NF PE RVU: 2.09
2022 Fac PE RVU: 0.51

RUC Recommendation: Review in 3 years (Jan 2025).

Referred to CPT September 2016

Result:

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

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

2020 Medicare Utilization: 122,481

2022 Work RVU: 1.22
2022 NF PE RVU: 3.05
2022 Fac PE RVU: 1.18

RUC Recommendation: 1.22

Referred to CPT

Result: Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 265,012

2022 Work RVU: 1.63
2022 NF PE RVU: 3.50
2022 Fac PE RVU: 1.40

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 **2020 Medicare Utilization:** 46,030

2022 Work RVU: 1.54
2022 NF PE RVU: 3.23
2022 Fac PE RVU: 1.35

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 73,725

2022 Work RVU: 1.82
2022 NF PE RVU: 3.59
2022 Fac PE RVU: 1.51

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 70,486

2022 Work RVU: 1.77
2022 NF PE RVU: 3.38
2022 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 **2020 Medicare Utilization:** 68,417

2022 Work RVU: 2.09
2022 NF PE RVU: 3.79
2022 Fac PE RVU: 1.66

RUC Recommendation: 2.09 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 755,119

2022 Work RVU: 6.20
2022 NF PE RVU: 13.07
2022 Fac PE RVU: 3.54

RUC Recommendation: 6.20 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 457,601

2022 Work RVU: 3.30
2022 NF PE RVU: 8.49
2022 Fac PE RVU: 1.88

RUC Recommendation: 3.30 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 140,420

2022 Work RVU: 5.56
2022 NF PE RVU: 12.56
2022 Fac PE RVU: 3.18

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 **2020 Medicare Utilization:** 56,304

2022 Work RVU: 3.06
2022 NF PE RVU: 8.24
2022 Fac PE RVU: 1.74

RUC Recommendation: 3.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 17,925

2022 Work RVU: 0.87
2022 NF PE RVU: 1.31
2022 Fac PE RVU: 0.50

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,451

2022 Work RVU: 3.83
2022 NF PE RVU: 9.45
2022 Fac PE RVU: 4.59

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 51,373

2022 Work RVU: 3.29
2022 NF PE RVU: 11.72
2022 Fac PE RVU: 1.19

RUC Recommendation: 3.29 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,920

2022 Work RVU: 1.65
2022 NF PE RVU: 10.20
2022 Fac PE RVU: 0.60

RUC Recommendation: 1.65 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 104,245

2022 Work RVU: 3.10
2022 NF PE RVU: 12.11
2022 Fac PE RVU: 1.12

RUC Recommendation: 3.10 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 13,958

2022 Work RVU: 1.55
2022 NF PE RVU: 10.20
2022 Fac PE RVU: 0.56

RUC Recommendation: 1.55 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19085 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

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 **2020 Medicare Utilization:** 5,690

2022 Work RVU: 3.64
2022 NF PE RVU: 19.92
2022 Fac PE RVU: 1.31

RUC Recommendation: 3.64 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19086 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure)**

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 **2020 Medicare Utilization:** 1,151

2022 Work RVU: 1.82
2022 NF PE RVU: 16.66
2022 Fac PE RVU: 0.66

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 24,887

2022 Work RVU: 2.00
2022 NF PE RVU: 4.99
2022 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,043

2022 Work RVU: 1.00
2022 NF PE RVU: 4.02
2022 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,274

2022 Work RVU: 2.00
2022 NF PE RVU: 5.62
2022 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 415

2022 Work RVU: 1.00
2022 NF PE RVU: 4.74
2022 Fac PE RVU: 0.36

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 **2020 Medicare Utilization:** 23,245

2022 Work RVU: 1.70
2022 NF PE RVU: 9.60
2022 Fac PE RVU: 0.61

RUC Recommendation: 1.70 **Referred to CPT** October 2012 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,932

2022 Work RVU: 0.85
2022 NF PE RVU: 8.53
2022 Fac PE RVU: 0.31

RUC Recommendation: 0.85 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 266

2022 Work RVU: 2.55
2022 NF PE RVU: 17.09
2022 Fac PE RVU: 0.92

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 **2020 Medicare Utilization:** 61

2022 Work RVU: 1.28
2022 NF PE RVU: 14.04
2022 Fac PE RVU: 0.46

RUC Recommendation: 1.51 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:** 22,732

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.88

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,145

2022 Work RVU: 17.99
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.83

RUC Recommendation: 17.99 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,722

2022 Work RVU: 16.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.31

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

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

2020 Medicare Utilization: 6,133

2022 Work RVU: 10.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.93

RUC Recommendation: 11.00

Referred to CPT

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

Result: Decrease

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

2020 Medicare Utilization: 5,820

2022 Work RVU: 14.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.66

RUC Recommendation: 15.36

Referred to CPT October 2009

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

Result: Decrease

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

2020 Medicare Utilization:

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

RUC Recommendation: Deleted from CPT

Referred to CPT June 2009

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

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 11,306

2022 Work RVU: 1.65
2022 NF PE RVU: 5.39
2022 Fac PE RVU: 0.75

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 **2020 Medicare Utilization:** 12,575

2022 Work RVU: 2.45
2022 NF PE RVU: 9.17
2022 Fac PE RVU: 1.11

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 **2020 Medicare Utilization:** 6,937

2022 Work RVU: 2.61
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.23

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,706

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.17

RUC Recommendation: 6.50 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,442

2022 Work RVU: 3.54
2022 NF PE RVU: 9.83
2022 Fac PE RVU: 3.12

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 **2020 Medicare Utilization:** 91,612

2022 Work RVU: 0.94
2022 NF PE RVU: 1.32
2022 Fac PE RVU: 0.57

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 754,987

2022 Work RVU: 0.75
2022 NF PE RVU: 0.85
2022 Fac PE RVU: 0.30

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 131,533

2022 Work RVU: 0.75
2022 NF PE RVU: 0.88
2022 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 **2020 Medicare Utilization:** 281,251

2022 Work RVU: 0.66
2022 NF PE RVU: 0.84
2022 Fac PE RVU: 0.36

RUC Recommendation: 0.66 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 320,696

2022 Work RVU: 0.75
2022 NF PE RVU: 0.98
2022 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 388,696

2022 Work RVU: 0.66
2022 NF PE RVU: 0.82
2022 Fac PE RVU: 0.30

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 **2020 Medicare Utilization:** 43,818

2022 Work RVU: 0.89
2022 NF PE RVU: 1.44
2022 Fac PE RVU: 0.36

RUC Recommendation: 0.89 **Referred to CPT** October 2013 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 389,042

2022 Work RVU: 0.68
2022 NF PE RVU: 0.85
2022 Fac PE RVU: 0.32

RUC Recommendation: 0.68 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 52,205

2022 Work RVU: 1.00
2022 NF PE RVU: 1.53
2022 Fac PE RVU: 0.41

RUC Recommendation: 1.00 **Referred to CPT** October 2013 **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 **2020 Medicare Utilization:** 5,497,402

2022 Work RVU: 0.79
2022 NF PE RVU: 1.01
2022 Fac PE RVU: 0.42

RUC Recommendation: 0.79 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 952,613

2022 Work RVU: 1.10
2022 NF PE RVU: 1.71
2022 Fac PE RVU: 0.50

RUC Recommendation: 1.10 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 22,763

2022 Work RVU: 0.70
2022 NF PE RVU: 1.10
2022 Fac PE RVU: 0.41

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

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 **2020 Medicare Utilization:** 47,394

2022 Work RVU: 5.96
2022 NF PE RVU: 10.98
2022 Fac PE RVU: 5.39

RUC Recommendation: 5.96 and adjustments to pre-service time package 3. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,130

2022 Work RVU: 16.27
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.01

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

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

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 **2020 Medicare Utilization:** 5,813

2022 Work RVU: 4.28
2022 NF PE RVU: 7.74
2022 Fac PE RVU: 5.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 798

2022 Work RVU: 1.50
2022 NF PE RVU: 0.72
2022 Fac PE RVU: 0.72

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

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

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 **2020 Medicare Utilization:** 202

2022 Work RVU: 1.13
2022 NF PE RVU: 0.55
2022 Fac PE RVU: 0.55

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 355

2022 Work RVU: 2.50
2022 NF PE RVU: 1.23
2022 Fac PE RVU: 1.23

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 66

2022 Work RVU: 1.80
2022 NF PE RVU: 0.91
2022 Fac PE RVU: 0.91

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 **2020 Medicare Utilization:** 353

2022 Work RVU: 2.60
2022 NF PE RVU: 1.33
2022 Fac PE RVU: 1.33

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 **2020 Medicare Utilization:** 128

2022 Work RVU: 2.15
2022 NF PE RVU: 1.09
2022 Fac PE RVU: 1.09

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,084

2022 Work RVU: 3.00
2022 NF PE RVU: 8.27
2022 Fac PE RVU: 1.83

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

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 **2020 Medicare Utilization:** 4,113

2022 Work RVU: 4.58
2022 NF PE RVU: NA
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 376

2022 Work RVU: 9.89
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.11

RUC Recommendation: 9.71 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,098

2022 Work RVU: 10.03
2022 NF PE RVU: 12.32
2022 Fac PE RVU: 8.40

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:** 429

2022 Work RVU: 14.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.55

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 439

2022 Work RVU: 10.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.27

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 **2020 Medicare Utilization:** 489

2022 Work RVU: 13.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.29

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 67

2022 Work RVU: 17.61
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.12

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 135

2022 Work RVU: 1.36
2022 NF PE RVU: 2.82
2022 Fac PE RVU: 2.73

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 **2020 Medicare Utilization:** 549

2022 Work RVU: 7.76
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.79

RUC Recommendation: Unrelated to the family **Referred to CPT** October 2013 **Result:** Remove from screen

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

Status Report: CMS Requests and Relativity Assessment Issues

21935 **Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm**

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 **2020 Medicare Utilization:** 213

2022 Work RVU: 15.72
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.21

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 6,664

2022 Work RVU: 21.02
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.88

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 5,711

2022 Work RVU: 3.45
2022 NF PE RVU: 5.06
2022 Fac PE RVU: 4.64

RUC Recommendation: 3.45. Flag for Rereview **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 2,489

2022 Work RVU: 7.90
2022 NF PE RVU: 47.24
2022 Fac PE RVU: 3.75

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 **2020 Medicare Utilization:** 3,052

2022 Work RVU: 7.33
2022 NF PE RVU: 47.76
2022 Fac PE RVU: 3.63

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 **2020 Medicare Utilization:** 1,935

2022 Work RVU: 4.00
2022 NF PE RVU: 17.90
2022 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 **2020 Medicare Utilization:** 19,696

2022 Work RVU: 8.65
2022 NF PE RVU: 169.35
2022 Fac PE RVU: 4.81

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 **2020 Medicare Utilization:** 21,668

2022 Work RVU: 7.99
2022 NF PE RVU: 169.26
2022 Fac PE RVU: 4.56

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 **2020 Medicare Utilization:** 13,498

2022 Work RVU: 4.00
2022 NF PE RVU: 87.68
2022 Fac PE RVU: 1.65

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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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

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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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

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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 582

2022 Work RVU: 24.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 18.16

RUC Recommendation: Remove from screen. CPT Assistant article published.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2020 Medicare Utilization:** 33,372

2022 Work RVU: 25.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.63

RUC Recommendation: 24.50

Referred to CPT October 2009

Result: Decrease

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

22552 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2, each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2020 Medicare Utilization:** 29,861

2022 Work RVU: 6.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.18

RUC Recommendation: 6.50

Referred to CPT October 2009

Result: Maintain

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

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 **2020 Medicare Utilization:** 4,006

2022 Work RVU: 17.69
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.26

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 **2020 Medicare Utilization:** 18,435

2022 Work RVU: 23.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.57

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 **2020 Medicare Utilization:** 15,353

2022 Work RVU: 5.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.54

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 interspace; 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 **2020 Medicare Utilization:** 39,083

2022 Work RVU: 23.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.02

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 **Result:** Maintain

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

22614 **Arthrodesis, posterior or posterolateral technique, 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 **2020 Medicare Utilization:** 134,805

2022 Work RVU: 6.43
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.16

RUC Recommendation: 6.43

Referred to CPT **Result:** Decrease

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 **2020 Medicare Utilization:** 4,864

2022 Work RVU: 22.09
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.52

RUC Recommendation: 22.09

Referred to CPT October 2010 **Result:** Maintain

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 **2020 Medicare Utilization:** 1,721

2022 Work RVU: 5.22
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.54

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; 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 **2020 Medicare Utilization:** 32,588

2022 Work RVU: 27.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 18.90

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; 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 **2020 Medicare Utilization:** 12,432

2022 Work RVU: 8.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.01

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 **2020 Medicare Utilization:** 8,394

2022 Work RVU: 13.44
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.61

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 **2020 Medicare Utilization:** 3,879

2022 Work RVU: 19.17
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.12

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,628

2022 Work RVU: 5.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.70

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:** Insertion of Interlaminar/Interspinous Device **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2020 Medicare Utilization:** 1,608

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.35

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 331

2022 Work RVU: 4.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.93

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 **2020 Medicare Utilization:** 490

2022 Work RVU: 8.32
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.64

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 **2020 Medicare Utilization:** 449

2022 Work RVU: 7.41
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.15

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 **2020 Medicare Utilization:** 5,044

2022 Work RVU: 7.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.63

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 **2020 Medicare Utilization:** 1,262

2022 Work RVU: 7.77
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.11

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 **2020 Medicare Utilization:** 28,129

2022 Work RVU: 1.00
2022 NF PE RVU: 3.98
2022 Fac PE RVU: 0.37

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

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

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 **2020 Medicare Utilization:** 1,931

2022 Work RVU: 8.54
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.33

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 2,627

2022 Work RVU: 11.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.70

RUC Recommendation: 11.23 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 9,154

2022 Work RVU: 11.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.00

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 312

2022 Work RVU: 9.23
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.69

RUC Recommendation: 9.23 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,571

2022 Work RVU: 13.54
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.63

RUC Recommendation: 13.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 18,394

2022 Work RVU: 10.17
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.98

RUC Recommendation: 10.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,196

2022 Work RVU: 10.64
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.71

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

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 **2020 Medicare Utilization:** 57,646

2022 Work RVU: 22.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.31

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 **2020 Medicare Utilization:** 283

2022 Work RVU: 2.36
2022 NF PE RVU: 4.36
2022 Fac PE RVU: 4.25

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 **2020 Medicare Utilization:** 28,950

2022 Work RVU: 3.00
2022 NF PE RVU: 6.44
2022 Fac PE RVU: 5.91

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 **2020 Medicare Utilization:** 162

2022 Work RVU: 4.10
2022 NF PE RVU: 6.63
2022 Fac PE RVU: 5.65

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 **2020 Medicare Utilization:** 13,496

2022 Work RVU: 3.53
2022 NF PE RVU: 5.58
2022 Fac PE RVU: 4.63

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 **2020 Medicare Utilization:** 2,079

2022 Work RVU: 4.76
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.56

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 **2020 Medicare Utilization:** 422

2022 Work RVU: 4.66
2022 NF PE RVU: 7.43
2022 Fac PE RVU: 6.40

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

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 **2020 Medicare Utilization:** 767

2022 Work RVU: 5.39
2022 NF PE RVU: 8.65
2022 Fac PE RVU: 7.10

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

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 **2020 Medicare Utilization:** 1,206

2022 Work RVU: 4.37
2022 NF PE RVU: 6.00
2022 Fac PE RVU: 4.93

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 380

2022 Work RVU: 5.64
2022 NF PE RVU: NA
2022 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

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 **2020 Medicare Utilization:** 861

2022 Work RVU: 7.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.99

RUC Recommendation: 7.56 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 2,762

2022 Work RVU: 6.12
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.45

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

25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, 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 **2020 Medicare Utilization:** 1,002

2022 Work RVU: 8.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.36

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 1,248

2022 Work RVU: 7.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.12

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 6,280

2022 Work RVU: 8.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.91

RUC Recommendation: 7.94 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 532

2022 Work RVU: 5.85
2022 NF PE RVU: 8.57
2022 Fac PE RVU: 6.94

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

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 **2020 Medicare Utilization:** 19,202

2022 Work RVU: 6.25
2022 NF PE RVU: 8.71
2022 Fac PE RVU: 7.82

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 1,528

2022 Work RVU: 8.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.92

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 **2020 Medicare Utilization:** 8,580

2022 Work RVU: 9.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.57

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 **2020 Medicare Utilization:** 6,568

2022 Work RVU: 11.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.36

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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 **2020 Medicare Utilization:** 17,635

2022 Work RVU: 14.38
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.06

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

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 **2020 Medicare Utilization:** 421

2022 Work RVU: 4.89
2022 NF PE RVU: 7.64
2022 Fac PE RVU: 6.33

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 2,274

2022 Work RVU: 6.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.45

RUC Recommendation: 7.79

Referred to CPT

Result: Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 91,853

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

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 **2020 Medicare Utilization:** 1,617

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

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 **2020 Medicare Utilization:** 13,564

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

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 **2020 Medicare Utilization:** 1,203

2022 Work RVU: 9.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.35

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 81

2022 Work RVU: 11.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.33

RUC Recommendation: 11.50 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 52

2022 Work RVU: 12.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.15

RUC Recommendation: 13.10 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 9,519

2022 Work RVU: 6.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.65

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 **2020 Medicare Utilization:** 476

2022 Work RVU: 3.83
2022 NF PE RVU: 5.60
2022 Fac PE RVU: 4.78

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 **2020 Medicare Utilization:** 5,738

2022 Work RVU: 1.80
2022 NF PE RVU: 3.49
2022 Fac PE RVU: 3.53

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 463

2022 Work RVU: 3.23
2022 NF PE RVU: 5.77
2022 Fac PE RVU: 4.40

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

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 **2020 Medicare Utilization:** 5,399

2022 Work RVU: 3.15
2022 NF PE RVU: 4.84
2022 Fac PE RVU: 4.06

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 **2020 Medicare Utilization:** 316

2022 Work RVU: 8.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.34

RUC Recommendation: 8.74 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,733

2022 Work RVU: 5.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.68

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 **2020 Medicare Utilization:** 399,563

2022 Work RVU: 1.48
2022 NF PE RVU: 3.25
2022 Fac PE RVU: 0.81

RUC Recommendation: 1.48 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 146,584

2022 Work RVU: 19.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.41

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 9,978

2022 Work RVU: 30.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 19.82

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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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

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

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 **2020 Medicare Utilization:** 8,791

2022 Work RVU: 1.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.15

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 **2020 Medicare Utilization:** 185

2022 Work RVU: 4.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.84

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,622

2022 Work RVU: 5.50
2022 NF PE RVU: 5.90
2022 Fac PE RVU: 5.71

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,276

2022 Work RVU: 5.81
2022 NF PE RVU: 7.58
2022 Fac PE RVU: 7.29

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

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 **2020 Medicare Utilization:** 189

2022 Work RVU: 11.72
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.79

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 **2020 Medicare Utilization:** 55,483

2022 Work RVU: 17.61
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.16

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 **2020 Medicare Utilization:** 257

2022 Work RVU: 13.81
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.86

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 4,927

2022 Work RVU: 18.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.47

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 79,407

2022 Work RVU: 18.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.46

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2,922

2022 Work RVU: 3.82
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.73

RUC Recommendation: 3.82 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 712

2022 Work RVU: 11.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.22

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

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 **2020 Medicare Utilization:** 7,736

2022 Work RVU: 5.24
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.97

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

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 **2020 Medicare Utilization:** 5,027

2022 Work RVU: 7.78
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.09

RUC Recommendation: PE Clinical staff pre-time revised **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 **2020 Medicare Utilization:** 4,778

2022 Work RVU: 12.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.89

RUC Recommendation: 9.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)** **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2020 Medicare Utilization:** 678

2022 Work RVU: 5.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.98

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 45,496

2022 Work RVU: 0.77
2022 NF PE RVU: 4.44
2022 Fac PE RVU: 0.30

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than $10 million / Site of Service Anomaly - 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2020 Medicare Utilization:** 12,458

2022 Work RVU: 17.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.13

RUC Recommendation: 17.13 **Referred to CPT** **Result:** Decrease

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: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2020 Medicare Utilization:** 246,923

2022 Work RVU: 19.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.38

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 **2020 Medicare Utilization:** 363

2022 Work RVU: 11.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.91

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 **2020 Medicare Utilization:** 335

2022 Work RVU: 9.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.43

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 **2020 Medicare Utilization:** 285

2022 Work RVU: 5.98
2022 NF PE RVU: 8.24
2022 Fac PE RVU: 6.98

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 **2020 Medicare Utilization:** 258

2022 Work RVU: 8.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.09

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

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 **2020 Medicare Utilization:** 213

2022 Work RVU: 15.72
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.41

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 463

2022 Work RVU: 6.91
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.66

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 **2020 Medicare Utilization:** 1,640

2022 Work RVU: 12.24
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.24

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 **2020 Medicare Utilization:** 985

2022 Work RVU: 9.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.91

RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,064

2022 Work RVU: 9.21
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.90

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,734

2022 Work RVU: 10.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.03

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 **2020 Medicare Utilization:** 3,677

2022 Work RVU: 6.69
2022 NF PE RVU: 11.90
2022 Fac PE RVU: 6.13

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **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 **2020 Medicare Utilization:** 5,972

2022 Work RVU: 6.41
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.09

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2020 Medicare Utilization:** 1,109

2022 Work RVU: 9.17
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.46

RUC Recommendation: 8.96 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2020 Medicare Utilization:** 3,911

2022 Work RVU: 10.49
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.81

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 **2020 Medicare Utilization:** 1,136

2022 Work RVU: 6.27
2022 NF PE RVU: 8.51
2022 Fac PE RVU: 7.15

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27762 **Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2020 Medicare Utilization:** 356

2022 Work RVU: 5.47
2022 NF PE RVU: 7.93
2022 Fac PE RVU: 6.56

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

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 **2020 Medicare Utilization:** 6,531

2022 Work RVU: 8.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.83

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

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

27810 **Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation**

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 **2020 Medicare Utilization:** 2,798

2022 Work RVU: 5.32
2022 NF PE RVU: 7.79
2022 Fac PE RVU: 6.39

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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 **2020 Medicare Utilization:** 10,116

2022 Work RVU: 10.62
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.07

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

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 **2020 Medicare Utilization:** 3,478

2022 Work RVU: 5.69
2022 NF PE RVU: 7.87
2022 Fac PE RVU: 6.30

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

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 **2020 Medicare Utilization:** 666

2022 Work RVU: 6.69
2022 NF PE RVU: 8.24
2022 Fac PE RVU: 6.66

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

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 **2020 Medicare Utilization:** 2,066

2022 Work RVU: 4.77
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.74

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,705

2022 Work RVU: 2.00
2022 NF PE RVU: 2.98
2022 Fac PE RVU: 0.66

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 **2020 Medicare Utilization:** 6,205

2022 Work RVU: 2.79
2022 NF PE RVU: 4.37
2022 Fac PE RVU: 1.10

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 **2020 Medicare Utilization:** 6,080

2022 Work RVU: 5.28
2022 NF PE RVU: 5.46
2022 Fac PE RVU: 1.80

RUC Recommendation: 5.28 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,064

2022 Work RVU: 5.15
2022 NF PE RVU: 8.52
2022 Fac PE RVU: 3.75

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

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 **2020 Medicare Utilization:** 5,001

2022 Work RVU: 7.31
2022 NF PE RVU: 11.66
2022 Fac PE RVU: 6.38

RUC Recommendation: 8.27 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 14,389

2022 Work RVU: 6.76
2022 NF PE RVU: 9.96
2022 Fac PE RVU: 5.38

RUC Recommendation: 7.72 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 9,041

2022 Work RVU: 5.00
2022 NF PE RVU: 8.61
2022 Fac PE RVU: 4.33

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 54,045

2022 Work RVU: 5.62
2022 NF PE RVU: 9.64
2022 Fac PE RVU: 5.06

RUC Recommendation: 5.62 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,586

2022 Work RVU: 6.90
2022 NF PE RVU: 12.65
2022 Fac PE RVU: 5.80

RUC Recommendation: 6.90 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 2,695

2022 Work RVU: 8.01
2022 NF PE RVU: 12.13
2022 Fac PE RVU: 5.61

RUC Recommendation: 8.01 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

28292 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method**

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 **2020 Medicare Utilization:** 4,884

2022 Work RVU: 7.44
2022 NF PE RVU: 12.34
2022 Fac PE RVU: 5.96

RUC Recommendation: 7.44 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 378

2022 Work RVU: 8.57
2022 NF PE RVU: 22.61
2022 Fac PE RVU: 8.32

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 **2020 Medicare Utilization:** 6,895

2022 Work RVU: 8.25
2022 NF PE RVU: 17.36
2022 Fac PE RVU: 6.02

RUC Recommendation: 8.25 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2,423

2022 Work RVU: 9.29
2022 NF PE RVU: 20.37
2022 Fac PE RVU: 7.35

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 **2020 Medicare Utilization:** 2,486

2022 Work RVU: 7.75
2022 NF PE RVU: 16.03
2022 Fac PE RVU: 6.13

RUC Recommendation: 7.75 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Bunionectomy **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 **2020 Medicare Utilization:** 3,605

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

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

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

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 **2020 Medicare Utilization:** 2,231

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

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 **2020 Medicare Utilization:** 1,366

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

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 **2020 Medicare Utilization:** 23,950

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

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 555

2022 Work RVU: 1.28
2022 NF PE RVU: 2.14
2022 Fac PE RVU: 1.24

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

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 **2020 Medicare Utilization:** 4,005

2022 Work RVU: 11.22
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.95

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 **2020 Medicare Utilization:** 3,431

2022 Work RVU: 10.70
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.31

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 **2020 Medicare Utilization:** 3,304

2022 Work RVU: 9.29
2022 NF PE RVU: 13.95
2022 Fac PE RVU: 7.65

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

28820 **Amputation, toe; metatarsophalangeal joint**

Global: 000 **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 **2020 Medicare Utilization:** 27,143

2022 Work RVU: 3.51
2022 NF PE RVU: 4.99
2022 Fac PE RVU: 1.32

RUC Recommendation: 4.10 **Referred to CPT** **Result:** Decrease

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

28825 **Amputation, toe; interphalangeal joint**

Global: 000 **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 **2020 Medicare Utilization:** 13,343

2022 Work RVU: 3.41
2022 NF PE RVU: 4.94
2022 Fac PE RVU: 1.29

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 59,186

2022 Work RVU: 0.77
2022 NF PE RVU: 1.63
2022 Fac PE RVU: 0.90

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 22,392

2022 Work RVU: 0.80
2022 NF PE RVU: 1.45
2022 Fac PE RVU: 0.28

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 9,806

2022 Work RVU: 0.39
2022 NF PE RVU: 0.57
2022 Fac PE RVU: 0.14

RUC Recommendation: 0.39

Referred to CPT

Result: Decrease

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

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 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

2020 Medicare Utilization: 14,158

2022 Work RVU: 0.39
2022 NF PE RVU: 0.48
2022 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

2020 Medicare Utilization: 3,914

2022 Work RVU: 0.39
2022 NF PE RVU: 0.45
2022 Fac PE RVU: 0.14

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

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 **2020 Medicare Utilization:** 3,111

2022 Work RVU: 0.39
2022 NF PE RVU: 0.44
2022 Fac PE RVU: 0.15

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 33,224

2022 Work RVU: 1.78
2022 NF PE RVU: 1.79
2022 Fac PE RVU: 0.93

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 **2020 Medicare Utilization:** 10,267

2022 Work RVU: 0.39
2022 NF PE RVU: 0.63
2022 Fac PE RVU: 0.13

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 **2020 Medicare Utilization:** 20,223

2022 Work RVU: 0.39
2022 NF PE RVU: 0.48
2022 Fac PE RVU: 0.12

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 **2020 Medicare Utilization:** 167,744

2022 Work RVU: 0.39
2022 NF PE RVU: 0.39
2022 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 **2020 Medicare Utilization:** 44,200

2022 Work RVU: 0.25
2022 NF PE RVU: 0.29
2022 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 **2020 Medicare Utilization:** 231,247

2022 Work RVU: 0.55
2022 NF PE RVU: 1.27
2022 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 **2020 Medicare Utilization:** 184,476

2022 Work RVU: 0.60
2022 NF PE RVU: 2.04
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

29584 **Application of multi-layer compression system; upper arm, forearm, hand, and fingers**

Global: 000 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2020 Medicare Utilization:** 1,728

2022 Work RVU: 0.35
2022 NF PE RVU: 2.10
2022 Fac PE RVU: 0.10

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

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 444

2022 Work RVU: 6.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.75

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,885

2022 Work RVU: 7.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.69

RUC Recommendation: 7.03 **Referred to CPT** September 2019 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 40,783

2022 Work RVU: 7.98
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.09

RUC Recommendation: 7.98 **Referred to CPT** September 2019 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 33,015

2022 Work RVU: 8.98
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.39

RUC Recommendation: 8.82 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (list separately in addition to code for primary procedure)**

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 **2020 Medicare Utilization:** 66,775

2022 Work RVU: 3.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.50

RUC Recommendation: 3.00

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

Result: Decrease

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 **2020 Medicare Utilization:** 60,014

2022 Work RVU: 15.59
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.06

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 **2020 Medicare Utilization:** 17,169

2022 Work RVU: 13.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.45

RUC Recommendation: 13.16

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 108

2022 Work RVU: 5.88
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.62

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 135

2022 Work RVU: 5.68
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.72

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

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 **2020 Medicare Utilization:** 693

2022 Work RVU: 5.19
2022 NF PE RVU: 10.33
2022 Fac PE RVU: 5.94

RUC Recommendation: New PE non-facility inputs **Referred to CPT** **Result:** PE Only

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 **2020 Medicare Utilization:** 1,016

2022 Work RVU: 14.30
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.89

RUC Recommendation: 14.14 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 5

2022 Work RVU: 5.88
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.91

RUC Recommendation: No NF PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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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 **2020 Medicare Utilization:** 37,031

2022 Work RVU: 3.00
2022 NF PE RVU: 5.46
2022 Fac PE RVU: 1.81

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 **2020 Medicare Utilization:** 3,440

2022 Work RVU: 12.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.77

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 70,328

2022 Work RVU: 1.10
2022 NF PE RVU: 3.47
2022 Fac PE RVU: 0.38

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

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

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 **2020 Medicare Utilization:** 39,728

2022 Work RVU: 1.54
2022 NF PE RVU: 5.66
2022 Fac PE RVU: 0.48

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 **2020 Medicare Utilization:** 4,585

2022 Work RVU: 1.97
2022 NF PE RVU: 8.35
2022 Fac PE RVU: 0.80

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 824

2022 Work RVU: 2.45
2022 NF PE RVU: 8.35
2022 Fac PE RVU: 1.16

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 **2020 Medicare Utilization:** 476,427

2022 Work RVU: 1.10
2022 NF PE RVU: 4.42
2022 Fac PE RVU: 0.63

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

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

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 **2020 Medicare Utilization:** 105,242

2022 Work RVU: 2.60
2022 NF PE RVU: 4.66
2022 Fac PE RVU: 1.71

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 23,984

2022 Work RVU: 2.74
2022 NF PE RVU: 4.32
2022 Fac PE RVU: 1.77

RUC Recommendation: 2.74 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,012

2022 Work RVU: 9.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.90

RUC Recommendation: 9.04 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,630

2022 Work RVU: 2.61
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.67

RUC Recommendation: 2.61 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 397

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.93

RUC Recommendation: 8.51 **Referred to CPT** September 2016 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,522

2022 Work RVU: 9.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.42

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 **2020 Medicare Utilization:** 10,074

2022 Work RVU: 4.27
2022 NF PE RVU: 8.31
2022 Fac PE RVU: 2.27

RUC Recommendation: 4.27 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 7,772

2022 Work RVU: 5.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.95

RUC Recommendation: 5.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 10,991

2022 Work RVU: 3.11
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.74

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 **2020 Medicare Utilization:** 4,615

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.98

RUC Recommendation: 8.00 **Referred to CPT** September 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 6,410

2022 Work RVU: 8.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.18

RUC Recommendation: 8.48 **Referred to CPT** September 2016 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 21,660

2022 Work RVU: 4.68
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.45

RUC Recommendation: 4.68 **Referred to CPT** September 2016 **Result:** Decrease
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 **2020 Medicare Utilization:** 11,927

2022 Work RVU: 6.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.40

RUC Recommendation: 6.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,449

2022 Work RVU: 3.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.92

RUC Recommendation: 3.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,260

2022 Work RVU: 4.10
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.19

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 **2020 Medicare Utilization:** 21,542

2022 Work RVU: 2.70
2022 NF PE RVU: 48.76
2022 Fac PE RVU: 1.55

RUC Recommendation: 2.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,960

2022 Work RVU: 3.10
2022 NF PE RVU: 49.06
2022 Fac PE RVU: 1.73

RUC Recommendation: 3.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,530

2022 Work RVU: 2.44
2022 NF PE RVU: 48.64
2022 Fac PE RVU: 1.43

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 **2020 Medicare Utilization:** 15,631

2022 Work RVU: 4.50
2022 NF PE RVU: 92.54
2022 Fac PE RVU: 2.37

RUC Recommendation: 4.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 298,685

2022 Work RVU: 3.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.73

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2016

Status Report: CMS Requests and Relativity Assessment Issues

31551 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age**

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 **2020 Medicare Utilization:**

2022 Work RVU: 21.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 21.37

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 **2020 Medicare Utilization:** 12

2022 Work RVU: 20.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 20.94

RUC Recommendation: 20.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1

2022 Work RVU: 22.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 25.13

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 **2020 Medicare Utilization:** 17

2022 Work RVU: 22.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 25.16

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,609

2022 Work RVU: 4.26
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.42

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

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 **2020 Medicare Utilization:** 478,910

2022 Work RVU: 0.94
2022 NF PE RVU: 2.79
2022 Fac PE RVU: 0.91

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 **2020 Medicare Utilization:** 63,562

2022 Work RVU: 1.88
2022 NF PE RVU: 3.78
2022 Fac PE RVU: 1.36

RUC Recommendation: 1.94

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

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 20

2022 Work RVU: 14.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 21.79

RUC Recommendation: 14.60 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 18

2022 Work RVU: 17.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 22.27

RUC Recommendation: 20.00 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 9

2022 Work RVU: 15.27
2022 NF PE RVU: NA
2022 Fac PE RVU: 18.56

RUC Recommendation: 15.27 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 857

2022 Work RVU: 13.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.33

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 **2020 Medicare Utilization:** 24

2022 Work RVU: 25.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 22.99

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 **2020 Medicare Utilization:** 24,837

2022 Work RVU: 5.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.41

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 5

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.08

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 740

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.37

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 254

2022 Work RVU: 6.45
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.07

RUC Recommendation: 6.45 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 1,570

2022 Work RVU: 12.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.85

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 729

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.16

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 39,918

2022 Work RVU: 2.53
2022 NF PE RVU: 4.60
2022 Fac PE RVU: 1.04

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 **2020 Medicare Utilization:** 19,304

2022 Work RVU: 2.63
2022 NF PE RVU: 5.48
2022 Fac PE RVU: 1.02

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

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 **2020 Medicare Utilization:** 91,904

2022 Work RVU: 2.63
2022 NF PE RVU: 4.82
2022 Fac PE RVU: 1.05

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 14,651

2022 Work RVU: 3.11
2022 NF PE RVU: 7.26
2022 Fac PE RVU: 1.18

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 **2020 Medicare Utilization:** 1,820

2022 Work RVU: 3.91
2022 NF PE RVU: 20.18
2022 Fac PE RVU: 1.41

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 **2020 Medicare Utilization:** 26,147

2022 Work RVU: 3.55
2022 NF PE RVU: 7.48
2022 Fac PE RVU: 1.30

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 12,212

2022 Work RVU: 3.75
2022 NF PE RVU: 9.80
2022 Fac PE RVU: 1.36

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,345

2022 Work RVU: 1.03
2022 NF PE RVU: 0.80
2022 Fac PE RVU: 0.32

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 **2020 Medicare Utilization:** 965

2022 Work RVU: 1.32
2022 NF PE RVU: 0.95
2022 Fac PE RVU: 0.41

RUC Recommendation: 1.32 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 30,487

2022 Work RVU: 2.88
2022 NF PE RVU: 5.07
2022 Fac PE RVU: 1.15

RUC Recommendation: 2.88 **Referred to CPT** May 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,746

2022 Work RVU: 2.78
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.11

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 **2020 Medicare Utilization:** 21,872

2022 Work RVU: 4.46
2022 NF PE RVU: 34.63
2022 Fac PE RVU: 1.59

RUC Recommendation: 5.00 **Referred to CPT** October 2014 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 12,420

2022 Work RVU: 4.96
2022 NF PE RVU: 35.59
2022 Fac PE RVU: 1.75

RUC Recommendation: 5.50 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 7,822

2022 Work RVU: 1.40
2022 NF PE RVU: 2.12
2022 Fac PE RVU: 0.44

RUC Recommendation: 1.70 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

32405 **Biopsy, lung or mediastinum, percutaneous needle**

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:** October 2017 **2020 Medicare Utilization:** 58,546

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

32408 **Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed**

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:** April 2019 **2020 Medicare Utilization:**

2022 Work RVU: 3.18
2022 NF PE RVU: 23.07
2022 Fac PE RVU: 1.00

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 217

2022 Work RVU: 27.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.44

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

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 **2020 Medicare Utilization:** 3,477

2022 Work RVU: 25.82
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.61

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:**

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 **2020 Medicare Utilization:** 243

2022 Work RVU: 27.44
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.65

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 **2020 Medicare Utilization:** 15

2022 Work RVU: 25.24
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.07

RUC Recommendation: Request further information from CMS

Referred to CPT

Result: Remove from Screen

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 34,718

2022 Work RVU: 3.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.02

RUC Recommendation: 3.50 **Referred to CPT** February 2012 **Result:** Increase

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

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 **2020 Medicare Utilization:** 11,100

2022 Work RVU: 1.82
2022 NF PE RVU: 5.19
2022 Fac PE RVU: 0.60

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 **2020 Medicare Utilization:** 203,967

2022 Work RVU: 2.27
2022 NF PE RVU: 7.19
2022 Fac PE RVU: 0.74

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 **2020 Medicare Utilization:** 4,846

2022 Work RVU: 2.50
2022 NF PE RVU: 20.19
2022 Fac PE RVU: 0.81

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 35,023

2022 Work RVU: 3.12
2022 NF PE RVU: 17.11
2022 Fac PE RVU: 0.97

RUC Recommendation: 3.62 **Referred to CPT** February 2012 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 8,115

2022 Work RVU: 24.64
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.60

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 4,498

2022 Work RVU: 4.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.54

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 **2020 Medicare Utilization:** 2,767

2022 Work RVU: 4.62
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.61

RUC Recommendation: 5.50 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6

2022 Work RVU: 5.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.86

RUC Recommendation: 6.00 **Referred to CPT** September 2018 **Result:** Increase

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

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 **2020 Medicare Utilization:** 275

2022 Work RVU: 4.29
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.42

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase

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

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 **2020 Medicare Utilization:** 145

2022 Work RVU: 14.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.69

RUC Recommendation: 14.31 **Referred to CPT** May 2018 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,936

2022 Work RVU: 13.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.33

RUC Recommendation: 13.20 **Referred to CPT** May 2018 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 9,601

2022 Work RVU: 7.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.57

RUC Recommendation: 8.05 **Referred to CPT** February 2011 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 89,252

2022 Work RVU: 8.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.89

RUC Recommendation: 8.77 **Referred to CPT** February 2011 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 258

2022 Work RVU: 5.01
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.39

RUC Recommendation: 5.26 **Referred to CPT** February 2011 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 988

2022 Work RVU: 5.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.49

RUC Recommendation: 5.53 **Referred to CPT** February 2011 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 228

2022 Work RVU: 5.55
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.88

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 **2020 Medicare Utilization:** 3,157

2022 Work RVU: 5.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.61

RUC Recommendation: 5.50 **Referred to CPT** February 2011 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 26,170

2022 Work RVU: 5.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.73

RUC Recommendation: 5.77

Referred to CPT February 2011

Result: Decrease

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

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

2020 Medicare Utilization: 5,499

2022 Work RVU: 5.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.00

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

2020 Medicare Utilization: 102

2022 Work RVU: 6.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.93

RUC Recommendation: 6.32

Referred to CPT February 2011

Result: Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 111

2022 Work RVU: 6.34
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.06

RUC Recommendation: 6.59

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

2020 Medicare Utilization: 7,698

2022 Work RVU: 3.14
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.06

RUC Recommendation: 3.39

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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

2020 Medicare Utilization: 174

2022 Work RVU: 5.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.71

RUC Recommendation: 6.06

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 5,115

2022 Work RVU: 3.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.63

RUC Recommendation: 3.29

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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

2020 Medicare Utilization: 34,980

2022 Work RVU: 14.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.76

RUC Recommendation: 15.17

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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

2020 Medicare Utilization: 2,466

2022 Work RVU: 5.81
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.94

RUC Recommendation: 6.06

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 6,837

2022 Work RVU: 6.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.04

RUC Recommendation: 6.33

Referred to CPT February 2011

Result: Decrease

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

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

2020 Medicare Utilization: 11,676

2022 Work RVU: 6.35
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.18

RUC Recommendation: 6.60

Referred to CPT February 2011

Result: Decrease

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

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

2020 Medicare Utilization:

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

RUC Recommendation: 3.50

Referred to CPT February 2017

Result: Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

RUC Recommendation: 3.00 **Referred to CPT** February 2017 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 12,189

2022 Work RVU: 41.32
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.56

RUC Recommendation: 41.32 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 6,096

2022 Work RVU: 50.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 19.28

RUC Recommendation: 50.93 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 46,522

2022 Work RVU: 33.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.24

RUC Recommendation: 34.98 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 66

2022 Work RVU: 30.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.22

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 **2020 Medicare Utilization:** 1

2022 Work RVU: 16.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.28

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

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 **2020 Medicare Utilization:**

2022 Work RVU: 64.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 21.27

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

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

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: 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:** September 2019 **2020 Medicare Utilization:**

2022 Work RVU: 14.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.83

RUC Recommendation: 14.00

Referred to CPT September 2019 **Result:** Maintain

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

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 catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, fontan fenestration, right ventricular outflow tract, mustard/senning/warden baffles); initial intracardiac shunt**

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:** September 2019 **2020 Medicare Utilization:**

2022 Work RVU: 20.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.90

RUC Recommendation: 20.00

Referred to CPT September 2019 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

33746 **Transcatheter intracardiac shunt (tis) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, fontan fenestration, right ventricular outflow tract, mustard/senning/warden baffles); each additional intracardiac shunt location (list separately in addition to code for primary procedure)**

Global: ZZZ **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 **2020 Medicare Utilization:**

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.76

RUC Recommendation: 10.50 **Referred to CPT** September 2019 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,627

2022 Work RVU: 58.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 19.58

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 **2020 Medicare Utilization:** 668

2022 Work RVU: 89.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 31.93

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 604

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.83

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 **2020 Medicare Utilization:** 1,278

2022 Work RVU: 6.63
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.00

RUC Recommendation: 6.63 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 6,049

2022 Work RVU: 4.73
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.48

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 **2020 Medicare Utilization:** 5,136

2022 Work RVU: 4.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.40

RUC Recommendation: 4.60 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,399

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

RUC Recommendation: 8.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1

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

RUC Recommendation: 9.83 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 298

2022 Work RVU: 9.11
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.74

RUC Recommendation: 9.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 370

2022 Work RVU: 16.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.70

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 **2020 Medicare Utilization:**

2022 Work RVU: 3.51
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.07

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 74

2022 Work RVU: 3.51
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.07

RUC Recommendation: 4.05 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 4.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.34

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 18

2022 Work RVU: 4.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.34

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

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

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 **2020 Medicare Utilization:**

2022 Work RVU: 9.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.58

RUC Recommendation: 9.00 **Referred to CPT** February 2014 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 13

2022 Work RVU: 9.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.72

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 3.51
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.07

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 **2020 Medicare Utilization:** 477

2022 Work RVU: 4.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.43

RUC Recommendation: 4.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU: 5.22
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.54

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 426

2022 Work RVU: 5.46
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.56

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 **2020 Medicare Utilization:** 1

2022 Work RVU: 9.89
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.83

RUC Recommendation: 9.89 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 212

2022 Work RVU: 10.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.99

RUC Recommendation: 10.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 36

2022 Work RVU: 4.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.12

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 **2020 Medicare Utilization:** 29

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.23

RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 15

2022 Work RVU: 9.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.72

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 650

2022 Work RVU: 23.71
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.99

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 **2020 Medicare Utilization:** 97

2022 Work RVU: 36.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.41

RUC Recommendation: 36.00 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 795

2022 Work RVU: 26.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.36

RUC Recommendation: 26.52 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 99

2022 Work RVU: 45.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.84

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 10,152

2022 Work RVU: 29.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.06

RUC Recommendation: 29.58 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 609

2022 Work RVU: 45.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.84

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 453

2022 Work RVU: 22.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.34

RUC Recommendation: 22.28 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 76

2022 Work RVU: 36.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.06

RUC Recommendation: 36.50 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 2,552

2022 Work RVU: 6.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.38

RUC Recommendation: 6.50 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 1,049

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.70

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 306

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.19

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 1,001

2022 Work RVU: 12.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.34

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 13,909

2022 Work RVU: 2.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.51

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 472

2022 Work RVU: 5.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.37

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

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 **2020 Medicare Utilization:** 205

2022 Work RVU: 6.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.29

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 966

2022 Work RVU: 7.19
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.99

RUC Recommendation: 7.19 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:** 6,601

2022 Work RVU: 4.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.90

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 **2020 Medicare Utilization:** 57

2022 Work RVU: 7.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.12

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:** 40

2022 Work RVU: 8.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.30

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 **2020 Medicare Utilization:** 374

2022 Work RVU: 2.65
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.48

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:** 27,259

2022 Work RVU: 21.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.70

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 885

2022 Work RVU: 7.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.09

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 **2020 Medicare Utilization:** 499

2022 Work RVU: 7.12
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.20

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 **2020 Medicare Utilization:** 666

2022 Work RVU: 7.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.04

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.18
2022 NF PE RVU: 0.70
2022 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:**

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 **2020 Medicare Utilization:** 13,423

2022 Work RVU: 2.18
2022 NF PE RVU: 14.32
2022 Fac PE RVU: 0.61

RUC Recommendation: Remove from re-review. **Referred to CPT** February 2011 **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 17,418

2022 Work RVU: 1.76
2022 NF PE RVU: 13.78
2022 Fac PE RVU: 0.50

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 42,749

2022 Work RVU: 4.17
2022 NF PE RVU: 27.20
2022 Fac PE RVU: 1.46

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 4,110

2022 Work RVU: 5.27
2022 NF PE RVU: 26.59
2022 Fac PE RVU: 1.63

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

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 **2020 Medicare Utilization:** 3,625

2022 Work RVU: 6.29
2022 NF PE RVU: 46.84
2022 Fac PE RVU: 1.99

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 **2020 Medicare Utilization:** 1,773

2022 Work RVU: 1.01
2022 NF PE RVU: 4.97
2022 Fac PE RVU: 0.31

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 1,758

2022 Work RVU: 3.92
2022 NF PE RVU: 25.89
2022 Fac PE RVU: 1.09

RUC Recommendation: 4.51 **Referred to CPT** February 2012 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 5,920

2022 Work RVU: 5.28
2022 NF PE RVU: 30.52
2022 Fac PE RVU: 1.79

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 **2020 Medicare Utilization:** 24,795

2022 Work RVU: 5.75
2022 NF PE RVU: 41.86
2022 Fac PE RVU: 2.25

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 32,350

2022 Work RVU: 6.25
2022 NF PE RVU: 53.61
2022 Fac PE RVU: 2.70

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

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 **2020 Medicare Utilization:** 9,398

2022 Work RVU: 5.75
2022 NF PE RVU: 39.34
2022 Fac PE RVU: 2.17

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 **2020 Medicare Utilization:** 28,231

2022 Work RVU: 6.25
2022 NF PE RVU: 51.43
2022 Fac PE RVU: 2.65

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 13,420

2022 Work RVU: 2.09
2022 NF PE RVU: 4.40
2022 Fac PE RVU: 0.84

RUC Recommendation: 2.32 **Referred to CPT** February 2012 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,948

2022 Work RVU: 4.25
2022 NF PE RVU: 32.82
2022 Fac PE RVU: 1.71

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 **2020 Medicare Utilization:** 35,341

2022 Work RVU: 4.65
2022 NF PE RVU: 33.01
2022 Fac PE RVU: 1.42

RUC Recommendation: 4.90 **Referred to CPT** February 2010 and February 2011 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 31,792

2022 Work RVU: 5.02
2022 NF PE RVU: 19.75
2022 Fac PE RVU: 1.34

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 60,496

2022 Work RVU: 6.04
2022 NF PE RVU: 37.03
2022 Fac PE RVU: 1.63

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 **2020 Medicare Utilization:** 25,988

2022 Work RVU: 1.01
2022 NF PE RVU: 2.43
2022 Fac PE RVU: 0.28

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen

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

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 **2020 Medicare Utilization:** 3,009

2022 Work RVU: 5.10
2022 NF PE RVU: 33.88
2022 Fac PE RVU: 1.49

RUC Recommendation: 5.45 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,222

2022 Work RVU: 6.74
2022 NF PE RVU: 34.76
2022 Fac PE RVU: 2.25

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 **2020 Medicare Utilization:** 1,559

2022 Work RVU: 7.30
2022 NF PE RVU: 54.16
2022 Fac PE RVU: 2.15

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 154

2022 Work RVU: 7.90
2022 NF PE RVU: 52.13
2022 Fac PE RVU: 2.50

RUC Recommendation: 8.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 137,370

2022 Work RVU: 0.18
2022 NF PE RVU: 0.32
2022 Fac PE RVU: 0.07

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 82,131

2022 Work RVU: 5.30
2022 NF PE RVU: 26.97
2022 Fac PE RVU: 1.72

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,868

2022 Work RVU: 2.65
2022 NF PE RVU: 5.47
2022 Fac PE RVU: 0.72

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

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 **2020 Medicare Utilization:** 37,437

2022 Work RVU: 5.30
2022 NF PE RVU: 24.09
2022 Fac PE RVU: 1.76

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 4,399

2022 Work RVU: 2.65
2022 NF PE RVU: 5.91
2022 Fac PE RVU: 0.78

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 709

2022 Work RVU: 6.73
2022 NF PE RVU: 46.31
2022 Fac PE RVU: 2.01

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

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 **2020 Medicare Utilization:** 278

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.07

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 **2020 Medicare Utilization:** 2,926

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.00

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 **2020 Medicare Utilization:** 179

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.90

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

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 **2020 Medicare Utilization:** 25,754

2022 Work RVU: 1.81
2022 NF PE RVU: 15.21
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 978

2022 Work RVU: 1.56
2022 NF PE RVU: 52.81
2022 Fac PE RVU: 0.65

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

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 **2020 Medicare Utilization:** 8,511

2022 Work RVU: 1.75
2022 NF PE RVU: 39.97
2022 Fac PE RVU: 0.97

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 34

2022 Work RVU: 1.93
2022 NF PE RVU: 3.64
2022 Fac PE RVU: 0.38

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 **2020 Medicare Utilization:** 422,378

2022 Work RVU: 1.75
2022 NF PE RVU: 4.53
2022 Fac PE RVU: 0.50

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2

2022 Work RVU: 2.11
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.35

RUC Recommendation: 2.11 **Referred to CPT** September 2017 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 11,928

2022 Work RVU: 1.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.60

RUC Recommendation: 1.90. Review at RAW in October 2021. **Referred to CPT** September 2017 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 26

2022 Work RVU: 1.82
2022 NF PE RVU: 9.46
2022 Fac PE RVU: 0.33

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

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

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 **2020 Medicare Utilization:** 75,480

2022 Work RVU: 1.70
2022 NF PE RVU: 9.96
2022 Fac PE RVU: 0.56

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,570

2022 Work RVU: 1.20
2022 NF PE RVU: 8.86
2022 Fac PE RVU: 0.40

RUC Recommendation: 1.47 **Referred to CPT** September 2017 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 537,935

2022 Work RVU: 1.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.20

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

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

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 **2020 Medicare Utilization:** 4,375

2022 Work RVU: 12.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.83

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,123

2022 Work RVU: 13.29
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.90

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 **2020 Medicare Utilization:** 1,070

2022 Work RVU: 13.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.88

RUC Recommendation: 13.99 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 26,218

2022 Work RVU: 11.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.63

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 1,533

2022 Work RVU: 14.17
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.64

RUC Recommendation: 15.93 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 17,399

2022 Work RVU: 12.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.60

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 58,681

2022 Work RVU: 3.36
2022 NF PE RVU: 17.91
2022 Fac PE RVU: 1.05

RUC Recommendation: 3.36 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 180,136

2022 Work RVU: 4.83
2022 NF PE RVU: 31.90
2022 Fac PE RVU: 1.47

RUC Recommendation: 4.83 **Referred to CPT** October 2015 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 19,278

2022 Work RVU: 6.39
2022 NF PE RVU: 127.30
2022 Fac PE RVU: 1.82

RUC Recommendation: 6.39 **Referred to CPT** October 2015 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,960

2022 Work RVU: 7.50
2022 NF PE RVU: 47.32
2022 Fac PE RVU: 2.15

RUC Recommendation: 7.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 38,039

2022 Work RVU: 9.00
2022 NF PE RVU: 60.63
2022 Fac PE RVU: 2.72

RUC Recommendation: 9.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 13,925

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

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 **2020 Medicare Utilization:** 62,214

2022 Work RVU: 3.00
2022 NF PE RVU: 14.83
2022 Fac PE RVU: 0.83

RUC Recommendation: 3.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,044

2022 Work RVU: 4.25
2022 NF PE RVU: 39.30
2022 Fac PE RVU: 1.11

RUC Recommendation: 4.25 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,891

2022 Work RVU: 4.12
2022 NF PE RVU: 55.62
2022 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 **2020 Medicare Utilization:** 850

2022 Work RVU: 7.74
2022 NF PE RVU: 174.69
2022 Fac PE RVU: 2.35

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 22,388

2022 Work RVU: 4.46
2022 NF PE RVU: 58.48
2022 Fac PE RVU: 1.36

RUC Recommendation: 4.71 **Referred to CPT** February 2011 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 22

2022 Work RVU: 7.10
2022 NF PE RVU: 30.64
2022 Fac PE RVU: 1.21

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,916

2022 Work RVU: 7.10
2022 NF PE RVU: 38.17
2022 Fac PE RVU: 1.99

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 10,346

2022 Work RVU: 7.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.10

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,474

2022 Work RVU: 6.81
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.89

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 **2020 Medicare Utilization:** 1,877

2022 Work RVU: 4.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.22

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,072

2022 Work RVU: 2.49
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.64

RUC Recommendation: 3.04 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 11,274

2022 Work RVU: 7.90
2022 NF PE RVU: 68.59
2022 Fac PE RVU: 2.02

RUC Recommendation: Refer to CPT. 8.15 **Referred to CPT** February 2022 **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 **2020 Medicare Utilization:** 30,206

2022 Work RVU: 9.75
2022 NF PE RVU: 84.63
2022 Fac PE RVU: 2.47

RUC Recommendation: Refer to CPT. 10.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,085

2022 Work RVU: 3.73
2022 NF PE RVU: 14.34
2022 Fac PE RVU: 0.85

RUC Recommendation: Refer to CPT. 3.73 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,092

2022 Work RVU: 4.25
2022 NF PE RVU: 34.68
2022 Fac PE RVU: 0.98

RUC Recommendation: Refer to CPT. 4.25 **Referred to CPT** February 2022 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 30,467

2022 Work RVU: 8.75
2022 NF PE RVU: 80.87
2022 Fac PE RVU: 2.27

RUC Recommendation: Refer to CPT. 9.00 **Referred to CPT** February 2022 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 41,114

2022 Work RVU: 11.75
2022 NF PE RVU: 261.72
2022 Fac PE RVU: 3.21

RUC Recommendation: Refer to CPT. **Referred to CPT** February 2022 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 22,168

2022 Work RVU: 10.24
2022 NF PE RVU: 244.93
2022 Fac PE RVU: 2.60

RUC Recommendation: Refer to CPT. 10.49 **Referred to CPT** February 2022 **Result:** Decrease
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 **2020 Medicare Utilization:** 21,431

2022 Work RVU: 14.25
2022 NF PE RVU: 336.35
2022 Fac PE RVU: 3.65

RUC Recommendation: Refer to CPT. 14.50 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 32,986

2022 Work RVU: 10.75
2022 NF PE RVU: 117.11
2022 Fac PE RVU: 2.69

RUC Recommendation: Refer to CPT. 11.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 39,090

2022 Work RVU: 13.80
2022 NF PE RVU: 262.74
2022 Fac PE RVU: 3.66

RUC Recommendation: Refer to CPT. 14.05 **Referred to CPT** February 2022 **Result:** Decrease
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 **2020 Medicare Utilization:** 2,731

2022 Work RVU: 13.55
2022 NF PE RVU: 264.62
2022 Fac PE RVU: 3.78

RUC Recommendation: Refer to CPT. 13.80 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,909

2022 Work RVU: 14.75
2022 NF PE RVU: 349.39
2022 Fac PE RVU: 4.00

RUC Recommendation: Refer to CPT. 15.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 15,768

2022 Work RVU: 4.00
2022 NF PE RVU: 20.61
2022 Fac PE RVU: 1.01

RUC Recommendation: Refer to CPT. 4.00 **Referred to CPT** February 2022 **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 **2020 Medicare Utilization:** 8,651

2022 Work RVU: 6.50
2022 NF PE RVU: 24.00
2022 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 6.50 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 402

2022 Work RVU: 5.50
2022 NF PE RVU: 106.58
2022 Fac PE RVU: 1.56

RUC Recommendation: Refer to CPT. 5.50 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 139

2022 Work RVU: 7.80
2022 NF PE RVU: 112.18
2022 Fac PE RVU: 2.12

RUC Recommendation: Refer to CPT. 7.80 **Referred to CPT** February 2022 **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 **2020 Medicare Utilization:** 11,118

2022 Work RVU: 8.75
2022 NF PE RVU: 75.20
2022 Fac PE RVU: 2.28

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37237 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (list separately in addition to code for primary procedure)**

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 **2020 Medicare Utilization:** 1,341

2022 Work RVU: 4.25
2022 NF PE RVU: 34.98
2022 Fac PE RVU: 0.97

RUC Recommendation: 4.25 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 10,491

2022 Work RVU: 6.04
2022 NF PE RVU: 100.31
2022 Fac PE RVU: 1.71

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 **2020 Medicare Utilization:** 4,194

2022 Work RVU: 2.97
2022 NF PE RVU: 49.57
2022 Fac PE RVU: 0.82

RUC Recommendation: 3.34 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,852

2022 Work RVU: 8.75
2022 NF PE RVU: 136.01
2022 Fac PE RVU: 2.47

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

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 **2020 Medicare Utilization:** 8,018

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

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 **2020 Medicare Utilization:** 13,506

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

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 13,195

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

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

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 **2020 Medicare Utilization:** 7,743

2022 Work RVU: 7.00
2022 NF PE RVU: 48.61
2022 Fac PE RVU: 1.89

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 **2020 Medicare Utilization:** 651

2022 Work RVU: 3.50
2022 NF PE RVU: 12.64
2022 Fac PE RVU: 0.73

RUC Recommendation: 3.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 14,716

2022 Work RVU: 6.00
2022 NF PE RVU: 35.48
2022 Fac PE RVU: 1.79

RUC Recommendation: 6.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,590

2022 Work RVU: 2.97
2022 NF PE RVU: 10.13
2022 Fac PE RVU: 0.76

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 68,320

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

RUC Recommendation: 1.80 **Referred to CPT** 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 **2020 Medicare Utilization:** 105,426

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

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2020 Medicare Utilization:** 11,518

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

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37619 **Ligation of inferior vena cava** **Global:** 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** February 2011 **2020 Medicare Utilization:** 51

2022 Work RVU: 30.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.84

RUC Recommendation: 37.60 **Referred to CPT** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 39

2022 Work RVU: 10.78
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.47

RUC Recommendation: 10.69 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 227

2022 Work RVU: 9.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.46

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 9,983

2022 Work RVU: 4.80
2022 NF PE RVU: 7.04
2022 Fac PE RVU: 2.12

RUC Recommendation: 4.80 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 8,158

2022 Work RVU: 6.00
2022 NF PE RVU: 7.69
2022 Fac PE RVU: 2.44

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 707

2022 Work RVU: 3.93
2022 NF PE RVU: 5.77
2022 Fac PE RVU: 2.69

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

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 **2020 Medicare Utilization:** 4,953

2022 Work RVU: 1.20
2022 NF PE RVU: 3.35
2022 Fac PE RVU: 0.70

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 **2020 Medicare Utilization:** 8,935

2022 Work RVU: 1.28
2022 NF PE RVU: 3.46
2022 Fac PE RVU: 0.70

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 **2020 Medicare Utilization:** 112,874

2022 Work RVU: 1.44
2022 NF PE RVU: 3.68
2022 Fac PE RVU: 0.68

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 **2020 Medicare Utilization:** 32,769

2022 Work RVU: 1.59
2022 NF PE RVU: 3.60
2022 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 **2020 Medicare Utilization:** 503

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

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 **2020 Medicare Utilization:** 5,794

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

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

2020 Medicare Utilization: 16,802

2022 Work RVU: 12.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.89

RUC Recommendation: 12.00

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

Result: Decrease

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

2020 Medicare Utilization: 1,824

2022 Work RVU: 15.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.72

RUC Recommendation: 15.60

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

Result: Decrease

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

2020 Medicare Utilization: 29,251

2022 Work RVU: 0.65
2022 NF PE RVU: 1.72
2022 Fac PE RVU: 0.23

RUC Recommendation: 0.65

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

Result: Increase

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 375

2022 Work RVU: 5.44
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.32

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 **2020 Medicare Utilization:** 3,044

2022 Work RVU: 7.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.87

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 **2020 Medicare Utilization:** 26,035

2022 Work RVU: 1.22
2022 NF PE RVU: 2.32
2022 Fac PE RVU: 0.68

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 **2020 Medicare Utilization:** 311

2022 Work RVU: 3.78
2022 NF PE RVU: 9.90
2022 Fac PE RVU: 4.74

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

2020 Medicare Utilization: 2,838

2022 Work RVU: 1.23
2022 NF PE RVU: 4.76
2022 Fac PE RVU: 2.15

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

2020 Medicare Utilization: 1,342

2022 Work RVU: 2.63
2022 NF PE RVU: 5.75
2022 Fac PE RVU: 2.91

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

2020 Medicare Utilization: 7,939

2022 Work RVU: 1.05
2022 NF PE RVU: 3.89
2022 Fac PE RVU: 1.40

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 **2020 Medicare Utilization:** 5,069

2022 Work RVU: 2.37
2022 NF PE RVU: 5.94
2022 Fac PE RVU: 2.85

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 **2020 Medicare Utilization:** 870

2022 Work RVU: 1.34
2022 NF PE RVU: 6.44
2022 Fac PE RVU: 3.54

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 **2020 Medicare Utilization:** 248

2022 Work RVU: 3.50
2022 NF PE RVU: 24.36
2022 Fac PE RVU: 7.41

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 **2020 Medicare Utilization:** 359

2022 Work RVU: 9.78
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.25

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 **2020 Medicare Utilization:** 4,301

2022 Work RVU: 17.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.64

RUC Recommendation: 18.12 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 1,345

2022 Work RVU: 19.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.70

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 1,464

2022 Work RVU: 6.14
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.27

RUC Recommendation: 7.13 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 2,534

2022 Work RVU: 2.49
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.69

RUC Recommendation: 2.78 **Referred to CPT** **Result:** Increase
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 **2020 Medicare Utilization:** 164

2022 Work RVU: 2.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.79

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 196

2022 Work RVU: 2.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.78

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 118

2022 Work RVU: 3.51
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.60

RUC Recommendation: 3.99 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 493

2022 Work RVU: 3.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.91

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 375

2022 Work RVU: 3.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.00

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 909

2022 Work RVU: 1.52
2022 NF PE RVU: 4.04
2022 Fac PE RVU: 0.67

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 210

2022 Work RVU: 1.82
2022 NF PE RVU: 4.33
2022 Fac PE RVU: 0.82

RUC Recommendation: 1.89 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 4,190

2022 Work RVU: 1.42
2022 NF PE RVU: 6.43
2022 Fac PE RVU: 0.94

RUC Recommendation: 1.59 **Referred to CPT** May 2012 **Result:** Maintain

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 **2020 Medicare Utilization:** 200

2022 Work RVU: 1.72
2022 NF PE RVU: 5.98
2022 Fac PE RVU: 1.06

RUC Recommendation: 1.90 **Referred to CPT** May 2012 **Result:** Decrease
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 **2020 Medicare Utilization:** 1,940

2022 Work RVU: 1.72
2022 NF PE RVU: 9.12
2022 Fac PE RVU: 1.07

RUC Recommendation: 1.89 **Referred to CPT** May 2012 **Result:** Maintain
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 **2020 Medicare Utilization:** 17

2022 Work RVU: 2.33
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.36

RUC Recommendation: 2.89 **Referred to CPT** May 2012 **Result:** Decrease
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 **2020 Medicare Utilization:** 109

2022 Work RVU: 2.44
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.41

RUC Recommendation: 3.00 **Referred to CPT** May 2012 **Result:** Decrease
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 **2020 Medicare Utilization:** 26

2022 Work RVU: 2.29
2022 NF PE RVU: 6.70
2022 Fac PE RVU: 1.35

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

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 **2020 Medicare Utilization:** 67

2022 Work RVU: 4.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.20

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 493

2022 Work RVU: 3.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.58

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 179

2022 Work RVU: 4.63
2022 NF PE RVU: 33.29
2022 Fac PE RVU: 2.26

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

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 **2020 Medicare Utilization:** 146

2022 Work RVU: 3.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.81

RUC Recommendation: 3.78 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 752

2022 Work RVU: 2.44
2022 NF PE RVU: 9.33
2022 Fac PE RVU: 1.34

RUC Recommendation: 2.60 **Referred to CPT** May 2012 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 135

2022 Work RVU: 2.30
2022 NF PE RVU: 10.15
2022 Fac PE RVU: 1.35

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 28

2022 Work RVU: 2.80
2022 NF PE RVU: 9.85
2022 Fac PE RVU: 1.57

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Result:** Maintain

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,676

2022 Work RVU: 2.00
2022 NF PE RVU: 26.03
2022 Fac PE RVU: 1.20

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 **2020 Medicare Utilization:** 1,386

2022 Work RVU: 2.24
2022 NF PE RVU: 9.29
2022 Fac PE RVU: 1.25

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 **2020 Medicare Utilization:** 164

2022 Work RVU: 2.89
2022 NF PE RVU: 15.26
2022 Fac PE RVU: 1.59

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 1,542

2022 Work RVU: 3.49
2022 NF PE RVU: 18.25
2022 Fac PE RVU: 1.85

RUC Recommendation: 3.72 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 486

2022 Work RVU: 2.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.55

RUC Recommendation: 3.19 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 330

2022 Work RVU: 3.59
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.85

RUC Recommendation: 3.83 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,145

2022 Work RVU: 4.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.06

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 253,237

2022 Work RVU: 2.09
2022 NF PE RVU: 6.75
2022 Fac PE RVU: 1.25

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 **2020 Medicare Utilization:** 13,996

2022 Work RVU: 2.39
2022 NF PE RVU: 9.76
2022 Fac PE RVU: 1.38

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 **2020 Medicare Utilization:** 16,466

2022 Work RVU: 3.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.87

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 **2020 Medicare Utilization:** 13,506

2022 Work RVU: 4.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.18

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 **2020 Medicare Utilization:** 1,131,001

2022 Work RVU: 2.39
2022 NF PE RVU: 8.97
2022 Fac PE RVU: 1.38

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 **2020 Medicare Utilization:** 1,053

2022 Work RVU: 7.15
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.51

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 **2020 Medicare Utilization:** 4,196

2022 Work RVU: 2.49
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.37

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 **2020 Medicare Utilization:** 23,675

2022 Work RVU: 4.73
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.44

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 **2020 Medicare Utilization:** 491

2022 Work RVU: 4.27
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.16

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 **2020 Medicare Utilization:** 18,306

2022 Work RVU: 4.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.29

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 **2020 Medicare Utilization:** 12,727

2022 Work RVU: 3.08
2022 NF PE RVU: 15.01
2022 Fac PE RVU: 1.65

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 **2020 Medicare Utilization:** 66,201

2022 Work RVU: 3.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.79

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 **2020 Medicare Utilization:** 23,932

2022 Work RVU: 3.11
2022 NF PE RVU: 8.25
2022 Fac PE RVU: 1.68

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 **2020 Medicare Utilization:** 86,776

2022 Work RVU: 2.91
2022 NF PE RVU: 9.47
2022 Fac PE RVU: 1.61

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 **2020 Medicare Utilization:** 103,830

2022 Work RVU: 2.67
2022 NF PE RVU: 31.12
2022 Fac PE RVU: 1.50

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 **2020 Medicare Utilization:** 2,969

2022 Work RVU: 2.97
2022 NF PE RVU: 10.58
2022 Fac PE RVU: 1.59

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 **2020 Medicare Utilization:** 31,307

2022 Work RVU: 3.47
2022 NF PE RVU: 11.44
2022 Fac PE RVU: 1.86

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 **2020 Medicare Utilization:** 2,011

2022 Work RVU: 4.73
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.43

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 **2020 Medicare Utilization:** 4,869

2022 Work RVU: 4.87
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.49

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 **2020 Medicare Utilization:** 57,096

2022 Work RVU: 3.56
2022 NF PE RVU: 15.52
2022 Fac PE RVU: 1.91

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 106

2022 Work RVU: 4.15
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.13

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 28,786

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

RUC Recommendation: 4.74 **Referred to CPT** February 2013 **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 **2020 Medicare Utilization:** 4,228

2022 Work RVU: 5.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.93

RUC Recommendation: 5.95 **Referred to CPT** February 2013 **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 **2020 Medicare Utilization:** 6,788

2022 Work RVU: 6.15
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.07

RUC Recommendation: 6.25 **Referred to CPT** January 2013 **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 **2020 Medicare Utilization:** 26,478

2022 Work RVU: 6.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.23

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 **2020 Medicare Utilization:** 47

2022 Work RVU: 6.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.23

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 **2020 Medicare Utilization:** 51,951

2022 Work RVU: 6.63
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.28

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 **2020 Medicare Utilization:** 2,379

2022 Work RVU: 7.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.87

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 **2020 Medicare Utilization:** 5,609

2022 Work RVU: 3.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.96

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 17,190

2022 Work RVU: 4.01
2022 NF PE RVU: 18.26
2022 Fac PE RVU: 2.11

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 7,409

2022 Work RVU: 2.24
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.00

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 **2020 Medicare Utilization:** 40,694

2022 Work RVU: 8.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.10

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 **2020 Medicare Utilization:** 12,746

2022 Work RVU: 6.86
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.38

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 **2020 Medicare Utilization:** 15,929

2022 Work RVU: 8.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.27

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 **2020 Medicare Utilization:** 6,431

2022 Work RVU: 6.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.41

RUC Recommendation: 7.11 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 456

2022 Work RVU: 7.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.86

RUC Recommendation: 8.08 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 53,506

2022 Work RVU: 1.28
2022 NF PE RVU: 4.29
2022 Fac PE RVU: 0.90

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

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 **2020 Medicare Utilization:** 1,132

2022 Work RVU: 1.41
2022 NF PE RVU: 23.63
2022 Fac PE RVU: 0.94

RUC Recommendation: 1.51 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 2022 **Tab:** 20 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2020 Medicare Utilization:** 46,820

2022 Work RVU: 0.75
2022 NF PE RVU: 6.14
2022 Fac PE RVU: 0.22

RUC Recommendation: 0.75. CPT Assistant article **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:**

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 2022 **Tab:** 20 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2020 Medicare Utilization:** 2,006

2022 Work RVU: 1.41
2022 NF PE RVU: 8.92
2022 Fac PE RVU: 0.84

RUC Recommendation: 1.41. CPT Assistant article.

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 **2020 Medicare Utilization:** 8,929

2022 Work RVU: 27.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.00

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 **2020 Medicare Utilization:** 10,094

2022 Work RVU: 22.95
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.81

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

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 **2020 Medicare Utilization:** 8,396

2022 Work RVU: 31.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.29

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

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 **2020 Medicare Utilization:** 1,720

2022 Work RVU: 0.87
2022 NF PE RVU: 5.01
2022 Fac PE RVU: 0.68

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 **2020 Medicare Utilization:** 155

2022 Work RVU: 1.38
2022 NF PE RVU: 28.87
2022 Fac PE RVU: 0.90

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 **2020 Medicare Utilization:** 1,292

2022 Work RVU: 1.17
2022 NF PE RVU: 7.95
2022 Fac PE RVU: 0.84

RUC Recommendation: 1.27 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 99

2022 Work RVU: 2.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.32

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 **2020 Medicare Utilization:** 1,065

2022 Work RVU: 1.20
2022 NF PE RVU: 5.18
2022 Fac PE RVU: 0.76

RUC Recommendation: 1.30 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,677

2022 Work RVU: 1.50
2022 NF PE RVU: 7.92
2022 Fac PE RVU: 0.92

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 **2020 Medicare Utilization:** 3,386

2022 Work RVU: 2.72
2022 NF PE RVU: 6.49
2022 Fac PE RVU: 1.46

RUC Recommendation: 2.82 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,086

2022 Work RVU: 3.02
2022 NF PE RVU: 9.22
2022 Fac PE RVU: 1.62

RUC Recommendation: 3.12 **Referred to CPT** October 2013 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 16

2022 Work RVU: 3.74
2022 NF PE RVU: 8.16
2022 Fac PE RVU: 1.99

RUC Recommendation: 3.82 **Referred to CPT** October 2013 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 150

2022 Work RVU: 4.12
2022 NF PE RVU: 15.15
2022 Fac PE RVU: 2.13

RUC Recommendation: 4.22 **Referred to CPT** October 2013 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 183

2022 Work RVU: 3.53
2022 NF PE RVU: 7.67
2022 Fac PE RVU: 1.77

RUC Recommendation: 3.63 **Referred to CPT** October 2013 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,664

2022 Work RVU: 4.03
2022 NF PE RVU: 8.82
2022 Fac PE RVU: 2.05

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 47

2022 Work RVU: 4.34
2022 NF PE RVU: 70.35
2022 Fac PE RVU: 2.26

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 **2020 Medicare Utilization:** 15

2022 Work RVU: 4.70
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.43

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 **2020 Medicare Utilization:** 68

2022 Work RVU: 5.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.78

RUC Recommendation: 5.81 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 176

2022 Work RVU: 3.02
2022 NF PE RVU: 9.55
2022 Fac PE RVU: 1.62

RUC Recommendation: 3.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 54

2022 Work RVU: 3.23
2022 NF PE RVU: 13.62
2022 Fac PE RVU: 1.77

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 **2020 Medicare Utilization:** 3

2022 Work RVU: 4.10
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.16

RUC Recommendation: 4.41 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2

2022 Work RVU: 4.96
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.54

RUC Recommendation: 5.06 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 60

2022 Work RVU: 4.14
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.17

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 20,116

2022 Work RVU: 9.45
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.25

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 1,966

2022 Work RVU: 8.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.81

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 **2020 Medicare Utilization:** 1,566

2022 Work RVU: 12.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.29

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 17,300

2022 Work RVU: 0.80
2022 NF PE RVU: 2.98
2022 Fac PE RVU: 0.49

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

Status Report: CMS Requests and Relativity Assessment Issues

45330 **Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

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 **2020 Medicare Utilization:** 40,039

2022 Work RVU: 0.84
2022 NF PE RVU: 4.72
2022 Fac PE RVU: 0.69

RUC Recommendation: 0.84 **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 **2020 Medicare Utilization:** 28,866

2022 Work RVU: 1.14
2022 NF PE RVU: 7.58
2022 Fac PE RVU: 0.83

RUC Recommendation: 1.14 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 279

2022 Work RVU: 1.76
2022 NF PE RVU: 6.51
2022 Fac PE RVU: 1.09

RUC Recommendation: 1.85 **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 **2020 Medicare Utilization:** 480

2022 Work RVU: 1.55
2022 NF PE RVU: 8.40
2022 Fac PE RVU: 0.98

RUC Recommendation: 1.65 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,921

2022 Work RVU: 2.00
2022 NF PE RVU: 13.14
2022 Fac PE RVU: 1.21

RUC Recommendation: 2.10 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,544

2022 Work RVU: 1.04
2022 NF PE RVU: 7.84
2022 Fac PE RVU: 0.77

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 **2020 Medicare Utilization:** 1,484

2022 Work RVU: 2.10
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.01

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 **2020 Medicare Utilization:** 4,295

2022 Work RVU: 2.05
2022 NF PE RVU: 6.87
2022 Fac PE RVU: 1.22

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,058

2022 Work RVU: 1.25
2022 NF PE RVU: 12.88
2022 Fac PE RVU: 0.86

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 **2020 Medicare Utilization:** 1,958

2022 Work RVU: 2.12
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.27

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 311

2022 Work RVU: 2.98
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.65

RUC Recommendation: 3.08 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 931

2022 Work RVU: 2.81
2022 NF PE RVU: 69.68
2022 Fac PE RVU: 1.55

RUC Recommendation: 2.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 613

2022 Work RVU: 2.72
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.48

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 **2020 Medicare Utilization:** 506

2022 Work RVU: 3.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.88

RUC Recommendation: 3.83 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 922

2022 Work RVU: 1.68
2022 NF PE RVU: 19.15
2022 Fac PE RVU: 1.06

RUC Recommendation: 1.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 263,929

2022 Work RVU: 3.26
2022 NF PE RVU: 6.66
2022 Fac PE RVU: 1.74

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 **2020 Medicare Utilization:** 781

2022 Work RVU: 4.28
2022 NF PE RVU: 8.45
2022 Fac PE RVU: 2.20

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 **2020 Medicare Utilization:** 811,967

2022 Work RVU: 3.56
2022 NF PE RVU: 9.33
2022 Fac PE RVU: 1.89

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 **2020 Medicare Utilization:** 63,277

2022 Work RVU: 3.56
2022 NF PE RVU: 9.60
2022 Fac PE RVU: 1.89

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 **2020 Medicare Utilization:** 21,198

2022 Work RVU: 4.66
2022 NF PE RVU: 15.39
2022 Fac PE RVU: 2.39

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 50,204

2022 Work RVU: 4.07
2022 NF PE RVU: 10.30
2022 Fac PE RVU: 2.03

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 **2020 Medicare Utilization:** 766,664

2022 Work RVU: 4.57
2022 NF PE RVU: 8.72
2022 Fac PE RVU: 2.34

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 **2020 Medicare Utilization:** 1,879

2022 Work RVU: 3.77
2022 NF PE RVU: 14.69
2022 Fac PE RVU: 1.97

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 19,852

2022 Work RVU: 4.88
2022 NF PE RVU: 72.13
2022 Fac PE RVU: 2.43

RUC Recommendation: 4.98 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 425

2022 Work RVU: 5.24
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.64

RUC Recommendation: 5.50 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 19,558

2022 Work RVU: 6.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.01

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 **2020 Medicare Utilization:** 714

2022 Work RVU: 4.64
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.39

RUC Recommendation: 4.95 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 104

2022 Work RVU: 5.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.77

RUC Recommendation: 5.60 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45393 **Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

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 **2020 Medicare Utilization:** 1,934

2022 Work RVU: 4.68
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.12

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 **2020 Medicare Utilization:** 2,937

2022 Work RVU: 4.20
2022 NF PE RVU: 20.94
2022 Fac PE RVU: 2.09

RUC Recommendation: 4.30 **Referred to CPT** October 2013 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,239

2022 Work RVU: 1.86
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.22

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 **2020 Medicare Utilization:** 301

2022 Work RVU: 1.48
2022 NF PE RVU: 6.09
2022 Fac PE RVU: 0.84

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

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

Status Report: CMS Requests and Relativity Assessment Issues

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS

First Identified: September 2007 **2020 Medicare Utilization:** 818

2022 Work RVU: 3.59
2022 NF PE RVU: 10.13
2022 Fac PE RVU: 5.85

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

46500 **Injection of sclerosing solution, hemorrhoids**

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

Most Recent RUC Meeting: January 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACS, ASCRS (colon)

First Identified: January 2014 **2020 Medicare Utilization:** 10,311

2022 Work RVU: 1.74
2022 NF PE RVU: 7.59
2022 Fac PE RVU: 3.56

RUC Recommendation: 2.00

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

Result: Increase

47011 **Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages**

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

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: January 2012 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 1,612

2022 Work RVU: 90.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 47.67

RUC Recommendation: 91.78 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 2,796

2022 Work RVU: 14.97
2022 NF PE RVU: 97.90
2022 Fac PE RVU: 5.00

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

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 **2020 Medicare Utilization:** 11,779

2022 Work RVU: 4.76
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.57

RUC Recommendation: 4.76 **Referred to CPT** June 2009 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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

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

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 **2020 Medicare Utilization:** 7,294

2022 Work RVU: 1.30
2022 NF PE RVU: 11.78
2022 Fac PE RVU: 0.62

RUC Recommendation: 1.30 **Referred to CPT** February 2015 **Result:** Increase

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

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 **2020 Medicare Utilization:** 514

2022 Work RVU: 4.25
2022 NF PE RVU: 21.33
2022 Fac PE RVU: 1.46

RUC Recommendation: 4.50 **Referred to CPT** February 2015 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,402

2022 Work RVU: 5.38
2022 NF PE RVU: 30.26
2022 Fac PE RVU: 1.78

RUC Recommendation: 5.63 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 4,184

2022 Work RVU: 7.60
2022 NF PE RVU: 31.09
2022 Fac PE RVU: 2.39

RUC Recommendation: 7.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 377

2022 Work RVU: 3.95
2022 NF PE RVU: 23.20
2022 Fac PE RVU: 1.36

RUC Recommendation: 4.20 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 13,827

2022 Work RVU: 2.61
2022 NF PE RVU: 16.89
2022 Fac PE RVU: 0.95

RUC Recommendation: 2.86 **Referred to CPT** February 2015 **Result:** Increase

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

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 **2020 Medicare Utilization:** 1,851

2022 Work RVU: 1.84
2022 NF PE RVU: 13.28
2022 Fac PE RVU: 0.77

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 **2020 Medicare Utilization:** 997

2022 Work RVU: 4.75
2022 NF PE RVU: 113.39
2022 Fac PE RVU: 1.60

RUC Recommendation: 5.00 **Referred to CPT** February 2015 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 160

2022 Work RVU: 8.75
2022 NF PE RVU: 121.81
2022 Fac PE RVU: 2.60

RUC Recommendation: 9.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 215

2022 Work RVU: 9.03
2022 NF PE RVU: 123.24
2022 Fac PE RVU: 2.83

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 **2020 Medicare Utilization:** 159

2022 Work RVU: 6.75
2022 NF PE RVU: 28.35
2022 Fac PE RVU: 2.26

RUC Recommendation: 7.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,063

2022 Work RVU: 2.85
2022 NF PE RVU: 12.27
2022 Fac PE RVU: 0.81

RUC Recommendation: 2.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 642

2022 Work RVU: 3.00
2022 NF PE RVU: 8.76
2022 Fac PE RVU: 0.88

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 312

2022 Work RVU: 3.28
2022 NF PE RVU: 22.48
2022 Fac PE RVU: 0.91

RUC Recommendation: 3.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT

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

Result: Maintain

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 **2020 Medicare Utilization:** 81,282

2022 Work RVU: 10.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.68

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 **2020 Medicare Utilization:** 32,357

2022 Work RVU: 11.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.18

RUC Recommendation: No further action. 12.11

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,677

2022 Work RVU: 17.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.19

RUC Recommendation: 20.00 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 1,050

2022 Work RVU: 18.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.65

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 **2020 Medicare Utilization:** 836

2022 Work RVU: 4.70
2022 NF PE RVU: 10.59
2022 Fac PE RVU: 1.74

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 10,481

2022 Work RVU: 1.24
2022 NF PE RVU: 5.05
2022 Fac PE RVU: 0.73

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 **2020 Medicare Utilization:** 252,899

2022 Work RVU: 2.00
2022 NF PE RVU: 6.78
2022 Fac PE RVU: 0.91

RUC Recommendation: 2.00 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,630

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.74

RUC Recommendation: 2.50 **Referred to CPT** June 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 5,663

2022 Work RVU: 4.00
2022 NF PE RVU: 23.06
2022 Fac PE RVU: 1.31

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 **2020 Medicare Utilization:** 30,881

2022 Work RVU: 4.00
2022 NF PE RVU: 23.05
2022 Fac PE RVU: 1.30

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

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

49407 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

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 **2020 Medicare Utilization:** 194

2022 Work RVU: 4.25
2022 NF PE RVU: 18.40
2022 Fac PE RVU: 1.33

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

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 **2020 Medicare Utilization:** 6,801

2022 Work RVU: 3.96
2022 NF PE RVU: 26.16
2022 Fac PE RVU: 1.49

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 1,637

2022 Work RVU: 4.21
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.52

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 12,418

2022 Work RVU: 4.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.63

RUC Recommendation: 4.00

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

Result: Decrease

49436 **Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter**

Global: 010 **Issue:** Delayed Creation of Exit Site from Embedded Catheter **Screen:** CMS Request - Final Rule for 2022 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 16 **Specialty Developing Recommendation:** ACS

First Identified: November 2021

2020 Medicare Utilization: 297

2022 Work RVU: 2.72
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.23

RUC Recommendation: PE Inputs

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

Result: PE Only

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

2020 Medicare Utilization: 39,341

2022 Work RVU: 7.96
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.72

RUC Recommendation: Reaffirmed

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

Result: Maintain

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

2020 Medicare Utilization: 8,333

2022 Work RVU: 9.09
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.26

RUC Recommendation: 10.05

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

Result: Maintain

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 **2020 Medicare Utilization:** 1,541

2022 Work RVU: 11.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.11

RUC Recommendation: 12.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49560 **Repair initial incisional or ventral hernia; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 16,538

2022 Work RVU: 11.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.23

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49561 **Repair initial incisional or ventral hernia; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 10,420

2022 Work RVU: 15.38
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.59

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49565 **Repair recurrent incisional or ventral hernia; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** October 2019 **2020 Medicare Utilization:** 3,719

2022 Work RVU: 12.37
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.58

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49566 **Repair recurrent incisional or ventral hernia; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 2,899

2022 Work RVU: 15.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.66

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49568 **Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (list separately in addition to code for the incisional or ventral hernia repair)** **Global:** ZZZ **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 20,800

2022 Work RVU: 4.88
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.83

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49570 **Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 461

2022 Work RVU: 6.05
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.03

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49572 **Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 393

2022 Work RVU: 7.87
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.73

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49580 **Repair umbilical hernia, younger than age 5 years; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 3

2022 Work RVU: 4.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.53

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49582 **Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU: 7.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.63

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49585 **Repair umbilical hernia, age 5 years or older; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 13,977

2022 Work RVU: 6.59
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.20

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** September 2007 **2020 Medicare Utilization:** 5,975

2022 Work RVU: 7.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.51

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49590 **Repair spigelian hernia** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 506

2022 Work RVU: 8.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.09

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
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:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2020 Medicare Utilization:** 7,685

2022 Work RVU: 11.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.37

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2020 Medicare Utilization:** 4,902

2022 Work RVU: 14.94
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.19

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2020 Medicare Utilization:** 6,115

2022 Work RVU: 13.76
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.08

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
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:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2020 Medicare Utilization:** 4,090

2022 Work RVU: 16.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.90

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49656 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 1,309

2022 Work RVU: 15.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.59

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49657 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:** 1,349

2022 Work RVU: 22.11
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.79

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X01

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 6.27 **Referred to CPT** February 2021 **Result:** Decrease

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

49X02

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 9.00 **Referred to CPT** February 2021 **Result:** Decrease

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

49X03

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 10.80 **Referred to CPT** February 2021 **Result:** Decrease

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

49X04

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 14.00 **Referred to CPT** February 2021 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

49X05

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 14.88 **Referred to CPT** February 2021 **Result:** Decrease

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

49X06

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 20.00 **Referred to CPT** February 2021 **Result:** Decrease

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

49X07

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 7.75 **Referred to CPT** February 2021 **Result:** Decrease

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

49X08

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 10.79 **Referred to CPT** February 2021 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

49X09

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 12.00 **Referred to CPT** February 2021 **Result:** Decrease

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

49X10

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 16.50 **Referred to CPT** February 2021 **Result:** Decrease

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

49X11

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 16.97 **Referred to CPT** February 2021 **Result:** Decrease

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

49X12

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 24.00 **Referred to CPT** February 2021 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

49X13n

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 14.24 **Referred to CPT** February 2021 **Result:** Decrease

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

49X14

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 18.00 **Referred to CPT** February 2021 **Result:** Decrease

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

49X15

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: 5.00 **Referred to CPT** February 2021 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 08 **Specialty Developing Recommendation:** AUA

First Identified: October 2019 **2020 Medicare Utilization:** 2,092

2022 Work RVU: 15.74

2022 NF PE RVU: NA

2022 Fac PE RVU: 7.76

RUC Recommendation: 13.50 **Referred to CPT** September 2021 **Result:** Decrease

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

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?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 08 **Specialty Developing Recommendation:** AUA

First Identified: October 2019 **2020 Medicare Utilization:** 5,083

2022 Work RVU: 23.50

2022 NF PE RVU: NA

2022 Fac PE RVU: 10.98

RUC Recommendation: 22.00 **Referred to CPT** September 2021 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 32,365

2022 Work RVU: 2.38
2022 NF PE RVU: 13.33
2022 Fac PE RVU: 1.10

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 12,214

2022 Work RVU: 39.88
2022 NF PE RVU: NA
2022 Fac PE RVU: 22.73

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 **2020 Medicare Utilization:** 7,840

2022 Work RVU: 1.75
2022 NF PE RVU: 15.44
2022 Fac PE RVU: 0.50

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

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

50398 **Change of nephrostomy or pyelostomy tube**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2020 Medicare Utilization:**

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

50430 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2020 Medicare Utilization:** 915

2022 Work RVU: 2.90
2022 NF PE RVU: 16.23
2022 Fac PE RVU: 1.27

RUC Recommendation: 3.15 **Referred to CPT** October 2014 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

50431 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and 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 **2020 Medicare Utilization:** 7,532

2022 Work RVU: 1.10
2022 NF PE RVU: 8.78
2022 Fac PE RVU: 0.69

RUC Recommendation: 1.42 **Referred to CPT** October 2014 **Result:** Increase

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

50432 **Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

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 **2020 Medicare Utilization:** 26,858

2022 Work RVU: 4.00
2022 NF PE RVU: 23.66
2022 Fac PE RVU: 1.56

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 **2020 Medicare Utilization:** 5,157

2022 Work RVU: 5.05
2022 NF PE RVU: 29.40
2022 Fac PE RVU: 1.83

RUC Recommendation: 5.05 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,127

2022 Work RVU: 3.75
2022 NF PE RVU: 23.98
2022 Fac PE RVU: 1.42

RUC Recommendation: 4.20 **Referred to CPT** October 2014 **Result:** Increase

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

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 **2020 Medicare Utilization:** 45,304

2022 Work RVU: 1.82
2022 NF PE RVU: 16.69
2022 Fac PE RVU: 0.89

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 **2020 Medicare Utilization:** 502

2022 Work RVU: 2.78
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.31

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

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 **2020 Medicare Utilization:** 778

2022 Work RVU: 4.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.92

RUC Recommendation: 5.44

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

Result: Decrease

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 **2020 Medicare Utilization:** 113

2022 Work RVU: 21.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.11

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 **2020 Medicare Utilization:** 2,275

2022 Work RVU: 25.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.74

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

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 **2020 Medicare Utilization:** 44,104

2022 Work RVU: 9.77
2022 NF PE RVU: 11.05
2022 Fac PE RVU: 5.78

RUC Recommendation: 9.77 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 3,249

2022 Work RVU: 16.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.26

RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

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 **2020 Medicare Utilization:** 78

2022 Work RVU: 3.16
2022 NF PE RVU: 11.31
2022 Fac PE RVU: 0.52

RUC Recommendation: 3.16 **Referred to CPT** October 2014 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,910

2022 Work RVU: 3.96
2022 NF PE RVU: 26.44
2022 Fac PE RVU: 1.56

RUC Recommendation: 4.60 **Referred to CPT** October 2014 **Result:** Increase

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

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 **2020 Medicare Utilization:** 826

2022 Work RVU: 5.25
2022 NF PE RVU: 28.70
2022 Fac PE RVU: 1.97

RUC Recommendation: 6.00 **Referred to CPT** October 2014 **Result:** Increase

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

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 **2020 Medicare Utilization:** 1,243

2022 Work RVU: 6.80
2022 NF PE RVU: 33.93
2022 Fac PE RVU: 2.48

RUC Recommendation: 7.55 **Referred to CPT** October 2014 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

50705 **Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

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 **2020 Medicare Utilization:** 63

2022 Work RVU: 4.03
2022 NF PE RVU: 52.88
2022 Fac PE RVU: 0.66

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 **2020 Medicare Utilization:** 1,346

2022 Work RVU: 3.80
2022 NF PE RVU: 21.82
2022 Fac PE RVU: 1.09

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Increase

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

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 **2020 Medicare Utilization:** 3,927

2022 Work RVU: 4.49
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.51

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

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 **2020 Medicare Utilization:** 12,346

2022 Work RVU: 2.70
2022 NF PE RVU: 4.24
2022 Fac PE RVU: 1.22

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 **2020 Medicare Utilization:** 173,053

2022 Work RVU: 0.60
2022 NF PE RVU: 1.60
2022 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 **2020 Medicare Utilization:** 128,393

2022 Work RVU: 0.50
2022 NF PE RVU: 0.75
2022 Fac PE RVU: 0.18

RUC Recommendation: 0.50

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

Result: Maintain

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 **2020 Medicare Utilization:** 214,430

2022 Work RVU: 0.50
2022 NF PE RVU: 1.28
2022 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

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 **2020 Medicare Utilization:** 51,547

2022 Work RVU: 1.47
2022 NF PE RVU: 2.84
2022 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 **2020 Medicare Utilization:** 154,326

2022 Work RVU: 0.87
2022 NF PE RVU: 1.62
2022 Fac PE RVU: 0.30

RUC Recommendation: 0.87 **Referred to CPT** **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 **2020 Medicare Utilization:** 3,276

2022 Work RVU: 1.71
2022 NF PE RVU: 7.24
2022 Fac PE RVU: NA

RUC Recommendation: 1.71 **Referred to CPT** February 2009 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 1,347

2022 Work RVU: 2.11
2022 NF PE RVU: 8.66
2022 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 67,834

2022 Work RVU: 2.11
2022 NF PE RVU: 8.76
2022 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 **2020 Medicare Utilization:** 46,890

2022 Work RVU: 2.51
2022 NF PE RVU: 8.93
2022 Fac PE RVU: NA

RUC Recommendation: 2.51 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 7,700

2022 Work RVU: 0.17
2022 NF PE RVU: 0.20
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA

First Identified: October 2009 **2020 Medicare Utilization:** 321,257

2022 Work RVU: 0.17
2022 NF PE RVU: 0.21
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 107,600

2022 Work RVU: 0.75
2022 NF PE RVU: 1.06
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,508

2022 Work RVU: 1.10
2022 NF PE RVU: 6.98
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 88,637

2022 Work RVU: 0.80
2022 NF PE RVU: 5.04
2022 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,685,762

2022 Work RVU: 0.00
2022 NF PE RVU: 0.30
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 760,641

2022 Work RVU: 1.53
2022 NF PE RVU: 5.59
2022 Fac PE RVU: 0.63

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 15,203

2022 Work RVU: 3.50
2022 NF PE RVU: 19.10
2022 Fac PE RVU: 1.19

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 31,440

2022 Work RVU: 4.05
2022 NF PE RVU: 19.48
2022 Fac PE RVU: 1.36

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 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2020 Medicare Utilization:** 25,413

2022 Work RVU: 4.62
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.95

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

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 **2020 Medicare Utilization:** 31,288

2022 Work RVU: 5.44
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.26

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

Status Report: CMS Requests and Relativity Assessment Issues

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 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2020 Medicare Utilization:** 20,714

2022 Work RVU: 7.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.96

RUC Recommendation: 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 **2020 Medicare Utilization:** 52,605

2022 Work RVU: 2.75
2022 NF PE RVU: 6.81
2022 Fac PE RVU: 1.33

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 46,656

2022 Work RVU: 3.20
2022 NF PE RVU: 8.19
2022 Fac PE RVU: 1.32

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

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 **2020 Medicare Utilization:** 138,775

2022 Work RVU: 2.82
2022 NF PE RVU: 9.07
2022 Fac PE RVU: 1.35

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 **2020 Medicare Utilization:** 212

2022 Work RVU: 3.37
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.52

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 2,126

2022 Work RVU: 5.35
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.23

RUC Recommendation: 5.35 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 150

2022 Work RVU: 5.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.40

RUC Recommendation: 5.85 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 27

2022 Work RVU: 6.55
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.64

RUC Recommendation: 6.55 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 3,404

2022 Work RVU: 7.05
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.81

RUC Recommendation: 7.05 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 414

2022 Work RVU: 7.55
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.97

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

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 **2020 Medicare Utilization:** 280

2022 Work RVU: 8.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.34

RUC Recommendation: 8.58

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

Result: Decrease

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 **2020 Medicare Utilization:** 21,257

2022 Work RVU: 5.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.33

RUC Recommendation: 5.75

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

Result: Decrease

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 **2020 Medicare Utilization:** 21,065

2022 Work RVU: 6.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.71

RUC Recommendation: 6.75

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

Result: Decrease

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 **2020 Medicare Utilization:** 10,162

2022 Work RVU: 7.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.96

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 **2020 Medicare Utilization:** 8,420

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.13

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 **2020 Medicare Utilization:** 892

2022 Work RVU: 9.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.46

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 **2020 Medicare Utilization:** 72,899

2022 Work RVU: 8.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.09

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 72

2022 Work RVU: 8.69
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.20

RUC Recommendation: 8.69 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 97,548

2022 Work RVU: 1.01
2022 NF PE RVU: 25.86
2022 Fac PE RVU: 0.34

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

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 **2020 Medicare Utilization:** 2,486

2022 Work RVU: 8.14
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.29

RUC Recommendation: 8.14 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 37,340

2022 Work RVU: 13.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.58

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,312

2022 Work RVU: 4.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.05

RUC Recommendation: 4.79 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 14,196

2022 Work RVU: 12.15
2022 NF PE RVU: 35.48
2022 Fac PE RVU: 6.66

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

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

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 **2020 Medicare Utilization:** 1,617

2022 Work RVU: 13.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.60

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,438

2022 Work RVU: 5.42
2022 NF PE RVU: 37.52
2022 Fac PE RVU: 4.31

RUC Recommendation: 10.08 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 4,163

2022 Work RVU: 14.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.41

RUC Recommendation: 14.39

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

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 **2020 Medicare Utilization:** 1,160

2022 Work RVU: 15.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.27

RUC Recommendation: 15.18

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

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 **2020 Medicare Utilization:** 2,160

2022 Work RVU: 5.30
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.64

RUC Recommendation: Reduce 99238 to 0.5

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

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 **2020 Medicare Utilization:** 1,033

2022 Work RVU: 8.46
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.41

RUC Recommendation: 8.46

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

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 **2020 Medicare Utilization:** 131,593

2022 Work RVU: 2.50
2022 NF PE RVU: 4.43
2022 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 **2020 Medicare Utilization:** 1,955

2022 Work RVU: 6.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.00

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 **2020 Medicare Utilization:** 1,486

2022 Work RVU: 21.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.22

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 **2020 Medicare Utilization:** 126

2022 Work RVU: 21.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.23

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 **2020 Medicare Utilization:** 728

2022 Work RVU: 25.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.51

RUC Recommendation: 29.07 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 18,557

2022 Work RVU: 26.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.02

RUC Recommendation: 26.80 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,362

2022 Work RVU: 13.60
2022 NF PE RVU: 162.77
2022 Fac PE RVU: 7.14

RUC Recommendation: 13.45 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,423

2022 Work RVU: 13.46
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.83

RUC Recommendation: Review data at RAW **Referred to CPT** **Result:** Not Part of RAW

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

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 **2020 Medicare Utilization:** 2,247

2022 Work RVU: 3.08
2022 NF PE RVU: 4.79
2022 Fac PE RVU: 2.76

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 2,636

2022 Work RVU: 7.53
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.74

RUC Recommendation: 7.35 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 19,829

2022 Work RVU: 0.50
2022 NF PE RVU: 1.20
2022 Fac PE RVU: 0.19

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

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

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 **2020 Medicare Utilization:** 2,870

2022 Work RVU: 5.15
2022 NF PE RVU: 6.05
2022 Fac PE RVU: 2.72

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 **2020 Medicare Utilization:** 14,536

2022 Work RVU: 2.69
2022 NF PE RVU: 3.84
2022 Fac PE RVU: 1.51

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 **2020 Medicare Utilization:** 68,682

2022 Work RVU: 0.89
2022 NF PE RVU: 1.21
2022 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 **2020 Medicare Utilization:** 6,545

2022 Work RVU: 10.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.66

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 **2020 Medicare Utilization:** 6,951

2022 Work RVU: 10.08
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.70

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 **2020 Medicare Utilization:** 7,243

2022 Work RVU: 13.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.86

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 **2020 Medicare Utilization:** 3,214

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.57

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 **2020 Medicare Utilization:** 5,394

2022 Work RVU: 11.63
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.25

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 **2020 Medicare Utilization:** 4,549

2022 Work RVU: 11.66
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.31

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 **2020 Medicare Utilization:** 1,245

2022 Work RVU: 11.15
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.37

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 **2020 Medicare Utilization:** 18,279

2022 Work RVU: 12.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.17

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

2020 Medicare Utilization: 8,288

2022 Work RVU: 17.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.29

RUC Recommendation: 18.02

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

Result: Increase

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

2020 Medicare Utilization: 59,095

2022 Work RVU: 1.21
2022 NF PE RVU: 1.66
2022 Fac PE RVU: 0.47

RUC Recommendation: 1.21

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

Result: Decrease

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

2020 Medicare Utilization: 583

2022 Work RVU: 0.77
2022 NF PE RVU: 0.59
2022 Fac PE RVU: 0.30

RUC Recommendation: 0.77

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

Result: Maintain

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 **2020 Medicare Utilization:** 1,214

2022 Work RVU: 2.65
2022 NF PE RVU: 8.03
2022 Fac PE RVU: 1.37

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 **2020 Medicare Utilization:** 37,701

2022 Work RVU: 4.17
2022 NF PE RVU: 36.73
2022 Fac PE RVU: 1.96

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 **2020 Medicare Utilization:** 101

2022 Work RVU: 5.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.34

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 **2020 Medicare Utilization:** 43

2022 Work RVU: 5.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.53

RUC Recommendation: 6.15 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 1,828

2022 Work RVU: 6.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.88

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 204

2022 Work RVU: 4.00
2022 NF PE RVU: 8.54
2022 Fac PE RVU: 1.88

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

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 **2020 Medicare Utilization:** 1,978

2022 Work RVU: 4.47
2022 NF PE RVU: 61.14
2022 Fac PE RVU: 2.05

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 **2020 Medicare Utilization:** 669

2022 Work RVU: 11.59
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.57

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 **2020 Medicare Utilization:** 10,413

2022 Work RVU: 11.35
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.17

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 2,504

2022 Work RVU: 36.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 24.98

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 **2020 Medicare Utilization:** 1,424

2022 Work RVU: 14.37
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.63

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 **2020 Medicare Utilization:** 692

2022 Work RVU: 18.34
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.29

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 **2020 Medicare Utilization:** 24

2022 Work RVU: 1.71
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.82

RUC Recommendation: 1.71 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 62

2022 Work RVU: 1.61
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.61

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 586

2022 Work RVU: 7.80
2022 NF PE RVU: 6.81
2022 Fac PE RVU: 3.02

RUC Recommendation: 6.31 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 572

2022 Work RVU: 14.30
2022 NF PE RVU: 12.43
2022 Fac PE RVU: 5.57

RUC Recommendation: 11.16 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 815

2022 Work RVU: 3.22
2022 NF PE RVU: 3.84
2022 Fac PE RVU: 1.25

RUC Recommendation: 2.47 **Referred to CPT** **Result:** Increase
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 **2020 Medicare Utilization:** 2,156

2022 Work RVU: 40.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 26.62

RUC Recommendation: 36.17 **Referred to CPT** **Result:** Increase
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 **2020 Medicare Utilization:** 1,159

2022 Work RVU: 16.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.19

RUC Recommendation: 16.13 **Referred to CPT** **Result:** Increase
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 **2020 Medicare Utilization:** 662

2022 Work RVU: 22.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.21

RUC Recommendation: 22.00 **Referred to CPT** **Result:** Increase
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 **2020 Medicare Utilization:** 69

2022 Work RVU: 38.29
2022 NF PE RVU: NA
2022 Fac PE RVU: 25.05

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 **2020 Medicare Utilization:** 51

2022 Work RVU: 16.09
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.08

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 **2020 Medicare Utilization:** 29

2022 Work RVU: 20.06
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.04

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 **2020 Medicare Utilization:** 18

2022 Work RVU: 40.91
2022 NF PE RVU: NA
2022 Fac PE RVU: 26.67

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 **2020 Medicare Utilization:** 18

2022 Work RVU: 16.66
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.30

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 **2020 Medicare Utilization:** 9

2022 Work RVU: 22.66
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.94

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 **2020 Medicare Utilization:** 6,083

2022 Work RVU: 11.19
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.70

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 **2020 Medicare Utilization:** 210

2022 Work RVU: 14.79
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.34

RUC Recommendation: 14.67

Referred to CPT

Result: Maintain

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

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 **2020 Medicare Utilization:** 336

2022 Work RVU: 17.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.09

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:**

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 **2020 Medicare Utilization:** 214

2022 Work RVU: 19.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.35

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:**

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 **2020 Medicare Utilization:** 91

2022 Work RVU: 23.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.28

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 **2020 Medicare Utilization:** 166

2022 Work RVU: 2.10
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.03

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 **2020 Medicare Utilization:** 15,164

2022 Work RVU: 3.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.78

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 **2020 Medicare Utilization:** 15,306

2022 Work RVU: 3.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.45

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 **2020 Medicare Utilization:** 19,623

2022 Work RVU: 3.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.82

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 6,404

2022 Work RVU: 13.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.07

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 **2020 Medicare Utilization:** 8,507

2022 Work RVU: 3.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.66

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 **2020 Medicare Utilization:** 3,174

2022 Work RVU: 19.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.75

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 **2020 Medicare Utilization:** 786

2022 Work RVU: 4.81
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.29

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 **2020 Medicare Utilization:** 4,520

2022 Work RVU: 2.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.36

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 **2020 Medicare Utilization:** 4,795

2022 Work RVU: 6.05
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.43

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 **2020 Medicare Utilization:** 205

2022 Work RVU: 5.00
2022 NF PE RVU: 13.50
2022 Fac PE RVU: 3.70

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 **2020 Medicare Utilization:** 25,821

2022 Work RVU: 1.22
2022 NF PE RVU: 2.35
2022 Fac PE RVU: 0.40

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 **2020 Medicare Utilization:** 3,334

2022 Work RVU: 1.58
2022 NF PE RVU: 3.17
2022 Fac PE RVU: 0.66

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 **2020 Medicare Utilization:** 244

2022 Work RVU: 2.66
2022 NF PE RVU: 4.20
2022 Fac PE RVU: 1.73

RUC Recommendation: Remove 99238 **Referred to CPT** **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 **2020 Medicare Utilization:** 14,134

2022 Work RVU: 1.54
2022 NF PE RVU: 4.11
2022 Fac PE RVU: 0.76

RUC Recommendation: 1.54 **Referred to CPT** October 2013 **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 **2020 Medicare Utilization:** 96

2022 Work RVU: 9.03
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.98

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **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 **2020 Medicare Utilization:** 5,808

2022 Work RVU: 3.00
2022 NF PE RVU: 7.56
2022 Fac PE RVU: 1.42

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

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 **2020 Medicare Utilization:** 2,942

2022 Work RVU: 2.29
2022 NF PE RVU: 5.35
2022 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 340

2022 Work RVU: 2.29
2022 NF PE RVU: 5.49
2022 Fac PE RVU: 1.01

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 12,583

2022 Work RVU: 2.25
2022 NF PE RVU: 5.30
2022 Fac PE RVU: 0.99

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 **2020 Medicare Utilization:** 4,788

2022 Work RVU: 2.35
2022 NF PE RVU: 5.89
2022 Fac PE RVU: 1.03

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 3,992

2022 Work RVU: 1.80
2022 NF PE RVU: 2.87
2022 Fac PE RVU: 0.89

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 179,705

2022 Work RVU: 1.95
2022 NF PE RVU: 5.77
2022 Fac PE RVU: 0.99

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 **2020 Medicare Utilization:** 31,138

2022 Work RVU: 1.55
2022 NF PE RVU: 2.43
2022 Fac PE RVU: 0.64

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 **2020 Medicare Utilization:** 565,221

2022 Work RVU: 1.80
2022 NF PE RVU: 5.82
2022 Fac PE RVU: 0.92

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 **2020 Medicare Utilization:** 15,111

2022 Work RVU: 1.89
2022 NF PE RVU: 2.06
2022 Fac PE RVU: 0.56

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 **2020 Medicare Utilization:** 933

2022 Work RVU: 2.20
2022 NF PE RVU: 5.26
2022 Fac PE RVU: 0.85

RUC Recommendation: 2.20 **Referred to CPT** May 2015 **Result:** Decrease
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 **2020 Medicare Utilization:** 3,169

2022 Work RVU: 1.78
2022 NF PE RVU: 2.22
2022 Fac PE RVU: 0.57

RUC Recommendation: 1.78 **Referred to CPT** May 2015 **Result:** Decrease
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 **2020 Medicare Utilization:** 1,681

2022 Work RVU: 1.90
2022 NF PE RVU: 5.89
2022 Fac PE RVU: 0.97

RUC Recommendation: 1.90 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 38,297

2022 Work RVU: 1.73
2022 NF PE RVU: 5.32
2022 Fac PE RVU: 0.62

RUC Recommendation: 1.95 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,956

2022 Work RVU: 2.03
2022 NF PE RVU: 6.76
2022 Fac PE RVU: 0.82

RUC Recommendation: 2.25 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 4,328

2022 Work RVU: 6.05
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.54

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 **2020 Medicare Utilization:** 899

2022 Work RVU: 3.55
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.75

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 **2020 Medicare Utilization:** 182

2022 Work RVU: 4.33
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.23

RUC Recommendation: 4.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 16

2022 Work RVU: 5.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.00

RUC Recommendation: 5.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,365

2022 Work RVU: 5.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.53

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 **2020 Medicare Utilization:** 1,020

2022 Work RVU: 3.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.89

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 7,561

2022 Work RVU: 0.48
2022 NF PE RVU: 0.39
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 33,073

2022 Work RVU: 0.67
2022 NF PE RVU: 0.55
2022 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 **2020 Medicare Utilization:** 27,725

2022 Work RVU: 0.67
2022 NF PE RVU: 2.00
2022 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 100,936

2022 Work RVU: 0.90
2022 NF PE RVU: 1.78
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

63020 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical**

Global: 090 **Issue:** Lumbar Laminotomy with Decompression **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 17 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** January 2022 **2020 Medicare Utilization:** 1,043

2022 Work RVU: 16.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.26

RUC Recommendation: 15.95 **Referred to CPT** **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:** Lumbar Laminotomy with Decompression **Screen:** Pre-Time Analysis / Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 17 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** January 2014 **2020 Medicare Utilization:** 22,190

2022 Work RVU: 13.18
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.76

RUC Recommendation: 13.18 **Referred to CPT** September 2021 **Result:** Maintain

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

63035 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Laminotomy with Decompression **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 17 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** January 2022 **2020 Medicare Utilization:** 5,431

2022 Work RVU: 3.15
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.54

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 9,447

2022 Work RVU: 18.76
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.36

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:**

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 **2020 Medicare Utilization:** 10,007

2022 Work RVU: 17.95
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.31

RUC Recommendation: 17.95

Referred to CPT

Result: Maintain

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

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 **2020 Medicare Utilization:** 3,965

2022 Work RVU: 17.25
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.80

RUC Recommendation: 17.25

Referred to CPT

Result: Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 83,353

2022 Work RVU: 15.37
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.81

RUC Recommendation: 15.37 **Referred to CPT** **Result:** Maintain

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

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 vertebral 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 **2020 Medicare Utilization:** 108,554

2022 Work RVU: 3.47
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.70

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 **2020 Medicare Utilization:** 4,943

2022 Work RVU: 21.86
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.60

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

Status Report: CMS Requests and Relativity Assessment Issues

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

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 **2020 Medicare Utilization:** 346

2022 Work RVU: 19.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.70

RUC Recommendation: 19.60 **Referred to CPT** October 2009 **Result:** Maintain

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

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)**

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:** **2020 Medicare Utilization:** 274

2022 Work RVU: 4.04
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.98

RUC Recommendation: 4.04 **Referred to CPT** October 2009 **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 **2020 Medicare Utilization:** 738

2022 Work RVU: 30.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 18.90

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**

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

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 570

2022 Work RVU: 15.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.88

RUC Recommendation: 15.50

Referred to CPT

Result: Decrease

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

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

2020 Medicare Utilization: 177

2022 Work RVU: 4.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.91

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

2020 Medicare Utilization: 76,274

2022 Work RVU: 7.15
2022 NF PE RVU: 62.84
2022 Fac PE RVU: 4.23

RUC Recommendation: 7.20. New PE Inputs

Referred to CPT

Result: Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,648

2022 Work RVU: 10.92
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.41

RUC Recommendation: 11.43 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** April 2008 **2020 Medicare Utilization:** 3,183

2022 Work RVU: 5.08
2022 NF PE RVU: 14.57
2022 Fac PE RVU: 3.66

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:** April 2008 **2020 Medicare Utilization:** 2,049

2022 Work RVU: 11.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.58

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:** April 2008 **2020 Medicare Utilization:** 1,472

2022 Work RVU: 7.75
2022 NF PE RVU: 18.26
2022 Fac PE RVU: 4.45

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:** April 2008 **2020 Medicare Utilization:** 580

2022 Work RVU: 11.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.88

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: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2020 Medicare Utilization:** 24,783

2022 Work RVU: 5.19
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.43

RUC Recommendation: Review action plan in 2 years after CPT article published. 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 **2020 Medicare Utilization:** 6,983

2022 Work RVU: 5.30
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.57

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

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

64400 **Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAN, AAPM&R, AAPM, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 34,519

2022 Work RVU: 0.75
2022 NF PE RVU: 2.44
2022 Fac PE RVU: 0.54

RUC Recommendation: 1.00 **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:** Somatic Nerve Injections **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAN, AAPM, AAPM&R, NANS, SIS **First Identified:** July 2016 **2020 Medicare Utilization:** 116,809

2022 Work RVU: 0.94
2022 NF PE RVU: 1.09
2022 Fac PE RVU: 0.41

RUC Recommendation: 0.94 **Referred to CPT** **Result:** Maintain

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

64408 **Injection(s), anesthetic agent(s) and/or steroid; vagus nerve**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 873

2022 Work RVU: 0.75
2022 NF PE RVU: 1.58
2022 Fac PE RVU: 0.46

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

64415 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2020 Medicare Utilization:** 179,440

2022 Work RVU: 1.35
2022 NF PE RVU: 1.89
2022 Fac PE RVU: 0.38

RUC Recommendation: 1.50 **Referred to CPT** May 2021 **Result:** Increase
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:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** September 2007 **2020 Medicare Utilization:** 14,758

2022 Work RVU: 1.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.27

RUC Recommendation: 1.80 **Referred to CPT** May 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 Injections **Screen:** part of New/Revised Review **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2018 **2020 Medicare Utilization:** 15,139

2022 Work RVU: 1.27
2022 NF PE RVU: 2.80
2022 Fac PE RVU: 0.40

RUC Recommendation: 1.31 **Referred to CPT** May 2021 **Result:** Decrease
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:** Somatic Nerve Injections **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, SIS **First Identified:** October 2015 **2020 Medicare Utilization:** 29,410

2022 Work RVU: 1.10
2022 NF PE RVU: 1.40
2022 Fac PE RVU: 0.43

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

64420 **Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 18,096

2022 Work RVU: 1.08
2022 NF PE RVU: 1.71
2022 Fac PE RVU: 0.54

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

64421 **Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 16,120

2022 Work RVU: 0.50
2022 NF PE RVU: 0.43
2022 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64425 **Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 6,884

2022 Work RVU: 1.00
2022 NF PE RVU: 2.23
2022 Fac PE RVU: 0.51

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

Status Report: CMS Requests and Relativity Assessment Issues

64430 **Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ACOG, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 3,768

2022 Work RVU: 1.00
2022 NF PE RVU: 1.83
2022 Fac PE RVU: 0.48

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64435 **Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ACOG, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 30

2022 Work RVU: 0.75
2022 NF PE RVU: 1.56
2022 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **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:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ASA **First Identified:** October 2008 **2020 Medicare Utilization:** 120,873

2022 Work RVU: 1.00
2022 NF PE RVU: 2.66
2022 Fac PE RVU: 0.47

RUC Recommendation: 1.39 **Referred to CPT** **Result:** Decrease
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:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** February 2008 **2020 Medicare Utilization:** 5,151

2022 Work RVU: 1.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.25

RUC Recommendation: 1.75 **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64447 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2020 Medicare Utilization:** 257,364

2022 Work RVU: 1.10
2022 NF PE RVU: 1.44
2022 Fac PE RVU: 0.35

RUC Recommendation: 1.34 **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64448 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** February 2008 **2020 Medicare Utilization:** 31,899

2022 Work RVU: 1.41
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.25

RUC Recommendation: 1.68 **Referred to CPT** May 2021 **Result:** Increase
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:** Somatic Nerve Injections **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** September 2007 **2020 Medicare Utilization:** 1,353

2022 Work RVU: 1.27
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.42

RUC Recommendation: 1.55 **Referred to CPT** February 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64450 **Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch** **Global:** 000 **Issue:** Somatic Nerve Injections **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 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, APMA, NANS, SIS **First Identified:** October 2009 **2020 Medicare Utilization:** 345,018

2022 Work RVU: 0.75
2022 NF PE RVU: 1.42
2022 Fac PE RVU: 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2013

64451 **Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 18,395

2022 Work RVU: 1.52
2022 NF PE RVU: 5.27
2022 Fac PE RVU: 0.73

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Maintain

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

64454 **Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** October 2021 **2020 Medicare Utilization:** 26,332

2022 Work RVU: 1.52
2022 NF PE RVU: 5.05
2022 Fac PE RVU: 0.74

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Maintain

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

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:** Somatic Nerve Injections **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, APMA, NANS, SIS **First Identified:** October 2016 **2020 Medicare Utilization:** 61,227

2022 Work RVU: 0.75
2022 NF PE RVU: 0.65
2022 Fac PE RVU: 0.17

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 **2020 Medicare Utilization:** 5,928

2022 Work RVU: 1.75
2022 NF PE RVU: 2.14
2022 Fac PE RVU: 0.38

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **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 **2020 Medicare Utilization:** 1,686

2022 Work RVU: 1.10
2022 NF PE RVU: 0.97
2022 Fac PE RVU: 0.24

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **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 **2020 Medicare Utilization:** 1,574

2022 Work RVU: 1.90
2022 NF PE RVU: 5.02
2022 Fac PE RVU: 0.35

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 37,416

2022 Work RVU: 2.29
2022 NF PE RVU: 5.49
2022 Fac PE RVU: 1.33

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 **2020 Medicare Utilization:** 16,251

2022 Work RVU: 1.20
2022 NF PE RVU: 2.75
2022 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 **2020 Medicare Utilization:** 876,575

2022 Work RVU: 1.90
2022 NF PE RVU: 5.35
2022 Fac PE RVU: 1.17

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 **2020 Medicare Utilization:** 358,506

2022 Work RVU: 1.00
2022 NF PE RVU: 2.27
2022 Fac PE RVU: 0.41

RUC Recommendation: 1.00 **Referred to CPT** June 2009 **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:** **2020 Medicare Utilization:** 219,560

2022 Work RVU: 1.82
2022 NF PE RVU: 3.68
2022 Fac PE RVU: 1.08

RUC Recommendation: 1.82 **Referred to CPT** **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:** **2020 Medicare Utilization:** 195,781

2022 Work RVU: 1.16
2022 NF PE RVU: 1.60
2022 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** **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:** **2020 Medicare Utilization:** 126,112

2022 Work RVU: 1.16
2022 NF PE RVU: 1.61
2022 Fac PE RVU: 0.49

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:** **2020 Medicare Utilization:** 738,559

2022 Work RVU: 1.52
2022 NF PE RVU: 3.56
2022 Fac PE RVU: 0.97

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:** **2020 Medicare Utilization:** 655,091

2022 Work RVU: 1.00
2022 NF PE RVU: 1.60
2022 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:** **2020 Medicare Utilization:** 372,208

2022 Work RVU: 1.00
2022 NF PE RVU: 1.59
2022 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 **2020 Medicare Utilization:** 5,831

2022 Work RVU: 1.22
2022 NF PE RVU: 3.07
2022 Fac PE RVU: 0.92

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 **2020 Medicare Utilization:** 15,244

2022 Work RVU: 1.35
2022 NF PE RVU: 5.48
2022 Fac PE RVU: 1.00

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 199

2022 Work RVU: 6.13
2022 NF PE RVU: 69.85
2022 Fac PE RVU: 4.32

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 **2020 Medicare Utilization:** 5,358

2022 Work RVU: 5.76
2022 NF PE RVU: 60.81
2022 Fac PE RVU: 3.21

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 **2020 Medicare Utilization:** 14,187

2022 Work RVU: 5.44
2022 NF PE RVU: 16.41
2022 Fac PE RVU: 2.75

RUC Recommendation: 5.44. 99214 visit appropriate. Remove from screen.

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 144,067

2022 Work RVU: 0.60
2022 NF PE RVU: 2.89
2022 Fac PE RVU: 0.21

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

64568 **Open 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: February 2009 **2020 Medicare Utilization:** 1,108

2022 Work RVU: 9.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.06

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **Open 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 **2020 Medicare Utilization:** 9,833

2022 Work RVU: 12.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 5.49

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 **2020 Medicare Utilization:** 11,819

2022 Work RVU: 2.45
2022 NF PE RVU: 5.11
2022 Fac PE RVU: 1.94

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 **2020 Medicare Utilization:** 137,679

2022 Work RVU: 1.85
2022 NF PE RVU: 2.14
2022 Fac PE RVU: 1.19

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 76,381

2022 Work RVU: 3.32
2022 NF PE RVU: 9.61
2022 Fac PE RVU: 1.97

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 **2020 Medicare Utilization:** 122,270

2022 Work RVU: 1.32
2022 NF PE RVU: 6.41
2022 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 **2020 Medicare Utilization:** 307,360

2022 Work RVU: 3.32
2022 NF PE RVU: 9.74
2022 Fac PE RVU: 1.98

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 **2020 Medicare Utilization:** 473,019

2022 Work RVU: 1.16
2022 NF PE RVU: 6.14
2022 Fac PE RVU: 0.46

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 **2020 Medicare Utilization:** 67,205

2022 Work RVU: 1.98
2022 NF PE RVU: 5.25
2022 Fac PE RVU: 1.30

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 **2020 Medicare Utilization:** 5,462

2022 Work RVU: 6.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.41

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 **2020 Medicare Utilization:** 692

2022 Work RVU: 8.07
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.96

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 **2020 Medicare Utilization:** 929

2022 Work RVU: 9.16
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.71

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 **2020 Medicare Utilization:** 711

2022 Work RVU: 9.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.60

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 **2020 Medicare Utilization:** 21,465

2022 Work RVU: 0.49
2022 NF PE RVU: 0.32
2022 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 **2020 Medicare Utilization:** 20,949

2022 Work RVU: 0.61
2022 NF PE RVU: 0.49
2022 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 **2020 Medicare Utilization:** 21,931

2022 Work RVU: 0.84
2022 NF PE RVU: 1.09
2022 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 **2020 Medicare Utilization:** 683

2022 Work RVU: 15.36
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.47

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 **2020 Medicare Utilization:** 1,462

2022 Work RVU: 7.81
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.96

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 **2020 Medicare Utilization:** 19,460

2022 Work RVU: 1.53
2022 NF PE RVU: 1.83
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 122,871

2022 Work RVU: 3.00
2022 NF PE RVU: 3.95
2022 Fac PE RVU: 2.71

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 **2020 Medicare Utilization:** 5,495

2022 Work RVU: 13.94
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.66

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 **2020 Medicare Utilization:** 2,201

2022 Work RVU: 14.84
2022 NF PE RVU: NA
2022 Fac PE RVU: 18.58

RUC Recommendation: 14.81 **Referred to CPT** **Result:** Decrease

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

66174 **Transluminal dilation of aqueous outflow canal; without retention of device or stent**

Global: 090 **Issue:** Dilation of Aqueous Outflow Canal **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO

First Identified: April 2010 **2020 Medicare Utilization:** 10,433

2022 Work RVU: 7.62
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.77

RUC Recommendation: 8.53 **Referred to CPT** October 2020 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

66175 **Transluminal dilation of aqueous outflow canal; with retention of device or stent** **Global:** 090 **Issue:** Dilation of Aqueous Outflow Cana **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO **First Identified:** October 2020 **2020 Medicare Utilization:** 253

2022 Work RVU: 9.34
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.02

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 666

2022 Work RVU: 14.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.23

RUC Recommendation: 14.00 **Referred to CPT** October 2013 **Result:** Decrease
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 **2020 Medicare Utilization:** 9,414

2022 Work RVU: 15.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.83

RUC Recommendation: Maintain. 15.00 **Referred to CPT** October 2013 **Result:** Decrease
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 **2020 Medicare Utilization:** 5,855

2022 Work RVU: 13.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.60

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 **2020 Medicare Utilization:** 500

2022 Work RVU: 9.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.62

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 **2020 Medicare Utilization:** 1,457

2022 Work RVU: 10.58
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.24

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 **2020 Medicare Utilization:** 894

2022 Work RVU: 5.62
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.60

RUC Recommendation: 6.36 **Referred to CPT** May 2018 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 47,614

2022 Work RVU: 3.00
2022 NF PE RVU: 5.54
2022 Fac PE RVU: 3.62

RUC Recommendation: Maintain. 3.00 **Referred to CPT** February 2010 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 560,886

2022 Work RVU: 3.42
2022 NF PE RVU: 6.08
2022 Fac PE RVU: 5.37

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

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

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?** Yes

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

First Identified: September 2007 **2020 Medicare Utilization:** 123,553

2022 Work RVU: 10.25 **2022 NF PE RVU:** NA **2022 Fac PE RVU:** 10.54

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 **2020 Medicare Utilization:** 86

2022 Work RVU: 0.00 **2022 NF PE RVU:** 0.00 **2022 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?** Yes

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

First Identified: February 2008 **2020 Medicare Utilization:** 1,297,557

2022 Work RVU: 7.35 **2022 NF PE RVU:** NA **2022 Fac PE RVU:** 7.83

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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2019 **2020 Medicare Utilization:** 733

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 13.15 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 3,826

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

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

66989 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 12.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.69

RUC Recommendation: 12.13 **Referred to CPT** October 2020 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

66991 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 9.23
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.84

RUC Recommendation: 9.23 **Referred to CPT** October 2020 **Result:** Maintain
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 **2020 Medicare Utilization:** 3,738,345

2022 Work RVU: 1.44
2022 NF PE RVU: 1.75
2022 Fac PE RVU: 1.10

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 **2020 Medicare Utilization:** 14,918

2022 Work RVU: 12.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 12.85

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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2007 **Result:** Deleted from CPT

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

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 **2020 Medicare Utilization:** 3,085

2022 Work RVU: 13.20
2022 NF PE RVU: NA
2022 Fac PE RVU: 13.51

RUC Recommendation: 13.20 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 6,722

2022 Work RVU: 14.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 14.32

RUC Recommendation: 14.50 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 10,410

2022 Work RVU: 16.33
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 22,238

2022 Work RVU: 16.33
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 268

2022 Work RVU: 17.40
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.10

RUC Recommendation: 17.40 **Referred to CPT** **Result:** Decrease
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 **2020 Medicare Utilization:** 254

2022 Work RVU: 3.50
2022 NF PE RVU: 5.99
2022 Fac PE RVU: 4.45

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 **2020 Medicare Utilization:** 2,811

2022 Work RVU: 3.39
2022 NF PE RVU: 4.97
2022 Fac PE RVU: 4.30

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 **2020 Medicare Utilization:** 452

2022 Work RVU: 16.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.24

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 **2020 Medicare Utilization:** 14,871

2022 Work RVU: 17.13
2022 NF PE RVU: NA
2022 Fac PE RVU: 15.93

RUC Recommendation: 17.13 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,101

2022 Work RVU: 10.25
2022 NF PE RVU: 14.93
2022 Fac PE RVU: 12.48

RUC Recommendation: 10.25. Remove 99238 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67112 **Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 11,077

2022 Work RVU: 19.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 17.96

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; 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 **2020 Medicare Utilization:** 1,048

2022 Work RVU: 2.53
2022 NF PE RVU: 5.15
2022 Fac PE RVU: 3.54

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; photocoagulation**

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 **2020 Medicare Utilization:** 27,120

2022 Work RVU: 2.53
2022 NF PE RVU: 4.33
2022 Fac PE RVU: 3.54

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 **2020 Medicare Utilization:** 43,032

2022 Work RVU: 6.36
2022 NF PE RVU: 8.13
2022 Fac PE RVU: 7.55

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 **2020 Medicare Utilization:** 2,533

2022 Work RVU: 6.36
2022 NF PE RVU: 8.58
2022 Fac PE RVU: 7.55

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 **2020 Medicare Utilization:** 124

2022 Work RVU: 0.47
2022 NF PE RVU: 0.34
2022 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 **2020 Medicare Utilization:** 48,375

2022 Work RVU: 4.39
2022 NF PE RVU: 5.14
2022 Fac PE RVU: 4.04

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 **2020 Medicare Utilization:** 703

2022 Work RVU: 8.38
2022 NF PE RVU: NA
2022 Fac PE RVU: 10.92

RUC Recommendation: 10.17 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,593

2022 Work RVU: 5.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 7.61

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,095

2022 Work RVU: 9.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.01

RUC Recommendation: 9.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,882

2022 Work RVU: 5.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.63

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 120

2022 Work RVU: 10.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.48

RUC Recommendation: 10.31 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 142

2022 Work RVU: 9.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 9.36

RUC Recommendation: 9.80 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 274

2022 Work RVU: 3.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.16

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

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 **2020 Medicare Utilization:** 682

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.85

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 **2020 Medicare Utilization:** 1,233

2022 Work RVU: 3.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.86

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 **2020 Medicare Utilization:** 84

2022 Work RVU: 2.06
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.69

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 **2020 Medicare Utilization:** 1,197

2022 Work RVU: 3.23
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.96

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 **2020 Medicare Utilization:** 67

2022 Work RVU: 5.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.08

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 **2020 Medicare Utilization:** 7,335

2022 Work RVU: 1.18
2022 NF PE RVU: 0.95
2022 Fac PE RVU: 0.55

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 **2020 Medicare Utilization:** 102

2022 Work RVU: 1.18
2022 NF PE RVU: 1.26
2022 Fac PE RVU: 0.82

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 **2020 Medicare Utilization:** 20,437

2022 Work RVU: 0.75
2022 NF PE RVU: 0.70
2022 Fac PE RVU: 0.55

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 **2020 Medicare Utilization:** 172,505

2022 Work RVU: 0.32
2022 NF PE RVU: 0.22
2022 Fac PE RVU: 0.30

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

2020 Medicare Utilization: 1,131

2022 Work RVU: 3.75
2022 NF PE RVU: 10.45
2022 Fac PE RVU: 5.42

RUC Recommendation: 3.75

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

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

2020 Medicare Utilization: 234

2022 Work RVU: 2.03
2022 NF PE RVU: 7.24
2022 Fac PE RVU: 3.55

RUC Recommendation: 2.03

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

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

2020 Medicare Utilization: 1,129

2022 Work RVU: 5.48
2022 NF PE RVU: 12.18
2022 Fac PE RVU: 6.50

RUC Recommendation: 5.48

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

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

2020 Medicare Utilization: 16,879

2022 Work RVU: 5.93
2022 NF PE RVU: 12.06
2022 Fac PE RVU: 6.77

RUC Recommendation: 5.93

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

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

2020 Medicare Utilization: 2,789

2022 Work RVU: 3.47
2022 NF PE RVU: 10.49
2022 Fac PE RVU: 5.27

RUC Recommendation: 3.47

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

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

2020 Medicare Utilization: 74

2022 Work RVU: 2.03
2022 NF PE RVU: 6.94
2022 Fac PE RVU: 3.56

RUC Recommendation: 2.03

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

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 **2020 Medicare Utilization:** 856

2022 Work RVU: 5.48
2022 NF PE RVU: 12.19
2022 Fac PE RVU: 6.51

RUC Recommendation: 5.48 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 8,656

2022 Work RVU: 5.93
2022 NF PE RVU: 12.85
2022 Fac PE RVU: 6.78

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,295

2022 Work RVU: 0.85
2022 NF PE RVU: 0.92
2022 Fac PE RVU: 0.49

RUC Recommendation: Revised parenthetical **Referred to CPT** February 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,203

2022 Work RVU: 0.49
2022 NF PE RVU: 0.69
2022 Fac PE RVU: 0.46

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 20,489

2022 Work RVU: 0.82
2022 NF PE RVU: 1.96
2022 Fac PE RVU: 1.40

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

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

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 **2020 Medicare Utilization:** 20,304

2022 Work RVU: 1.54
2022 NF PE RVU: 3.09
2022 Fac PE RVU: 2.03

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 338

2022 Work RVU: 1.74
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.02

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 **2020 Medicare Utilization:** 5,830

2022 Work RVU: 2.70
2022 NF PE RVU: 8.30
2022 Fac PE RVU: 3.50

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 **2020 Medicare Utilization:** 180

2022 Work RVU: 2.10
2022 NF PE RVU: 23.97
2022 Fac PE RVU: 2.27

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 **2020 Medicare Utilization:** 144,999

2022 Work RVU: 0.81
2022 NF PE RVU: 1.98
2022 Fac PE RVU: 0.46

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 **2020 Medicare Utilization:** 49,625

2022 Work RVU: 0.77
2022 NF PE RVU: 1.50
2022 Fac PE RVU: 0.51

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 **2020 Medicare Utilization:** 1,236,622

2022 Work RVU: 0.61
2022 NF PE RVU: 0.70
2022 Fac PE RVU: 0.27

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 34,666

2022 Work RVU: 1.57
2022 NF PE RVU: 4.25
2022 Fac PE RVU: 2.10

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 **2020 Medicare Utilization:** 22,431

2022 Work RVU: 2.06
2022 NF PE RVU: 4.49
2022 Fac PE RVU: 1.31

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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 3,396

2022 Work RVU: 17.73
2022 NF PE RVU: NA
2022 Fac PE RVU: 16.05

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 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2020 Medicare Utilization:** 19,577

2022 Work RVU: 0.18
2022 NF PE RVU: 0.77
2022 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 **2020 Medicare Utilization:** 17,628

2022 Work RVU: 0.18
2022 NF PE RVU: 0.95
2022 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:**

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 **2020 Medicare Utilization:** 17,688

2022 Work RVU: 0.17
2022 NF PE RVU: 0.78
2022 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT

Result: Increase

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

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 **2020 Medicare Utilization:** 36,640

2022 Work RVU: 0.22
2022 NF PE RVU: 0.89
2022 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

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

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 **2020 Medicare Utilization:** 39,086

2022 Work RVU: 0.18
2022 NF PE RVU: 0.87
2022 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 **2020 Medicare Utilization:** 7,934

2022 Work RVU: 0.28
2022 NF PE RVU: 1.04
2022 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 **2020 Medicare Utilization:** 1,961

2022 Work RVU: 0.16
2022 NF PE RVU: 0.96
2022 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 **2020 Medicare Utilization:** 36,813

2022 Work RVU: 0.18
2022 NF PE RVU: 0.74
2022 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 **2020 Medicare Utilization:** 1,348

2022 Work RVU: 0.84
2022 NF PE RVU: 2.24
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 4,813,481

2022 Work RVU: 0.85
2022 NF PE RVU: 2.37
2022 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 21,365

2022 Work RVU: 1.13
2022 NF PE RVU: 3.41
2022 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 70,900

2022 Work RVU: 1.27
2022 NF PE RVU: 4.06
2022 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 43,867

2022 Work RVU: 1.28
2022 NF PE RVU: 3.56
2022 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 **2020 Medicare Utilization:** 8,890

2022 Work RVU: 1.13
2022 NF PE RVU: 4.43
2022 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 **2020 Medicare Utilization:** 3,841

2022 Work RVU: 1.27
2022 NF PE RVU: 5.25
2022 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 **2020 Medicare Utilization:** 425,050

2022 Work RVU: 0.85
2022 NF PE RVU: 3.06
2022 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 **2020 Medicare Utilization:** 25,411

2022 Work RVU: 1.13
2022 NF PE RVU: 3.53
2022 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 **2020 Medicare Utilization:** 3,020

2022 Work RVU: 1.27
2022 NF PE RVU: 4.42
2022 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 **2020 Medicare Utilization:** 56,374

2022 Work RVU: 1.28
2022 NF PE RVU: 3.30
2022 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 **2020 Medicare Utilization:** 247,043

2022 Work RVU: 1.38
2022 NF PE RVU: 4.29
2022 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 **2020 Medicare Utilization:** 20,210

2022 Work RVU: 1.62
2022 NF PE RVU: 5.19
2022 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 **2020 Medicare Utilization:** 509,547

2022 Work RVU: 1.75
2022 NF PE RVU: 6.70
2022 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 **2020 Medicare Utilization:** 529,852

2022 Work RVU: 1.75
2022 NF PE RVU: 6.69
2022 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 **2020 Medicare Utilization:** 8,567

2022 Work RVU: 1.35
2022 NF PE RVU: 5.70
2022 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 **2020 Medicare Utilization:** 805

2022 Work RVU: 1.62
2022 NF PE RVU: 6.76
2022 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 **2020 Medicare Utilization:** 55,029

2022 Work RVU: 2.15
2022 NF PE RVU: 8.41
2022 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 **2020 Medicare Utilization:** 195,255

2022 Work RVU: 1.20
2022 NF PE RVU: 5.46
2022 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 **2020 Medicare Utilization:** 2,796

2022 Work RVU: 1.20
2022 NF PE RVU: 5.83
2022 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 **2020 Medicare Utilization:** 16,258

2022 Work RVU: 1.48
2022 NF PE RVU: 8.73
2022 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 **2020 Medicare Utilization:** 64,629

2022 Work RVU: 1.20
2022 NF PE RVU: 5.48
2022 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 **2020 Medicare Utilization:** 13,439

2022 Work RVU: 1.50
2022 NF PE RVU: 6.11
2022 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 **2020 Medicare Utilization:** 44,370

2022 Work RVU: 1.80
2022 NF PE RVU: 8.90
2022 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 988,012

2022 Work RVU: 1.48
2022 NF PE RVU: 4.55
2022 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 18,020

2022 Work RVU: 1.78
2022 NF PE RVU: 6.59
2022 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 868,451

2022 Work RVU: 2.29
2022 NF PE RVU: 7.57
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 15,258,006

2022 Work RVU: 0.18
2022 NF PE RVU: 0.57
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 6,588,226

2022 Work RVU: 0.22
2022 NF PE RVU: 0.76
2022 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** February 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 12,357

2022 Work RVU: 0.27
2022 NF PE RVU: 0.97
2022 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 8,226

2022 Work RVU: 0.31
2022 NF PE RVU: 1.05
2022 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2016 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: **Issue:** Insertion/Removal of Pacemeaker 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 131,612

2022 Work RVU: 0.22
2022 NF PE RVU: 0.86
2022 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 **2020 Medicare Utilization:** 228,061

2022 Work RVU: 0.27
2022 NF PE RVU: 0.97
2022 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

2020 Medicare Utilization: 19,903

2022 Work RVU: 0.29
2022 NF PE RVU: 1.00
2022 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

2020 Medicare Utilization: 25,320

2022 Work RVU: 0.32
2022 NF PE RVU: 1.23
2022 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

2020 Medicare Utilization: 2,090,446

2022 Work RVU: 1.08
2022 NF PE RVU: 2.97
2022 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 **2020 Medicare Utilization:** 1,677,657

2022 Work RVU: 1.16
2022 NF PE RVU: 3.95
2022 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 **2020 Medicare Utilization:** 57,503

2022 Work RVU: 1.25
2022 NF PE RVU: 4.81
2022 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: 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:** May 2019 **2020 Medicare Utilization:**

2022 Work RVU: 1.08
2022 NF PE RVU: 3.11
2022 Fac PE RVU: NA

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 **2020 Medicare Utilization:** 1,251,116

2022 Work RVU: 1.82
2022 NF PE RVU: 6.81
2022 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 **2020 Medicare Utilization:** 112,855

2022 Work RVU: 0.16
2022 NF PE RVU: 0.55
2022 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 **2020 Medicare Utilization:** 511,863

2022 Work RVU: 0.22
2022 NF PE RVU: 0.94
2022 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 **2020 Medicare Utilization:** 288,978

2022 Work RVU: 0.27
2022 NF PE RVU: 1.30
2022 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2011 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 60,768

2022 Work RVU: 0.30
2022 NF PE RVU: 1.53
2022 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2011 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 242,793

2022 Work RVU: 0.20
2022 NF PE RVU: 0.76
2022 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 139,106

2022 Work RVU: 0.23
2022 NF PE RVU: 0.92
2022 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 **2020 Medicare Utilization:** 9,899

2022 Work RVU: 0.25
2022 NF PE RVU: 1.06
2022 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 **2020 Medicare Utilization:** 38,221

2022 Work RVU: 0.21
2022 NF PE RVU: 0.81
2022 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 **2020 Medicare Utilization:** 1,440,021

2022 Work RVU: 0.22
2022 NF PE RVU: 0.95
2022 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 **2020 Medicare Utilization:** 650,097

2022 Work RVU: 0.26
2022 NF PE RVU: 1.25
2022 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 **2020 Medicare Utilization:** 77,915

2022 Work RVU: 0.30
2022 NF PE RVU: 1.53
2022 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 **2020 Medicare Utilization:** 41,713

2022 Work RVU: 0.22
2022 NF PE RVU: 0.98
2022 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain

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 **2020 Medicare Utilization:** 1,184,668

2022 Work RVU: 1.00
2022 NF PE RVU: 2.97
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 17,347

2022 Work RVU: 1.22
2022 NF PE RVU: 3.95
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 1,538

2022 Work RVU: 1.27
2022 NF PE RVU: 4.81
2022 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 181,393

2022 Work RVU: 1.00
2022 NF PE RVU: 2.96
2022 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 26,681

2022 Work RVU: 1.22
2022 NF PE RVU: 3.99
2022 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 1,246

2022 Work RVU: 1.27
2022 NF PE RVU: 4.84
2022 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 443,104

2022 Work RVU: 1.00
2022 NF PE RVU: 2.95
2022 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 53,885

2022 Work RVU: 1.22
2022 NF PE RVU: 3.95
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 3,482

2022 Work RVU: 1.27
2022 NF PE RVU: 4.80
2022 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 **2020 Medicare Utilization:** 487,773

2022 Work RVU: 1.48
2022 NF PE RVU: 4.41
2022 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 **2020 Medicare Utilization:** 2,683

2022 Work RVU: 1.78
2022 NF PE RVU: 6.79
2022 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 188,463

2022 Work RVU: 1.48
2022 NF PE RVU: 4.40
2022 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 2,667

2022 Work RVU: 1.78
2022 NF PE RVU: 6.70
2022 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 1,096,788

2022 Work RVU: 1.48
2022 NF PE RVU: 4.42
2022 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 4,533

2022 Work RVU: 1.78
2022 NF PE RVU: 6.63
2022 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 102,071

2022 Work RVU: 2.29
2022 NF PE RVU: 7.65
2022 Fac PE RVU: NA

RUC Recommendation: 2.29 **Referred to CPT** **Result:** Decrease

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

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

2020 Medicare Utilization: 88,842

2022 Work RVU: 2.29
2022 NF PE RVU: 7.66
2022 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

2020 Medicare Utilization: 203,972

2022 Work RVU: 2.29
2022 NF PE RVU: 7.62
2022 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

2020 Medicare Utilization: 671,286

2022 Work RVU: 0.17
2022 NF PE RVU: 0.64
2022 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

2020 Medicare Utilization: 49,156

2022 Work RVU: 0.25
2022 NF PE RVU: 0.99
2022 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

2020 Medicare Utilization: 2,365

2022 Work RVU: 1.81
2022 NF PE RVU: 7.65
2022 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

2020 Medicare Utilization: 160,045

2022 Work RVU: 1.09
2022 NF PE RVU: 2.97
2022 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 **2020 Medicare Utilization:** 32,629

2022 Work RVU: 1.16
2022 NF PE RVU: 6.05
2022 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 **2020 Medicare Utilization:** 4,605

2022 Work RVU: 1.22
2022 NF PE RVU: 6.71
2022 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 **2020 Medicare Utilization:** 73,312

2022 Work RVU: 1.46
2022 NF PE RVU: 5.70
2022 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 **2020 Medicare Utilization:** 2,001

2022 Work RVU: 1.73
2022 NF PE RVU: 6.66
2022 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 207,770

2022 Work RVU: 2.20
2022 NF PE RVU: 8.34
2022 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 12,099

2022 Work RVU: 0.17
2022 NF PE RVU: 0.79
2022 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 31,483

2022 Work RVU: 0.23
2022 NF PE RVU: 0.92
2022 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Increase

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

2020 Medicare Utilization: 91,400

2022 Work RVU: 0.17
2022 NF PE RVU: 0.78
2022 Fac PE RVU: NA

RUC Recommendation: 0.20

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

Result: Increase

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

2020 Medicare Utilization: 430

2022 Work RVU: 0.91
2022 NF PE RVU: 2.49
2022 Fac PE RVU: NA

RUC Recommendation: 0.91

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

Result: Maintain

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

2020 Medicare Utilization: 107

2022 Work RVU: 0.91
2022 NF PE RVU: 2.56
2022 Fac PE RVU: NA

RUC Recommendation: 0.91

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

Result: Maintain

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 **2020 Medicare Utilization:** 2,317

2022 Work RVU: 0.83
2022 NF PE RVU: 2.40
2022 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 **2020 Medicare Utilization:** 456

2022 Work RVU: 1.33
2022 NF PE RVU: 3.58
2022 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 **2020 Medicare Utilization:** 54,891

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 86,745

2022 Work RVU: 0.16
2022 NF PE RVU: 0.78
2022 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

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

2020 Medicare Utilization: 40,937

2022 Work RVU: 0.17
2022 NF PE RVU: 0.52
2022 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

2020 Medicare Utilization: 98,733

2022 Work RVU: 0.15
2022 NF PE RVU: 0.47
2022 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

2020 Medicare Utilization: 2,321,375

2022 Work RVU: 0.18
2022 NF PE RVU: 0.83
2022 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 **2020 Medicare Utilization:** 6,420

2022 Work RVU: 0.18
2022 NF PE RVU: 0.65
2022 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 **2020 Medicare Utilization:** 292,126

2022 Work RVU: 0.16
2022 NF PE RVU: 0.77
2022 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 **2020 Medicare Utilization:** 186,583

2022 Work RVU: 0.16
2022 NF PE RVU: 0.69
2022 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 **2020 Medicare Utilization:** 339,612

2022 Work RVU: 0.17
2022 NF PE RVU: 0.78
2022 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 **2020 Medicare Utilization:** 200,668

2022 Work RVU: 0.16
2022 NF PE RVU: 0.69
2022 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 **2020 Medicare Utilization:** 231,579

2022 Work RVU: 0.16
2022 NF PE RVU: 0.83
2022 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 **2020 Medicare Utilization:** 916,846

2022 Work RVU: 0.17
2022 NF PE RVU: 1.03
2022 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 **2020 Medicare Utilization:** 231,529

2022 Work RVU: 0.16
2022 NF PE RVU: 0.75
2022 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 **2020 Medicare Utilization:** 1,097,585

2022 Work RVU: 0.17
2022 NF PE RVU: 0.90
2022 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

2020 Medicare Utilization: 316,609

2022 Work RVU: 0.13
2022 NF PE RVU: 0.97
2022 Fac PE RVU: NA

RUC Recommendation: 0.13

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

Result: Maintain

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

2020 Medicare Utilization: 113,021

2022 Work RVU: 1.00
2022 NF PE RVU: 4.02
2022 Fac PE RVU: NA

RUC Recommendation: 1.09

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

Result: Maintain

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

2020 Medicare Utilization: 18,828

2022 Work RVU: 1.16
2022 NF PE RVU: 5.07
2022 Fac PE RVU: NA

RUC Recommendation: Remove from screen

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

Result: Remove from Screen

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

2020 Medicare Utilization: 1,767

2022 Work RVU: 1.22
2022 NF PE RVU: 6.58
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 6,441

2022 Work RVU: 1.81
2022 NF PE RVU: 7.39
2022 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 **2020 Medicare Utilization:** 28,452

2022 Work RVU: 1.35
2022 NF PE RVU: 8.21
2022 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 **2020 Medicare Utilization:** 396,179

2022 Work RVU: 1.35
2022 NF PE RVU: 4.89
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 227,987

2022 Work RVU: 0.18
2022 NF PE RVU: 0.77
2022 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 **2020 Medicare Utilization:** 2,236,429

2022 Work RVU: 0.22
2022 NF PE RVU: 1.16
2022 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 **2020 Medicare Utilization:** 42,499

2022 Work RVU: 0.27
2022 NF PE RVU: 1.47
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 125,940

2022 Work RVU: 0.22
2022 NF PE RVU: 0.99
2022 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 **2020 Medicare Utilization:** 148,965

2022 Work RVU: 0.29
2022 NF PE RVU: 1.29
2022 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 **2020 Medicare Utilization:** 90,087

2022 Work RVU: 0.31
2022 NF PE RVU: 1.50
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 32,983

2022 Work RVU: 0.16
2022 NF PE RVU: 0.69
2022 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** October 2014 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 482,114

2022 Work RVU: 0.18
2022 NF PE RVU: 0.85
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** October 2014 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,367,423

2022 Work RVU: 0.16
2022 NF PE RVU: 0.84
2022 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,967,688

2022 Work RVU: 0.18
2022 NF PE RVU: 1.02
2022 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

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 **2020 Medicare Utilization:** 1,347,467

2022 Work RVU: 0.22
2022 NF PE RVU: 1.14
2022 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 **2020 Medicare Utilization:** 134,804

2022 Work RVU: 0.16
2022 NF PE RVU: 1.03
2022 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?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2020 Medicare Utilization:** 18,114

2022 Work RVU: 0.54
2022 NF PE RVU: 3.85
2022 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 418,045

2022 Work RVU: 0.16
2022 NF PE RVU: 0.76
2022 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 **2020 Medicare Utilization:** 199,747

2022 Work RVU: 0.16
2022 NF PE RVU: 0.78
2022 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 **2020 Medicare Utilization:** 1,053,621

2022 Work RVU: 0.17
2022 NF PE RVU: 0.91
2022 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 **2020 Medicare Utilization:** 442,295

2022 Work RVU: 0.16
2022 NF PE RVU: 0.66
2022 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 **2020 Medicare Utilization:** 2,308,194

2022 Work RVU: 0.17
2022 NF PE RVU: 0.84
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 66,375

2022 Work RVU: 0.16
2022 NF PE RVU: 0.68
2022 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 90,504

2022 Work RVU: 0.13
2022 NF PE RVU: 0.72
2022 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 301,802

2022 Work RVU: 1.00
2022 NF PE RVU: 2.95
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 45,725

2022 Work RVU: 1.16
2022 NF PE RVU: 3.96
2022 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 **2020 Medicare Utilization:** 4,095

2022 Work RVU: 1.22
2022 NF PE RVU: 4.77
2022 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 **2020 Medicare Utilization:** 16,505

2022 Work RVU: 1.90
2022 NF PE RVU: 8.09
2022 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:**

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 **2020 Medicare Utilization:** 122,818

2022 Work RVU: 1.35
2022 NF PE RVU: 5.61
2022 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 954

2022 Work RVU: 1.62
2022 NF PE RVU: 6.57
2022 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 **2020 Medicare Utilization:** 55,927

2022 Work RVU: 2.15
2022 NF PE RVU: 8.39
2022 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 537,072

2022 Work RVU: 1.35
2022 NF PE RVU: 4.88
2022 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 1,924,615

2022 Work RVU: 0.18
2022 NF PE RVU: 0.70
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 315,025

2022 Work RVU: 0.23
2022 NF PE RVU: 0.85
2022 Fac PE RVU: NA

RUC Recommendation: 0.23 **Referred to CPT** February 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 42,821

2022 Work RVU: 0.27
2022 NF PE RVU: 1.00
2022 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 182,235

2022 Work RVU: 0.32
2022 NF PE RVU: 1.15
2022 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** February 2016 **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 62,958

2022 Work RVU: 1.19
2022 NF PE RVU: 2.98
2022 Fac PE RVU: NA

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009

Result: Maintain

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

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

2020 Medicare Utilization: 87,750

2022 Work RVU: 1.27
2022 NF PE RVU: 6.07
2022 Fac PE RVU: NA

RUC Recommendation: 0.42

Referred to CPT October 2009

Result: Maintain

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

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

2020 Medicare Utilization: 92,433

2022 Work RVU: 1.40
2022 NF PE RVU: 6.81
2022 Fac PE RVU: NA

RUC Recommendation: 1.40

Referred to CPT October 2009

Result: Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** **2020 Medicare Utilization:** 280,481

2022 Work RVU: 2.20
2022 NF PE RVU: 9.58
2022 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 30,560

2022 Work RVU: 1.82
2022 NF PE RVU: 7.65
2022 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2010 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 1,952,320

2022 Work RVU: 1.74
2022 NF PE RVU: 3.82
2022 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 3,041,941

2022 Work RVU: 1.82
2022 NF PE RVU: 7.70
2022 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 **2020 Medicare Utilization:** 463,043

2022 Work RVU: 2.01
2022 NF PE RVU: 8.66
2022 Fac PE RVU: NA

RUC Recommendation: 2.01 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 100,049

2022 Work RVU: 1.46
2022 NF PE RVU: 4.60
2022 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

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 **2020 Medicare Utilization:** 3,561

2022 Work RVU: 1.73
2022 NF PE RVU: 7.73
2022 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:** 334,598

2022 Work RVU: 2.20
2022 NF PE RVU: 8.36
2022 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,111

2022 Work RVU: 0.59
2022 NF PE RVU: 2.34
2022 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

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 **2020 Medicare Utilization:** 100,962

2022 Work RVU: 0.60
2022 NF PE RVU: 2.36
2022 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 **2020 Medicare Utilization:** 46,438

2022 Work RVU: 0.70
2022 NF PE RVU: 2.64
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 285,714

2022 Work RVU: 0.53
2022 NF PE RVU: 3.32
2022 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

74240 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2020 Medicare Utilization:** 68,915

2022 Work RVU: 0.80
2022 NF PE RVU: 2.92
2022 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 50,036

2022 Work RVU: 0.90
2022 NF PE RVU: 3.35
2022 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 16,146

2022 Work RVU: 0.70
2022 NF PE RVU: 1.79
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 42,993

2022 Work RVU: 0.81
2022 NF PE RVU: 2.90
2022 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** May 2018 **Result:** Increase

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

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 **2020 Medicare Utilization:** 410

2022 Work RVU: 1.17
2022 NF PE RVU: 10.28
2022 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** May 2018 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

74260 **Duodenography, hypotonic**

Global: **Issue:** X-Ray Exam – Small Intestine/Colon **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 21,625

2022 Work RVU: 1.04
2022 NF PE RVU: 3.63
2022 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 5,683

2022 Work RVU: 1.26
2022 NF PE RVU: 5.48
2022 Fac PE RVU: NA

RUC Recommendation: 1.26 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 23,965

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 77

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:**

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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

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 **2020 Medicare Utilization:** 60,029

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,548

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 11,873

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 3,849

2022 Work RVU: 0.49
2022 NF PE RVU: 3.61
2022 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 144,313

2022 Work RVU: 0.52
2022 NF PE RVU: 1.74
2022 Fac PE RVU: NA

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 2,959

2022 Work RVU: 0.51
2022 NF PE RVU: 3.62
2022 Fac PE RVU: NA

RUC Recommendation: 0.51, editorially revised **Referred to CPT** September 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 1,239

2022 Work RVU: 0.83
2022 NF PE RVU: 2.72
2022 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2020 Medicare Utilization:** 27,884

2022 Work RVU: 2.60
2022 NF PE RVU: 8.87
2022 Fac PE RVU: NA

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

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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2020 Medicare Utilization:** 29,193

2022 Work RVU: 1.75
2022 NF PE RVU: 5.17
2022 Fac PE RVU: NA

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

Status Report: CMS Requests and Relativity Assessment Issues

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:** CMS Request - Final Rule for 2013 / High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, SIR, ACC **First Identified:** May 2013 **2020 Medicare Utilization:** 83,373

2022 Work RVU: 2.40
2022 NF PE RVU: 7.51
2022 Fac PE RVU: NA

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

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

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 **2020 Medicare Utilization:** 81,691

2022 Work RVU: 1.44
2022 NF PE RVU: 2.17
2022 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 **2020 Medicare Utilization:** 21,287

2022 Work RVU: 2.00
2022 NF PE RVU: 2.51
2022 Fac PE RVU: NA

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

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

Status Report: CMS Requests and Relativity Assessment Issues

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

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 **2020 Medicare Utilization:** 98,794

2022 Work RVU: 2.40
2022 NF PE RVU: 10.20
2022 Fac PE RVU: NA

RUC Recommendation: 2.40 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2020 Medicare Utilization:** 145,898

2022 Work RVU: 1.75
2022 NF PE RVU: 2.54
2022 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant and review after 2 years of data after publication available. 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2021

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 **2020 Medicare Utilization:** 60,864

2022 Work RVU: 1.97
2022 NF PE RVU: 2.68
2022 Fac PE RVU: NA

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 39,798

2022 Work RVU: 2.05
2022 NF PE RVU: 2.88
2022 Fac PE RVU: NA

RUC Recommendation: 2.05 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 75,593

2022 Work RVU: 1.01
2022 NF PE RVU: 1.80
2022 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

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

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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

75820 **Venography, extremity, unilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2020 Medicare Utilization:** 21,767

2022 Work RVU: 1.05
2022 NF PE RVU: 2.15
2022 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75822 **Venography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2020 Medicare Utilization:** 9,822

2022 Work RVU: 1.48
2022 NF PE RVU: 2.39
2022 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 **2020 Medicare Utilization:** 297

2022 Work RVU: 1.44
2022 NF PE RVU: 2.50
2022 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 **2020 Medicare Utilization:** 586

2022 Work RVU: 1.44
2022 NF PE RVU: 2.57
2022 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?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2020 Medicare Utilization:** 8,773

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** RAW will assess Oct 2018 **Result:** Maintain
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 11,852

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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:** **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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

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 **2020 Medicare Utilization:** 19,707

2022 Work RVU: 0.83
2022 NF PE RVU: 2.03
2022 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** RAW will assess Oct 2018 **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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 100,018

2022 Work RVU: 0.30
2022 NF PE RVU: 0.93
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 61,461

2022 Work RVU: 0.31
2022 NF PE RVU: 0.87
2022 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 **2020 Medicare Utilization:** 6,499

2022 Work RVU: 0.58
2022 NF PE RVU: 2.06
2022 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 **2020 Medicare Utilization:** 1

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

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 **2020 Medicare Utilization:** 2,071

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

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 **2020 Medicare Utilization:** 247,990

2022 Work RVU: 0.20
2022 NF PE RVU: 0.46
2022 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?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2019 **2020 Medicare Utilization:** 155,353

2022 Work RVU: 0.79
2022 NF PE RVU: 1.30
2022 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 11,064

2022 Work RVU: 0.70
2022 NF PE RVU: 1.33
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **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 **2020 Medicare Utilization:** 3,275

2022 Work RVU: 0.64
2022 NF PE RVU: 1.01
2022 Fac PE RVU: NA

RUC Recommendation: 0.64 **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 **2020 Medicare Utilization:** 186,858

2022 Work RVU: 0.56
2022 NF PE RVU: 0.83
2022 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 **2020 Medicare Utilization:** 20,686

2022 Work RVU: 0.60
2022 NF PE RVU: 1.62
2022 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 **2020 Medicare Utilization:** 370,154

2022 Work RVU: 0.14
2022 NF PE RVU: 0.18
2022 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 **2020 Medicare Utilization:** 1,806

2022 Work RVU: 0.40
2022 NF PE RVU: 0.95
2022 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 **2020 Medicare Utilization:** 126,280

2022 Work RVU: 0.54
2022 NF PE RVU: 1.42
2022 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 **2020 Medicare Utilization:** 783,204

2022 Work RVU: 0.56
2022 NF PE RVU: 2.76
2022 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 **2020 Medicare Utilization:** 96,497

2022 Work RVU: 0.59
2022 NF PE RVU: 1.10
2022 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 **2020 Medicare Utilization:** 598,115

2022 Work RVU: 0.73
2022 NF PE RVU: 2.32
2022 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 **2020 Medicare Utilization:** 680,621

2022 Work RVU: 0.68
2022 NF PE RVU: 1.81
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 731,528

2022 Work RVU: 0.81
2022 NF PE RVU: 2.67
2022 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 **2020 Medicare Utilization:** 934,222

2022 Work RVU: 0.59
2022 NF PE RVU: 2.00
2022 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 **2020 Medicare Utilization:** 122,567

2022 Work RVU: 0.55
2022 NF PE RVU: 2.61
2022 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 **2020 Medicare Utilization:** 1,144,777

2022 Work RVU: 0.74
2022 NF PE RVU: 2.48
2022 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 **2020 Medicare Utilization:** 427,811

2022 Work RVU: 0.58
2022 NF PE RVU: 1.10
2022 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 **2020 Medicare Utilization:** 11,226

2022 Work RVU: 0.77
2022 NF PE RVU: 1.68
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 354,483

2022 Work RVU: 0.69
2022 NF PE RVU: 2.87
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 335,800

2022 Work RVU: 0.69
2022 NF PE RVU: 2.45
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 170,089

2022 Work RVU: 0.50
2022 NF PE RVU: 0.89
2022 Fac PE RVU: NA

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

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 **2020 Medicare Utilization:** 124,259

2022 Work RVU: 0.64
2022 NF PE RVU: 2.35
2022 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 **2020 Medicare Utilization:** 185,018

2022 Work RVU: 0.69
2022 NF PE RVU: 5.38
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** Neuromuscular Ultrasound **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 11 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, ACR, ACRh, APMA **First Identified:** April 2010 **2020 Medicare Utilization:** 170,257

2022 Work RVU: 0.63
2022 NF PE RVU: 1.08
2022 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** June 2017 **Result:** Decrease

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:** Neuromuscular Ultrasound **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 11 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, ACR, ACRh, APMA **First Identified:** April 2010 **2020 Medicare Utilization:** 243,066

2022 Work RVU: 0.49
2022 NF PE RVU: 1.15
2022 Fac PE RVU: NA

RUC Recommendation: 0.69 **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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,148

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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

2020 Medicare Utilization: 675

2022 Work RVU: 1.99
2022 NF PE RVU: 5.59
2022 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

2020 Medicare Utilization: 638,180

2022 Work RVU: 0.30
2022 NF PE RVU: 0.85
2022 Fac PE RVU: NA

RUC Recommendation: Survey in 2 years (April 2022)

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

2020 Medicare Utilization: 1,176

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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:** Somatic Nerve Injections **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** April 2011 **2020 Medicare Utilization:** 1,039,361

2022 Work RVU: 0.67
2022 NF PE RVU: 1.00
2022 Fac PE RVU: NA

RUC Recommendation: 0.67 **Referred to CPT** May 2021 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 10

2022 Work RVU: 0.67
2022 NF PE RVU: 1.69
2022 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 5,396

2022 Work RVU: 1.34
2022 NF PE RVU: 1.34
2022 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:** **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth1 / CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2020 Medicare Utilization:** 20,100

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

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 Part1 **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 **2020 Medicare Utilization:** 26,174

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2022 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76XX0

Global: **Issue:** Neuromuscular Ultrasound **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 11 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, ACR, ACRh, APMA **First Identified:** October 2021 **2020 Medicare Utilization:**

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

RUC Recommendation: 1.21 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:** 286,956

2022 Work RVU: 0.38
2022 NF PE RVU: 2.65
2022 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:** Somatic Nerve Injections **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 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** January 2012 **2020 Medicare Utilization:** 466,846

2022 Work RVU: 0.54
2022 NF PE RVU: 2.90
2022 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:** Somatic Nerve Injections **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** October 2010 **2020 Medicare Utilization:** 26,632

2022 Work RVU: 0.60
2022 NF PE RVU: 2.51
2022 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** October 2015 **Result:** Maintain

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

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:** **2020 Medicare Utilization:** 3,549

2022 Work RVU: 1.21
2022 NF PE RVU: 5.46
2022 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

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

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 **2020 Medicare Utilization:** 185,999

2022 Work RVU: 1.50
2022 NF PE RVU: 2.65
2022 Fac PE RVU: NA

RUC Recommendation: Bundled 32405 and 77012. 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

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2020 Medicare Utilization:** 2,333,203

2022 Work RVU: 0.85
2022 NF PE RVU: 2.68
2022 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

2020 Medicare Utilization: 270

2022 Work RVU: 1.45
2022 NF PE RVU: 5.16
2022 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

2020 Medicare Utilization: 2,712

2022 Work RVU: 1.60
2022 NF PE RVU: 5.19
2022 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

2020 Medicare Utilization: 983

2022 Work RVU: 2.10
2022 NF PE RVU: 8.40
2022 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 **2020 Medicare Utilization:** 85,897

2022 Work RVU: 2.30
2022 NF PE RVU: 8.41
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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

2020 Medicare Utilization:

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 642,500

2022 Work RVU: 0.81
2022 NF PE RVU: 2.90
2022 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 **2020 Medicare Utilization:** 557,163

2022 Work RVU: 1.00
2022 NF PE RVU: 3.69
2022 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 **2020 Medicare Utilization:** 5,112,752

2022 Work RVU: 0.76
2022 NF PE RVU: 3.02
2022 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 **2020 Medicare Utilization:** 46,209

2022 Work RVU: 0.26
2022 NF PE RVU: 1.06
2022 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 **2020 Medicare Utilization:** 3,237

2022 Work RVU: 0.44
2022 NF PE RVU: 1.48
2022 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 **2020 Medicare Utilization:** 33,273

2022 Work RVU: 0.55
2022 NF PE RVU: 2.38
2022 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 **2020 Medicare Utilization:** 30

2022 Work RVU: 0.70
2022 NF PE RVU: 2.45
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 30,468

2022 Work RVU: 0.33
2022 NF PE RVU: 1.04
2022 Fac PE RVU: NA

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Increase

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 2,091,832

2022 Work RVU: 0.20
2022 NF PE RVU: 0.88
2022 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 **2020 Medicare Utilization:** 30,986

2022 Work RVU: 0.20
2022 NF PE RVU: 0.70
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

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

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:** **2020 Medicare Utilization:** 84,850

2022 Work RVU: 0.30
2022 NF PE RVU: 1.19
2022 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** May 2013 **Result:** Decrease

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

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:** **2020 Medicare Utilization:** 1,781

2022 Work RVU: 0.17
2022 NF PE RVU: 0.78
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** May 2013 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 8,505

2022 Work RVU: 1.30
2022 NF PE RVU: 0.69
2022 Fac PE RVU: 0.69

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

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 **2020 Medicare Utilization:** 2,829

2022 Work RVU: 2.00
2022 NF PE RVU: 1.03
2022 Fac PE RVU: 1.03

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

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 **2020 Medicare Utilization:** 280,220

2022 Work RVU: 3.14
2022 NF PE RVU: 1.55
2022 Fac PE RVU: 1.55

RUC Recommendation: 3.14 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 351,456

2022 Work RVU: 0.70
2022 NF PE RVU: 7.21
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 4,671

2022 Work RVU: 1.05
2022 NF PE RVU: 12.05
2022 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 185,187

2022 Work RVU: 1.56
2022 NF PE RVU: 11.91
2022 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 31,435

2022 Work RVU: 2.00
2022 NF PE RVU: 10.24
2022 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 **2020 Medicare Utilization:** 127,409

2022 Work RVU: 4.29
2022 NF PE RVU: 9.42
2022 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 **2020 Medicare Utilization:** 1,231,378

2022 Work RVU: 0.62
2022 NF PE RVU: 1.26
2022 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 **2020 Medicare Utilization:** 144,178

2022 Work RVU: 7.99
2022 NF PE RVU: 45.27
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,550

2022 Work RVU: 1.40
2022 NF PE RVU: 2.81
2022 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 **2020 Medicare Utilization:** 34,096

2022 Work RVU: 2.90
2022 NF PE RVU: 5.27
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 4,061

2022 Work RVU: 1.40
2022 NF PE RVU: 5.62
2022 Fac PE RVU: NA

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

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

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 **2020 Medicare Utilization:** 2,411

2022 Work RVU: 1.83
2022 NF PE RVU: 7.42
2022 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 5,224

2022 Work RVU: 2.90
2022 NF PE RVU: 10.23
2022 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** February 2014 **Result:** Decrease

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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:** 78,627

2022 Work RVU: 0.45
2022 NF PE RVU: 0.65
2022 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 **2020 Medicare Utilization:** 10,325

2022 Work RVU: 0.75
2022 NF PE RVU: 3.31
2022 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 **2020 Medicare Utilization:** 776,080

2022 Work RVU: 1.15
2022 NF PE RVU: 2.44
2022 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 **2020 Medicare Utilization:** 376,051

2022 Work RVU: 0.00
2022 NF PE RVU: 2.35
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
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 **2020 Medicare Utilization:** 163,112

2022 Work RVU: 4.29
2022 NF PE RVU: 8.92
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
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 **2020 Medicare Utilization:** 122

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
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:** October 2012 **2020 Medicare Utilization:** 721

2022 Work RVU: 0.00
2022 NF PE RVU: 28.91
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
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 **2020 Medicare Utilization:** 33,311

2022 Work RVU: 0.00
2022 NF PE RVU: 29.84
2022 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 212,288

2022 Work RVU: 0.00
2022 NF PE RVU: 1.21
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 959,196

2022 Work RVU: 3.37
2022 NF PE RVU: 1.95
2022 Fac PE RVU: 1.95

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 **2020 Medicare Utilization:** 38,736

2022 Work RVU: 11.87
2022 NF PE RVU: 5.99
2022 Fac PE RVU: 5.99

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

2020 Medicare Utilization: 85,083

2022 Work RVU: 2.03
2022 NF PE RVU: 1.85
2022 Fac PE RVU: NA

RUC Recommendation: 2.03

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

Result: Decrease

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

2020 Medicare Utilization: 157

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs

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

Result: PE Only

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

2020 Medicare Utilization: 10,315

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

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 **2020 Medicare Utilization:** 62,151

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 19,665

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 8,601

2022 Work RVU: 1.31
2022 NF PE RVU: 13.68
2022 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 **2020 Medicare Utilization:** 4,232

2022 Work RVU: 1.05
2022 NF PE RVU: 6.16
2022 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 **2020 Medicare Utilization:** 5,646

2022 Work RVU: 1.40
2022 NF PE RVU: 9.11
2022 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 **2020 Medicare Utilization:** 15,568

2022 Work RVU: 1.95
2022 NF PE RVU: 8.09
2022 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 **2020 Medicare Utilization:** 14,598

2022 Work RVU: 3.80
2022 NF PE RVU: 13.48
2022 Fac PE RVU: NA

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Decrease

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 **2020 Medicare Utilization:** 3,869

2022 Work RVU: 5.40
2022 NF PE RVU: 20.27
2022 Fac PE RVU: NA

RUC Recommendation: 5.40 **Referred to CPT** October 2014 **Result:** Decrease

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:**

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

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

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 **2020 Medicare Utilization:** 3,881

2022 Work RVU: 8.78
2022 NF PE RVU: 17.18
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 28

2022 Work RVU: 0.00
2022 NF PE RVU: 0.46
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:** 1,175

2022 Work RVU: 0.19
2022 NF PE RVU: 2.15
2022 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:** **2020 Medicare Utilization:** 894

2022 Work RVU: 0.37
2022 NF PE RVU: 5.08
2022 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:** **2020 Medicare Utilization:** 12,835

2022 Work RVU: 0.50
2022 NF PE RVU: 6.19
2022 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 **2020 Medicare Utilization:** 9,388

2022 Work RVU: 0.80
2022 NF PE RVU: 7.41
2022 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 **2020 Medicare Utilization:** 6,158

2022 Work RVU: 1.20
2022 NF PE RVU: 8.61
2022 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 **2020 Medicare Utilization:** 9,045

2022 Work RVU: 1.60
2022 NF PE RVU: 10.74
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:** 45,261

2022 Work RVU: 0.74
2022 NF PE RVU: 8.38
2022 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:** **2020 Medicare Utilization:** 52,391

2022 Work RVU: 0.90
2022 NF PE RVU: 11.38
2022 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 **2020 Medicare Utilization:** 752

2022 Work RVU: 0.98
2022 NF PE RVU: 9.99
2022 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 **2020 Medicare Utilization:** 228

2022 Work RVU: 1.08
2022 NF PE RVU: 11.23
2022 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 **2020 Medicare Utilization:** 21,405

2022 Work RVU: 0.99
2022 NF PE RVU: 8.78
2022 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 **2020 Medicare Utilization:** 5,238

2022 Work RVU: 0.62
2022 NF PE RVU: 5.77
2022 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 **2020 Medicare Utilization:** 1,047

2022 Work RVU: 0.83
2022 NF PE RVU: 6.89
2022 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 **2020 Medicare Utilization:** 223,016

2022 Work RVU: 0.86
2022 NF PE RVU: 7.45
2022 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 **2020 Medicare Utilization:** 765

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 361

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 33,533

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 61

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 1,120

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 34,085

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 26,107

2022 Work RVU: 1.38
2022 NF PE RVU: 8.15
2022 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 **2020 Medicare Utilization:** 1,369,821

2022 Work RVU: 1.62
2022 NF PE RVU: 11.65
2022 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 **2020 Medicare Utilization:** 1,308

2022 Work RVU: 1.00
2022 NF PE RVU: 7.28
2022 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 **2020 Medicare Utilization:** 6,551

2022 Work RVU: 1.34
2022 NF PE RVU: 10.81
2022 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 **2020 Medicare Utilization:** 998

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 13,479

2022 Work RVU: 0.98
2022 NF PE RVU: 5.42
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 501

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 137,725

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 294

2022 Work RVU: 0.49
2022 NF PE RVU: 4.75
2022 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 **2020 Medicare Utilization:** 60,193

2022 Work RVU: 0.74
2022 NF PE RVU: 5.88
2022 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 **2020 Medicare Utilization:** 64,152

2022 Work RVU: 1.07
2022 NF PE RVU: 8.25
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 2,258

2022 Work RVU: 0.75

2022 NF PE RVU: 4.90

2022 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 **2020 Medicare Utilization:** 1,446

2022 Work RVU: 0.85
2022 NF PE RVU: 7.67
2022 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 **2020 Medicare Utilization:** 32,628

2022 Work RVU: 1.09
2022 NF PE RVU: 9.68
2022 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 **2020 Medicare Utilization:** 573,750

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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

2020 Medicare Utilization: 9,835

2022 Work RVU: 1.96
2022 NF PE RVU: 2.28
2022 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 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP

First Identified: January 2019

2020 Medicare Utilization: 18,871

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

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 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP

First Identified: January 2021

2020 Medicare Utilization: 10,733

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

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

80503 **Pathology clinical consultation; for a clinical problem, with limited review of patient's history and medical records and straightforward medical decision making when using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 0.43
2022 NF PE RVU: 0.32
2022 Fac PE RVU: 0.20

RUC Recommendation: 0.50 **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

80504 **Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making when using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 0.91
2022 NF PE RVU: 0.58
2022 Fac PE RVU: 0.43

RUC Recommendation: 0.91 **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

80505 **Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making when using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 1.71
2022 NF PE RVU: 0.98
2022 Fac PE RVU: 0.81

RUC Recommendation: 1.80 **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80506 **Pathology clinical consultation; prolonged service, each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2020 Medicare Utilization:**

2022 Work RVU: 0.80
2022 NF PE RVU: 0.41
2022 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2020 **Result:** Decrease

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 **2020 Medicare Utilization:** 186,871

2022 Work RVU: 0.45
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.22

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 127,831

2022 Work RVU: 0.94
2022 NF PE RVU: 1.02
2022 Fac PE RVU: 0.41

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 **2020 Medicare Utilization:** 43,456

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 50,461

2022 Work RVU: 0.56
2022 NF PE RVU: 1.39
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 3,149

2022 Work RVU: 0.37
2022 NF PE RVU: 1.58
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 192,504

2022 Work RVU: 0.44
2022 NF PE RVU: 1.43
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56

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

Result: Maintain

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 **2020 Medicare Utilization:** 742,220

2022 Work RVU: 0.56
2022 NF PE RVU: 1.37
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56

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

Result: Decrease

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 **2020 Medicare Utilization:** 39,508

2022 Work RVU: 1.20
2022 NF PE RVU: 16.96
2022 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate.

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 26,633

2022 Work RVU: 1.00
2022 NF PE RVU: 11.80
2022 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate.

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

Result: Maintain

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 **2020 Medicare Utilization:** 45,239

2022 Work RVU: 0.26
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.38

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 **2020 Medicare Utilization:** 6,189

2022 Work RVU: 0.50
2022 NF PE RVU: 1.58
2022 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

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

2020 Medicare Utilization: 4,129

2022 Work RVU: 0.50
2022 NF PE RVU: 1.64
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

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

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

2020 Medicare Utilization: 1,315

2022 Work RVU: 0.76
2022 NF PE RVU: 2.54
2022 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

2020 Medicare Utilization: 98,149

2022 Work RVU: 0.00
2022 NF PE RVU: 1.98
2022 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

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

2020 Medicare Utilization: 1,818,730

2022 Work RVU: 0.00
2022 NF PE RVU: 0.64
2022 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:**

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

2020 Medicare Utilization: 37,046

2022 Work RVU: 0.74
2022 NF PE RVU: 0.26
2022 Fac PE RVU: 0.26

RUC Recommendation: 0.74

Referred to CPT

Result: Decrease

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

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

2020 Medicare Utilization: 36,578

2022 Work RVU: 1.20
2022 NF PE RVU: 0.54
2022 Fac PE RVU: 0.54

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

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 **2020 Medicare Utilization:** 217,514

2022 Work RVU: 1.70
2022 NF PE RVU: 0.65
2022 Fac PE RVU: 0.65

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

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

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 **2020 Medicare Utilization:** 171,012

2022 Work RVU: 0.08
2022 NF PE RVU: 0.35
2022 Fac PE RVU: NA

RUC Recommendation: 0.08 and new PE inputs **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 59,362

2022 Work RVU: 0.13
2022 NF PE RVU: 0.78
2022 Fac PE RVU: NA

RUC Recommendation: 0.13 and new PE inputs **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 772,276

2022 Work RVU: 0.22
2022 NF PE RVU: 0.98
2022 Fac PE RVU: NA

RUC Recommendation: 0.22 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

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 **2020 Medicare Utilization:** 14,541,874

2022 Work RVU: 0.75
2022 NF PE RVU: 1.31
2022 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 **2020 Medicare Utilization:** 891,815

2022 Work RVU: 1.59
2022 NF PE RVU: 6.73
2022 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 **2020 Medicare Utilization:** 135,905

2022 Work RVU: 2.80
2022 NF PE RVU: 9.87
2022 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 **2020 Medicare Utilization:** 1,147,300

2022 Work RVU: 0.54
2022 NF PE RVU: 2.75
2022 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 **2020 Medicare Utilization:** 1,182,080

2022 Work RVU: 0.24
2022 NF PE RVU: 2.12
2022 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 **2020 Medicare Utilization:** 24,592

2022 Work RVU: 0.45
2022 NF PE RVU: 2.43
2022 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:** **2020 Medicare Utilization:**

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

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:** **2020 Medicare Utilization:** 14,530

2022 Work RVU: 0.53
2022 NF PE RVU: 3.55
2022 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** June 2010 **Result:** Maintain

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

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 **2020 Medicare Utilization:** 151,719

2022 Work RVU: 1.63
2022 NF PE RVU: 1.11
2022 Fac PE RVU: 0.71

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

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

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 **2020 Medicare Utilization:** 32,600

2022 Work RVU: 1.83
2022 NF PE RVU: 1.44
2022 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Maintain

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

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 **2020 Medicare Utilization:** 11,119

2022 Work RVU: 2.85
2022 NF PE RVU: 1.62
2022 Fac PE RVU: 0.95

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 **2020 Medicare Utilization:** 24,272

2022 Work RVU: 0.67
2022 NF PE RVU: 0.97
2022 Fac PE RVU: 0.32

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 **2020 Medicare Utilization:** 375,991

2022 Work RVU: 1.19
2022 NF PE RVU: 1.77
2022 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 **2020 Medicare Utilization:** 138,570

2022 Work RVU: 0.59
2022 NF PE RVU: 0.98
2022 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 **2020 Medicare Utilization:** 62,352

2022 Work RVU: 1.20
2022 NF PE RVU: 1.50
2022 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 **2020 Medicare Utilization:** 29,657

2022 Work RVU: 0.73
2022 NF PE RVU: 0.90
2022 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 **2020 Medicare Utilization:** 2,978,970

2022 Work RVU: 0.56
2022 NF PE RVU: 2.02
2022 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 **2020 Medicare Utilization:** 1,882,442

2022 Work RVU: 0.70
2022 NF PE RVU: 2.24
2022 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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:** 126,400

2022 Work RVU: 0.77
2022 NF PE RVU: 4.21
2022 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 **2020 Medicare Utilization:** 54,989

2022 Work RVU: 0.74
2022 NF PE RVU: 3.74
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 15,300

2022 Work RVU: 1.51
2022 NF PE RVU: 11.76
2022 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 **2020 Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** Oct 2013 **Result:** Deleted from CPT

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

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 **2020 Medicare Utilization:** 235,065

2022 Work RVU: 0.59
2022 NF PE RVU: 2.86
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2014 **Result:** Decrease

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

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 **2020 Medicare Utilization:** 20,695

2022 Work RVU: 2.80
2022 NF PE RVU: 4.31
2022 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Decrease

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

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 **2020 Medicare Utilization:** 529,191

2022 Work RVU: 0.85
2022 NF PE RVU: 2.67
2022 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 **2020 Medicare Utilization:** 149,962

2022 Work RVU: 0.95
2022 NF PE RVU: 2.56
2022 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 **2020 Medicare Utilization:** 30,654

2022 Work RVU: 0.70
2022 NF PE RVU: 3.33
2022 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 **2020 Medicare Utilization:** 49,961

2022 Work RVU: 0.88
2022 NF PE RVU: 4.36
2022 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 **2020 Medicare Utilization:** 2,141

2022 Work RVU: 1.24
2022 NF PE RVU: 7.09
2022 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 **2020 Medicare Utilization:** 4,387

2022 Work RVU: 0.73
2022 NF PE RVU: 2.57
2022 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 **2020 Medicare Utilization:** 17,558

2022 Work RVU: 0.88
2022 NF PE RVU: 3.08
2022 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 **2020 Medicare Utilization:** 5,451

2022 Work RVU: 0.58
2022 NF PE RVU: 1.44
2022 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:** **2020 Medicare Utilization:** 125,957

2022 Work RVU: 0.93
2022 NF PE RVU: 8.64
2022 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 **2020 Medicare Utilization:** 137,903

2022 Work RVU: 1.40
2022 NF PE RVU: 10.46
2022 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

90460 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2020 Medicare Utilization:** 216

2022 Work RVU: 0.17
2022 NF PE RVU: 0.31
2022 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90461 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2020 Medicare Utilization:** 50

2022 Work RVU: 0.15
2022 NF PE RVU: 0.21
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

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

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 / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2020 Medicare Utilization:** 222,599

2022 Work RVU: 0.17

2022 NF PE RVU: 0.31

2022 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

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 / CMS Request – Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2020 Medicare Utilization:** 17,322

2022 Work RVU: 0.15
2022 NF PE RVU: 0.21
2022 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

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

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 / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2020 Medicare Utilization:** 1

2022 Work RVU: 0.17
2022 NF PE RVU: 0.31
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

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

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 / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2020 Medicare Utilization:**

2022 Work RVU: 0.15
2022 NF PE RVU: 0.21
2022 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 356,184

2022 Work RVU: 0.33
2022 NF PE RVU: 0.09
2022 Fac PE RVU: 0.04

RUC Recommendation: Refer to CPT Review in 3 years (Oct 2023). 0.33 **Referred to CPT** October 2020 **Result:** Increase

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 **2020 Medicare Utilization:** 706,157

2022 Work RVU: 3.84
2022 NF PE RVU: 1.21
2022 Fac PE RVU: 0.49

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase

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

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 **2020 Medicare Utilization:** 493,665

2022 Work RVU: 4.16
2022 NF PE RVU: 1.46
2022 Fac PE RVU: 0.75

RUC Recommendation: 3.25 **Referred to CPT** February 2012 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:**

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

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 **2020 Medicare Utilization:** 2,253,931

2022 Work RVU: 1.70
2022 NF PE RVU: 0.48
2022 Fac PE RVU: 0.22

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,363,088

2022 Work RVU: 1.50
2022 NF PE RVU: 0.49
2022 Fac PE RVU: 0.27

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **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 **2020 Medicare Utilization:** 4,442,413

2022 Work RVU: 2.24
2022 NF PE RVU: 0.64
2022 Fac PE RVU: 0.29

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Increase

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

90836 **Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)**

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 **2020 Medicare Utilization:** 483,506

2022 Work RVU: 1.90
2022 NF PE RVU: 0.62
2022 Fac PE RVU: 0.34

RUC Recommendation: 1.90 **Referred to CPT** February 2012 **Result:** Increase

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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 6,129,662

2022 Work RVU: 3.31
2022 NF PE RVU: 0.94
2022 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 **2020 Medicare Utilization:** 100,291

2022 Work RVU: 2.50
2022 NF PE RVU: 0.82
2022 Fac PE RVU: 0.47

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 25,447

2022 Work RVU: 3.13
2022 NF PE RVU: 0.92
2022 Fac PE RVU: 0.44

RUC Recommendation: 3.13 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 16,948

2022 Work RVU: 1.50
2022 NF PE RVU: 0.47
2022 Fac PE RVU: 0.25

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 **2020 Medicare Utilization:** 9,732

2022 Work RVU: 2.10
2022 NF PE RVU: 0.62
2022 Fac PE RVU: 0.31

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 **2020 Medicare Utilization:** 25,927

2022 Work RVU: 2.40
2022 NF PE RVU: 0.35
2022 Fac PE RVU: 0.33

RUC Recommendation: 2.40 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 147,608

2022 Work RVU: 2.50
2022 NF PE RVU: 0.35
2022 Fac PE RVU: 0.34

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

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 **2020 Medicare Utilization:** 458,068

2022 Work RVU: 0.59
2022 NF PE RVU: 0.18
2022 Fac PE RVU: 0.08

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.48
2022 NF PE RVU: 0.23
2022 Fac PE RVU: 0.19

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 195,379

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Review in 2 years (Oct 2023)

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 **2020 Medicare Utilization:** 96,127

2022 Work RVU: 2.50
2022 NF PE RVU: 2.52
2022 Fac PE RVU: 0.51

RUC Recommendation: 2.50

Referred to CPT **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 19,155

2022 Work RVU: 0.90
2022 NF PE RVU: 1.44
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 10,692

2022 Work RVU: 0.50
2022 NF PE RVU: 0.40
2022 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:**

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 **2020 Medicare Utilization:** 955,376

2022 Work RVU: 1.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.54

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 45,670

2022 Work RVU: 2.11
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.79

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 159,473

2022 Work RVU: 1.56
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.85

RUC Recommendation: 1.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

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

2020 Medicare Utilization: 13,348

2022 Work RVU: 2.52
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.93

RUC Recommendation: 2.52

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

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

2020 Medicare Utilization: 14

2022 Work RVU: 23.92
2022 NF PE RVU: 9.21
2022 Fac PE RVU: 9.21

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 5

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90953 **End-stage renal disease (esrd) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

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 **2020 Medicare Utilization:** 2

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **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 **2020 Medicare Utilization:** 580

2022 Work RVU: 20.86
2022 NF PE RVU: 7.62
2022 Fac PE RVU: 7.62

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 129

2022 Work RVU: 10.32
2022 NF PE RVU: 4.46
2022 Fac PE RVU: 4.46

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 94

2022 Work RVU: 6.64
2022 NF PE RVU: 3.16
2022 Fac PE RVU: 3.16

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 **2020 Medicare Utilization:** 1,717

2022 Work RVU: 15.46
2022 NF PE RVU: 6.35
2022 Fac PE RVU: 6.35

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

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 **2020 Medicare Utilization:** 455

2022 Work RVU: 9.87
2022 NF PE RVU: 4.35
2022 Fac PE RVU: 4.35

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 296

2022 Work RVU: 6.19
2022 NF PE RVU: 3.01
2022 Fac PE RVU: 3.01

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 **2020 Medicare Utilization:** 2,174,715

2022 Work RVU: 6.77
2022 NF PE RVU: 3.26
2022 Fac PE RVU: 3.26

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

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 **2020 Medicare Utilization:** 667,595

2022 Work RVU: 5.52
2022 NF PE RVU: 2.80
2022 Fac PE RVU: 2.80

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 198,834

2022 Work RVU: 3.57
2022 NF PE RVU: 2.16
2022 Fac PE RVU: 2.16

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 **2020 Medicare Utilization:** 189

2022 Work RVU: 12.09
2022 NF PE RVU: 5.06
2022 Fac PE RVU: 5.06

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

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 **2020 Medicare Utilization:** 960

2022 Work RVU: 10.25
2022 NF PE RVU: 4.47
2022 Fac PE RVU: 4.47

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,411

2022 Work RVU: 9.80
2022 NF PE RVU: 4.35
2022 Fac PE RVU: 4.35

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 **2020 Medicare Utilization:** 393,883

2022 Work RVU: 5.52
2022 NF PE RVU: 2.80
2022 Fac PE RVU: 2.80

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

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 **2020 Medicare Utilization:** 3,535

2022 Work RVU: 1.10
2022 NF PE RVU: 11.55
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 44,397

2022 Work RVU: 2.24
2022 NF PE RVU: 20.99
2022 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 **2020 Medicare Utilization:** 160

2022 Work RVU: 0.90
2022 NF PE RVU: 27.13
2022 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** **2020 Medicare Utilization:** 74

2022 Work RVU: 0.52
2022 NF PE RVU: 13.49
2022 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:** **2020 Medicare Utilization:** 45

2022 Work RVU: 0.66
2022 NF PE RVU: 13.99
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

92065 **Orthoptic training** **Global:** XXX **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2019 **2020 Medicare Utilization:** 21,846

2022 Work RVU: 0.37
2022 NF PE RVU: 1.16
2022 Fac PE RVU: NA

RUC Recommendation: 0.71 **Referred to CPT** February 2021 May 2020-Tab 37 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 67,895

2022 Work RVU: 0.30
2022 NF PE RVU: 0.65
2022 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 90,923

2022 Work RVU: 0.40
2022 NF PE RVU: 0.94
2022 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 2,336,097

2022 Work RVU: 0.50
2022 NF PE RVU: 1.32
2022 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

920XX

Global: **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

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 **2020 Medicare Utilization:** 22,903

2022 Work RVU: 0.61
2022 NF PE RVU: 1.87
2022 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 **2020 Medicare Utilization:** 2,297,798

2022 Work RVU: 0.40
2022 NF PE RVU: 0.66
2022 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 **2020 Medicare Utilization:** 6,490,708

2022 Work RVU: 0.45
2022 NF PE RVU: 0.72
2022 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 1,310,440

2022 Work RVU: 0.54
2022 NF PE RVU: 0.90
2022 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92140 **Provocative tests for glaucoma, with interpretation and report, without tonography**

Global: **Issue:** Glaucoma Provocative 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 410,263

2022 Work RVU: 0.40
2022 NF PE RVU: 0.30
2022 Fac PE RVU: 0.24

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 **2020 Medicare Utilization:** 670,751

2022 Work RVU: 0.26
2022 NF PE RVU: 0.19
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 327,141

2022 Work RVU: 0.75
2022 NF PE RVU: 2.92
2022 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 **2020 Medicare Utilization:** 8,502

2022 Work RVU: 0.80
2022 NF PE RVU: 4.82
2022 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 **2020 Medicare Utilization:** 31,617

2022 Work RVU: 0.95
2022 NF PE RVU: 6.38
2022 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 **2020 Medicare Utilization:** 2,952,367

2022 Work RVU: 0.40
2022 NF PE RVU: 0.67
2022 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 **2020 Medicare Utilization:** 1,420

2022 Work RVU: 0.81
2022 NF PE RVU: 2.36
2022 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: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2020 Medicare Utilization:** 72,856

2022 Work RVU: 0.69
2022 NF PE RVU: 3.01
2022 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: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2020 Medicare Utilization:** 5,242

2022 Work RVU: 0.61
2022 NF PE RVU: 1.92
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

92284 **Dark adaptation examination with interpretation and report**

Global: XXX **Issue:** Dark Adaption Eye Exam **Screen:** Harvard Valued - Utilization over 30,000-Part5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 20 **Specialty Developing Recommendation:** AAO, AOA (optometry), ASRS **First Identified:** October 2020 **2020 Medicare Utilization:** 28,131

2022 Work RVU: 0.24
2022 NF PE RVU: 1.43
2022 Fac PE RVU: NA

RUC Recommendation: 0.14. Review Technology **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 329,781

2022 Work RVU: 0.05
2022 NF PE RVU: 0.61
2022 Fac PE RVU: NA

RUC Recommendation: 0.05 and new PE inputs **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 88,824

2022 Work RVU: 0.40
2022 NF PE RVU: 0.73
2022 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: April 2021 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** **2020 Medicare Utilization:** 4,885

2022 Work RVU: 0.81
2022 NF PE RVU: 4.48
2022 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease
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 **2020 Medicare Utilization:** 193,751

2022 Work RVU: 0.18
2022 NF PE RVU: 0.67
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 324,893

2022 Work RVU: 1.30
2022 NF PE RVU: 0.91
2022 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:** **2020 Medicare Utilization:** 1,932

2022 Work RVU: 0.33
2022 NF PE RVU: 0.36
2022 Fac PE RVU: NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

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:** **2020 Medicare Utilization:** 202

2022 Work RVU: 2.24
2022 NF PE RVU: 1.59
2022 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:** **2020 Medicare Utilization:** 2,960

2022 Work RVU: 1.92
2022 NF PE RVU: 1.28
2022 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:** **2020 Medicare Utilization:** 19,046

2022 Work RVU: 3.84
2022 NF PE RVU: 2.73
2022 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:** **2020 Medicare Utilization:** 13,510

2022 Work RVU: 1.92
2022 NF PE RVU: 1.23
2022 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 **2020 Medicare Utilization:** 121,719

2022 Work RVU: 1.34
2022 NF PE RVU: 1.12
2022 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 **2020 Medicare Utilization:** 49,240

2022 Work RVU: 0.60
2022 NF PE RVU: 0.59
2022 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 **2020 Medicare Utilization:** 4,805

2022 Work RVU: 0.30
2022 NF PE RVU: 0.35
2022 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:** **2020 Medicare Utilization:** 63,471

2022 Work RVU: 1.50
2022 NF PE RVU: 1.72
2022 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 **2020 Medicare Utilization:** 10,417

2022 Work RVU: 0.40
2022 NF PE RVU: 0.33
2022 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 **2020 Medicare Utilization:** 14,257

2022 Work RVU: 0.48
2022 NF PE RVU: 0.36
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 2,100

2022 Work RVU: 0.27
2022 NF PE RVU: 0.24
2022 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 **2020 Medicare Utilization:** 3,176

2022 Work RVU: 0.25
2022 NF PE RVU: 0.23
2022 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 **2020 Medicare Utilization:** 30,767

2022 Work RVU: 0.29
2022 NF PE RVU: 3.38
2022 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 **2020 Medicare Utilization:** 18,829

2022 Work RVU: 0.00
2022 NF PE RVU: 0.31
2022 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 **2020 Medicare Utilization:** 34,199

2022 Work RVU: 0.67
2022 NF PE RVU: 0.74
2022 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 **2020 Medicare Utilization:** 3,573

2022 Work RVU: 0.87
2022 NF PE RVU: 0.99
2022 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:** **2020 Medicare Utilization:** 163,237

2022 Work RVU: 0.35
2022 NF PE RVU: 0.29
2022 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 **2020 Medicare Utilization:** 954,548

2022 Work RVU: 0.60
2022 NF PE RVU: 0.47
2022 Fac PE RVU: 0.31

RUC Recommendation: 0.60 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.17
2022 NF PE RVU: 0.10
2022 Fac PE RVU: 0.07

RUC Recommendation: 0.17 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 705,218

2022 Work RVU: 0.20
2022 NF PE RVU: 0.28
2022 Fac PE RVU: 0.10

RUC Recommendation: 0.20 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,217

2022 Work RVU: 0.29
2022 NF PE RVU: 0.15
2022 Fac PE RVU: 0.14

RUC Recommendation: 0.29 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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:** **2020 Medicare Utilization:** 27,717

2022 Work RVU: 0.55
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.28

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 8,218

2022 Work RVU: 1.00
2022 NF PE RVU: 2.35
2022 Fac PE RVU: NA

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

92585 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive**

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:** October 2017 **2020 Medicare Utilization:** 29,858

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

92586 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**

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 **2020 Medicare Utilization:** 1,476

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 39,376

2022 Work RVU: 0.35
2022 NF PE RVU: 0.28
2022 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:** **2020 Medicare Utilization:** 66,621

2022 Work RVU: 0.55
2022 NF PE RVU: 0.43
2022 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 **2020 Medicare Utilization:** 2,068

2022 Work RVU: 1.26
2022 NF PE RVU: 0.80
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU: 1.75
2022 NF PE RVU: 0.86
2022 Fac PE RVU: 0.68

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:** **2020 Medicare Utilization:**

2022 Work RVU: 1.40
2022 NF PE RVU: 0.90
2022 Fac PE RVU: 0.54

RUC Recommendation: 1.40 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 430

2022 Work RVU: 1.85
2022 NF PE RVU: 1.73
2022 Fac PE RVU: NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 222

2022 Work RVU: 0.70
2022 NF PE RVU: 0.71
2022 Fac PE RVU: NA

RUC Recommendation: 0.70 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

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:** **2020 Medicare Utilization:** 11,259

2022 Work RVU: 1.50
2022 NF PE RVU: 1.50
2022 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 **2020 Medicare Utilization:** 19,233

2022 Work RVU: 1.30
2022 NF PE RVU: 1.15
2022 Fac PE RVU: 0.69

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 **2020 Medicare Utilization:** 8,655

2022 Work RVU: 1.34
2022 NF PE RVU: 1.28
2022 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:** **2020 Medicare Utilization:**

2022 Work RVU: 0.65
2022 NF PE RVU: 0.26
2022 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 **2020 Medicare Utilization:** 773

2022 Work RVU: 1.50
2022 NF PE RVU: 1.11
2022 Fac PE RVU: 0.78

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 **2020 Medicare Utilization:** 10

2022 Work RVU: 0.35
2022 NF PE RVU: 0.29
2022 Fac PE RVU: 0.19

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 **2020 Medicare Utilization:** 7,029

2022 Work RVU: 1.15
2022 NF PE RVU: 0.82
2022 Fac PE RVU: 0.60

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 **2020 Medicare Utilization:** 17,801

2022 Work RVU: 1.40
2022 NF PE RVU: 1.15
2022 Fac PE RVU: 0.74

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 **2020 Medicare Utilization:** 4,603

2022 Work RVU: 0.33
2022 NF PE RVU: 0.27
2022 Fac PE RVU: 0.18

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 **2020 Medicare Utilization:** 12

2022 Work RVU: 1.76
2022 NF PE RVU: 1.45
2022 Fac PE RVU: 0.95

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:** 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.25
2022 NF PE RVU: 0.58
2022 Fac PE RVU: NA

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:** 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 **2020 Medicare Utilization:**

2022 Work RVU: 1.00
2022 NF PE RVU: 1.56
2022 Fac PE RVU: NA

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:** 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 **2020 Medicare Utilization:**

2022 Work RVU: 1.50
2022 NF PE RVU: 1.83
2022 Fac PE RVU: NA

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:** 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, AAN, AAO-HNS, ACNS, ASHA **First Identified:** February 2019 **2020 Medicare Utilization:**

2022 Work RVU: 1.05
2022 NF PE RVU: 1.42
2022 Fac PE RVU: NA

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 **2020 Medicare Utilization:** 20,223

2022 Work RVU: 9.85
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.43

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 2,004

2022 Work RVU: 11.74
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.08

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 206,070

2022 Work RVU: 10.96
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.81

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 17,056

2022 Work RVU: 12.29
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.26

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 5.50 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 15,072

2022 Work RVU: 10.95
2022 NF PE RVU: NA
2022 Fac PE RVU: 3.80

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 36,067

2022 Work RVU: 12.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.28

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 **2020 Medicare Utilization:** 7,498

2022 Work RVU: 12.31
2022 NF PE RVU: NA
2022 Fac PE RVU: 4.27

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 172,353

2022 Work RVU: 2.00
2022 NF PE RVU: 2.46
2022 Fac PE RVU: 1.02

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 **2020 Medicare Utilization:** 2,271

2022 Work RVU: 3.28
2022 NF PE RVU: NA
2022 Fac PE RVU: 1.15

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 2,239

2022 Work RVU: 22.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 11.06

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

92992 **Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)**

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:** October 2018 **2020 Medicare Utilization:** 65

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92993 **Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)**

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:** October 2018 **2020 Medicare Utilization:** 1

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 9,114,128

2022 Work RVU: 0.17
2022 NF PE RVU: 0.23
2022 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

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

2020 Medicare Utilization: 382,226

2022 Work RVU: 0.00
2022 NF PE RVU: 0.17
2022 Fac PE RVU: NA

RUC Recommendation: 0.00

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization: 15,897,234

2022 Work RVU: 0.17
2022 NF PE RVU: 0.06
2022 Fac PE RVU: 0.06

RUC Recommendation: 0.17

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 797,036

2022 Work RVU: 0.75
2022 NF PE RVU: 1.29
2022 Fac PE RVU: NA

RUC Recommendation: 0.75. CPT Assistant published. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

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 **2020 Medicare Utilization:** 782,311

2022 Work RVU: 0.45
2022 NF PE RVU: 0.16
2022 Fac PE RVU: 0.16

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

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 **2020 Medicare Utilization:** 77,084

2022 Work RVU: 0.00
2022 NF PE RVU: 1.02
2022 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 **2020 Medicare Utilization:** 939,343

2022 Work RVU: 0.30
2022 NF PE RVU: 0.11
2022 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 **2020 Medicare Utilization:** 154

2022 Work RVU: 0.75
2022 NF PE RVU: 2.77
2022 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 **2020 Medicare Utilization:** 78,637

2022 Work RVU: 0.15
2022 NF PE RVU: 0.20
2022 Fac PE RVU: NA

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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 **2020 Medicare Utilization:** 12,166

2022 Work RVU: 0.00
2022 NF PE RVU: 0.16
2022 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE only)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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 **2020 Medicare Utilization:** 294,197

2022 Work RVU: 0.15
2022 NF PE RVU: 0.04
2022 Fac PE RVU: 0.04

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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 **2020 Medicare Utilization:** 198,394

2022 Work RVU: 0.39
2022 NF PE RVU: 1.81
2022 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 **2020 Medicare Utilization:** 85,777

2022 Work RVU: 0.00
2022 NF PE RVU: 0.56
2022 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 **2020 Medicare Utilization:** 130,156

2022 Work RVU: 0.00
2022 NF PE RVU: 1.11
2022 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

2020 Medicare Utilization: 258,641

2022 Work RVU: 0.39
2022 NF PE RVU: 0.14
2022 Fac PE RVU: 0.14

RUC Recommendation: 0.52

Referred to CPT Feburary 2010

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization: 198,640

2022 Work RVU: 0.48
2022 NF PE RVU: 0.23
2022 Fac PE RVU: 0.23

RUC Recommendation: 0.52

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization: 281,682

2022 Work RVU: 0.00
2022 NF PE RVU: 26.25
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 10,346

2022 Work RVU: 0.52
2022 NF PE RVU: 4.91
2022 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 **2020 Medicare Utilization:** 33,495

2022 Work RVU: 0.00
2022 NF PE RVU: 0.24
2022 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 **2020 Medicare Utilization:** 45,016

2022 Work RVU: 0.00
2022 NF PE RVU: 4.49
2022 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 **2020 Medicare Utilization:** 92,987

2022 Work RVU: 0.52
2022 NF PE RVU: 0.18
2022 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 **2020 Medicare Utilization:** 107,697

2022 Work RVU: 0.65
2022 NF PE RVU: 1.37
2022 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 **2020 Medicare Utilization:** 732,353

2022 Work RVU: 0.77
2022 NF PE RVU: 1.61
2022 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 **2020 Medicare Utilization:** 60,251

2022 Work RVU: 0.85
2022 NF PE RVU: 1.67
2022 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 **2020 Medicare Utilization:** 79,726

2022 Work RVU: 0.85
2022 NF PE RVU: 1.55
2022 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 **2020 Medicare Utilization:** 155,222

2022 Work RVU: 1.15
2022 NF PE RVU: 1.78
2022 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 **2020 Medicare Utilization:** 184,356

2022 Work RVU: 1.25
2022 NF PE RVU: 1.91
2022 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 **2020 Medicare Utilization:** 31,578

2022 Work RVU: 0.52
2022 NF PE RVU: 1.30
2022 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 **2020 Medicare Utilization:** 20,521

2022 Work RVU: 0.30
2022 NF PE RVU: 1.10
2022 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 **2020 Medicare Utilization:** 11,501

2022 Work RVU: 0.45
2022 NF PE RVU: 1.16
2022 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 **2020 Medicare Utilization:** 179,035

2022 Work RVU: 0.43
2022 NF PE RVU: 1.27
2022 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 **2020 Medicare Utilization:** 71,124

2022 Work RVU: 0.75
2022 NF PE RVU: 1.41
2022 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 **2020 Medicare Utilization:** 81,381

2022 Work RVU: 0.43
2022 NF PE RVU: 1.19
2022 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 **2020 Medicare Utilization:** 51,779

2022 Work RVU: 0.37
2022 NF PE RVU: 1.13
2022 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 **2020 Medicare Utilization:** 1,054

2022 Work RVU: 0.43
2022 NF PE RVU: 1.08
2022 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 **2020 Medicare Utilization:** 32,414

2022 Work RVU: 0.31
2022 NF PE RVU: 1.08
2022 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 **2020 Medicare Utilization:** 1,454,135

2022 Work RVU: 0.60
2022 NF PE RVU: 0.24
2022 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

2020 Medicare Utilization: 722,096

2022 Work RVU: 0.74
2022 NF PE RVU: 0.30
2022 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

2020 Medicare Utilization: 1,556,454

2022 Work RVU: 0.00
2022 NF PE RVU: 0.68
2022 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

2020 Medicare Utilization: 436,620

2022 Work RVU: 0.52
2022 NF PE RVU: 0.21
2022 Fac PE RVU: 0.21

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 **2020 Medicare Utilization:** 884,510

2022 Work RVU: 0.52
2022 NF PE RVU: 0.21
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 6,273,165

2022 Work RVU: 1.46
2022 NF PE RVU: 4.39
2022 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 **2020 Medicare Utilization:** 23,577

2022 Work RVU: 0.92
2022 NF PE RVU: 3.17
2022 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 **2020 Medicare Utilization:** 437,576

2022 Work RVU: 0.53
2022 NF PE RVU: 2.38
2022 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 **2020 Medicare Utilization:** 289,973

2022 Work RVU: 0.38
2022 NF PE RVU: 1.13
2022 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

2020 Medicare Utilization: 232,010

2022 Work RVU: 0.15
2022 NF PE RVU: 0.60
2022 Fac PE RVU: NA

RUC Recommendation: 0.15

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

2020 Medicare Utilization: 522,631

2022 Work RVU: 0.07
2022 NF PE RVU: 0.64
2022 Fac PE RVU: NA

RUC Recommendation: 0.07

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

2020 Medicare Utilization: 69,260

2022 Work RVU: 1.46
2022 NF PE RVU: 4.09
2022 Fac PE RVU: NA

RUC Recommendation: 1.46; CPT Assistant article published

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 **2020 Medicare Utilization:** 174,967

2022 Work RVU: 1.75
2022 NF PE RVU: 5.12
2022 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:** **2020 Medicare Utilization:** 37,808

2022 Work RVU: 2.47
2022 NF PE RVU: 24.06
2022 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:** **2020 Medicare Utilization:** 2,869

2022 Work RVU: 4.50
2022 NF PE RVU: 22.56
2022 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:** **2020 Medicare Utilization:** 2,065

2022 Work RVU: 5.99
2022 NF PE RVU: 28.28
2022 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:** **2020 Medicare Utilization:** 99,930

2022 Work RVU: 4.54
2022 NF PE RVU: 22.55
2022 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:** **2020 Medicare Utilization:** 20,911

2022 Work RVU: 5.29
2022 NF PE RVU: 24.81
2022 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:** **2020 Medicare Utilization:** 17,270

2022 Work RVU: 5.90
2022 NF PE RVU: 27.76
2022 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:** **2020 Medicare Utilization:** 2,984

2022 Work RVU: 6.64
2022 NF PE RVU: 30.00
2022 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:** **2020 Medicare Utilization:** 407,727

2022 Work RVU: 5.60
2022 NF PE RVU: 25.40
2022 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:** **2020 Medicare Utilization:** 70,410

2022 Work RVU: 6.35
2022 NF PE RVU: 26.92
2022 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:** **2020 Medicare Utilization:** 74,971

2022 Work RVU: 7.10
2022 NF PE RVU: 29.86
2022 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:** **2020 Medicare Utilization:** 11,613

2022 Work RVU: 7.85
2022 NF PE RVU: 32.88
2022 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:** **2020 Medicare Utilization:** 6,201

2022 Work RVU: 3.73
2022 NF PE RVU: 1.57
2022 Fac PE RVU: 1.57

RUC Recommendation: 3.73 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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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:** **2020 Medicare Utilization:** 4,851

2022 Work RVU: 2.00
2022 NF PE RVU: 0.71
2022 Fac PE RVU: 0.71

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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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:** **2020 Medicare Utilization:** 1,108

2022 Work RVU: 1.80
2022 NF PE RVU: 4.75
2022 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 55,707

2022 Work RVU: 2.00

2022 NF PE RVU: NA

2022 Fac PE RVU: 0.39

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 4

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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 **2020 Medicare Utilization:** 10

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

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:** **2020 Medicare Utilization:** 127

2022 Work RVU: 1.11
2022 NF PE RVU: 0.40
2022 Fac PE RVU: 0.40

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:** **2020 Medicare Utilization:** 5

2022 Work RVU: 1.13
2022 NF PE RVU: 0.39
2022 Fac PE RVU: 0.39

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** Pulmonary Angiography **Screen:** Survey Below 30 Threshold **Complete?** No

Most Recent RUC Meeting: October 2021 **Tab:** 08 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2021 **2020 Medicare Utilization:** 5

2022 Work RVU: 1.13
2022 NF PE RVU: 0.39
2022 Fac PE RVU: 0.39

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
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:** **2020 Medicare Utilization:** 73

2022 Work RVU: 0.86
2022 NF PE RVU: 0.30
2022 Fac PE RVU: 0.30

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 236

2022 Work RVU: 0.86
2022 NF PE RVU: 2.85
2022 Fac PE RVU: 0.31

RUC Recommendation: 0.96 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (list separately in addition to code for primary procedure)**

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:** **2020 Medicare Utilization:** 21,505

2022 Work RVU: 0.97
2022 NF PE RVU: 2.10
2022 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:** **2020 Medicare Utilization:** 1,132

2022 Work RVU: 0.88
2022 NF PE RVU: 2.60
2022 Fac PE RVU: 0.32

RUC Recommendation: 0.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 62,062

2022 Work RVU: 0.00
2022 NF PE RVU: NA
2022 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 11,561

2022 Work RVU: 0.00
2022 NF PE RVU: NA
2022 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:** Cardiac Ablation Services Bundling **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2020 Medicare Utilization:** 73,995

2022 Work RVU: 5.23
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.25

RUC Recommendation: 5.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 7,030

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: 11.57 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93621 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2019 **2020 Medicare Utilization:** 24,799

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 34,636

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: Referral to CPT for parenthetical. 2.04 **Referred to CPT** May 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 10,622

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

93653 **Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; 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?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2020 Medicare Utilization:** 26,463

2022 Work RVU: 14.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 6.33

RUC Recommendation: 15.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93654 **Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2020 Medicare Utilization:** 6,998

2022 Work RVU: 19.75
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.44

RUC Recommendation: 18.10 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2020 Medicare Utilization:** 32,821

2022 Work RVU: 5.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.37

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and his bundle recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2020 Medicare Utilization:** 50,165

2022 Work RVU: 19.77
2022 NF PE RVU: NA
2022 Fac PE RVU: 8.51

RUC Recommendation: 17.00 **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?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2020 Medicare Utilization:** 23,509

2022 Work RVU: 5.50
2022 NF PE RVU: NA
2022 Fac PE RVU: 2.36

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2008 **2020 Medicare Utilization:** 60,838

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: 2.53 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,257

2022 Work RVU: 0.00
2022 NF PE RVU: 0.40
2022 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 **2020 Medicare Utilization:** 6,330

2022 Work RVU: 0.00
2022 NF PE RVU: 0.80
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 87,483

2022 Work RVU: 0.75
2022 NF PE RVU: 0.62
2022 Fac PE RVU: 0.31

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 2022 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: September 2016 **2020 Medicare Utilization:** 1,673

2022 Work RVU: 0.00
2022 NF PE RVU: 1.84
2022 Fac PE RVU: NA

RUC Recommendation: Review in 3 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 2022 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: September 2016 **2020 Medicare Utilization:** 1,710,558

2022 Work RVU: 0.18
2022 NF PE RVU: 0.14
2022 Fac PE RVU: NA

RUC Recommendation: Review in 3 years. 0.18

Referred to CPT September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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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Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,741,221

2022 Work RVU: 0.80
2022 NF PE RVU: 4.86
2022 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2010 **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 **2020 Medicare Utilization:** 26,394

2022 Work RVU: 0.50
2022 NF PE RVU: 3.17
2022 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 91,514

2022 Work RVU: 0.91
2022 NF PE RVU: 7.09
2022 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 8,867

2022 Work RVU: 0.50
2022 NF PE RVU: 4.26
2022 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 **2020 Medicare Utilization:** 49,307

2022 Work RVU: 1.00
2022 NF PE RVU: 7.17
2022 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 51,633

2022 Work RVU: 1.15
2022 NF PE RVU: 8.17
2022 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: NA

RUC Recommendation: Rescind April 2014 recommendation, contractor price. **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 575,223

2022 Work RVU: 0.25
2022 NF PE RVU: 2.15
2022 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 347,656

2022 Work RVU: 0.45
2022 NF PE RVU: 3.30
2022 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 **2020 Medicare Utilization:** 44,449

2022 Work RVU: 0.50
2022 NF PE RVU: 4.13
2022 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 **2020 Medicare Utilization:** 569,977

2022 Work RVU: 0.80
2022 NF PE RVU: 6.38
2022 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 **2020 Medicare Utilization:** 228,453

2022 Work RVU: 0.50
2022 NF PE RVU: 3.74
2022 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 **2020 Medicare Utilization:** 20,159

2022 Work RVU: 0.80
2022 NF PE RVU: 4.98
2022 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 **2020 Medicare Utilization:** 42,036

2022 Work RVU: 0.50
2022 NF PE RVU: 3.17
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,390,491

2022 Work RVU: 0.70
2022 NF PE RVU: 4.87
2022 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 **2020 Medicare Utilization:** 1,420,556

2022 Work RVU: 0.45
2022 NF PE RVU: 3.08
2022 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 190,604

2022 Work RVU: 1.16
2022 NF PE RVU: 6.71
2022 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

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 **2020 Medicare Utilization:** 144,445

2022 Work RVU: 0.80
2022 NF PE RVU: 3.89
2022 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

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

2020 Medicare Utilization: 240,410

2022 Work RVU: 0.80
2022 NF PE RVU: 4.51
2022 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

2020 Medicare Utilization: 56,070

2022 Work RVU: 0.50
2022 NF PE RVU: 2.96
2022 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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 20,345

2022 Work RVU: 0.80
2022 NF PE RVU: 6.60
2022 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 **2020 Medicare Utilization:** 8,253

2022 Work RVU: 0.50
2022 NF PE RVU: 3.89
2022 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 **2020 Medicare Utilization:** 119,874

2022 Work RVU: 0.50
2022 NF PE RVU: 3.83
2022 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 **2020 Medicare Utilization:** 732,785

2022 Work RVU: 0.17
2022 NF PE RVU: 0.60
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

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 **2020 Medicare Utilization:** 142

2022 Work RVU: 0.52
2022 NF PE RVU: 1.07
2022 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:**

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 **2020 Medicare Utilization:** 24

2022 Work RVU: 0.00
2022 NF PE RVU: 0.89
2022 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:**

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 **2020 Medicare Utilization:** 4,393

2022 Work RVU: 0.52
2022 NF PE RVU: 0.18
2022 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 **2020 Medicare Utilization:** 712,384

2022 Work RVU: 0.22
2022 NF PE RVU: 0.91
2022 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 **2020 Medicare Utilization:** 48,919

2022 Work RVU: 0.05
2022 NF PE RVU: 0.38
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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:**

94250 **Expired gas collection, quantitative, single procedure (separate procedure)**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2020 Medicare Utilization:** 14,545

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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: **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:** **2020 Medicare Utilization:** 1,104

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

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 **2020 Medicare Utilization:** 25

2022 Work RVU: 0.40
2022 NF PE RVU: 1.46
2022 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 **2020 Medicare Utilization:** 8,870

2022 Work RVU: 0.70
2022 NF PE RVU: 1.87
2022 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 **2020 Medicare Utilization:** 203,523

2022 Work RVU: 0.48
2022 NF PE RVU: 0.47
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 14,385

2022 Work RVU: 1.42
2022 NF PE RVU: 3.03
2022 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:** **2020 Medicare Utilization:** 234,550

2022 Work RVU: 0.00
2022 NF PE RVU: 0.32
2022 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 **2020 Medicare Utilization:** 2,593

2022 Work RVU: 0.00
2022 NF PE RVU: 0.65
2022 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:** **2020 Medicare Utilization:** 4,363

2022 Work RVU: 0.00
2022 NF PE RVU: 1.02
2022 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 **2020 Medicare Utilization:** 197

2022 Work RVU: 0.00
2022 NF PE RVU: 0.53
2022 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 **2020 Medicare Utilization:** 3,835

2022 Work RVU: 0.20
2022 NF PE RVU: 1.21
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 491,869

2022 Work RVU: 0.26
2022 NF PE RVU: 1.32
2022 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

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 **2020 Medicare Utilization:** 231,939

2022 Work RVU: 0.26
2022 NF PE RVU: 1.01
2022 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

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 **2020 Medicare Utilization:** 4,090

2022 Work RVU: 0.26
2022 NF PE RVU: 0.89
2022 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 **2020 Medicare Utilization:** 788,850

2022 Work RVU: 0.19
2022 NF PE RVU: 1.52
2022 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:** **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2020 Medicare Utilization:** 16,674

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:** 17,819

2022 Work RVU: 0.00
2022 NF PE RVU: 0.06
2022 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 **2020 Medicare Utilization:** 12,350

2022 Work RVU: 0.00
2022 NF PE RVU: 0.09
2022 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 **2020 Medicare Utilization:** 165,622

2022 Work RVU: 0.00
2022 NF PE RVU: 0.77
2022 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: **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 **2020 Medicare Utilization:** 2,651

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

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 **2020 Medicare Utilization:** 7,781,153

2022 Work RVU: 0.01
2022 NF PE RVU: 0.10
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 73,690

2022 Work RVU: 0.00
2022 NF PE RVU: 0.55
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 22,762

2022 Work RVU: 0.07
2022 NF PE RVU: 0.18
2022 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 **2020 Medicare Utilization:** 84,296

2022 Work RVU: 0.14
2022 NF PE RVU: 0.46
2022 Fac PE RVU: 0.06

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 **2020 Medicare Utilization:** 1,368,744

2022 Work RVU: 0.01
2022 NF PE RVU: 0.23
2022 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 **2020 Medicare Utilization:** 116,742

2022 Work RVU: 0.01
2022 NF PE RVU: 0.13
2022 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 **2020 Medicare Utilization:** 859,372

2022 Work RVU: 0.00
2022 NF PE RVU: 0.27
2022 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 **2020 Medicare Utilization:** 2,434,986

2022 Work RVU: 0.00
2022 NF PE RVU: 0.33
2022 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 **2020 Medicare Utilization:** 155,016

2022 Work RVU: 0.06
2022 NF PE RVU: 0.43
2022 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 **2020 Medicare Utilization:** 18,559

2022 Work RVU: 0.06
2022 NF PE RVU: 2.60
2022 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 **2020 Medicare Utilization:** 6,673,468

2022 Work RVU: 0.06
2022 NF PE RVU: 0.39
2022 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:** **2020 Medicare Utilization:** 10,344

2022 Work RVU: 0.00
2022 NF PE RVU: 1.69
2022 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

2020 Medicare Utilization: 48,697

2022 Work RVU: 0.00
2022 NF PE RVU: 4.34
2022 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

2020 Medicare Utilization: 296,345

2022 Work RVU: 0.70
2022 NF PE RVU: 0.28
2022 Fac PE RVU: 0.28

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

2020 Medicare Utilization: 13,701

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 1,248

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 217

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 83

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 8,127

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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

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 **2020 Medicare Utilization:** 1,361

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 146

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 356

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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

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 **2020 Medicare Utilization:** 744

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 1,555

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 6,404

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 14,730

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 2,549

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 3,137

2022 Work RVU: 2.00
2022 NF PE RVU: 0.85
2022 Fac PE RVU: 0.82

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 **2020 Medicare Utilization:** 29,737

2022 Work RVU: 2.50
2022 NF PE RVU: 1.28
2022 Fac PE RVU: 1.22

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 **2020 Medicare Utilization:** 5,966

2022 Work RVU: 3.00
2022 NF PE RVU: 1.39
2022 Fac PE RVU: 1.35

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 **2020 Medicare Utilization:** 123,778

2022 Work RVU: 3.86
2022 NF PE RVU: 1.96
2022 Fac PE RVU: 1.86

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 **2020 Medicare Utilization:** 2,378

2022 Work RVU: 3.86
2022 NF PE RVU: 1.97
2022 Fac PE RVU: 1.85

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 **2020 Medicare Utilization:** 2,167

2022 Work RVU: 4.70
2022 NF PE RVU: 2.39
2022 Fac PE RVU: 2.25

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 **2020 Medicare Utilization:** 2,904

2022 Work RVU: 4.75
2022 NF PE RVU: 2.40
2022 Fac PE RVU: 2.25

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 **2020 Medicare Utilization:** 4,668

2022 Work RVU: 6.00
2022 NF PE RVU: 3.02
2022 Fac PE RVU: 2.85

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 **2020 Medicare Utilization:** 181

2022 Work RVU: 5.40
2022 NF PE RVU: 2.82
2022 Fac PE RVU: 2.63

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 **2020 Medicare Utilization:** 583

2022 Work RVU: 7.58
2022 NF PE RVU: 3.85
2022 Fac PE RVU: 3.63

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 **2020 Medicare Utilization:** 26,905

2022 Work RVU: 0.85
2022 NF PE RVU: 3.84
2022 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 **2020 Medicare Utilization:** 273

2022 Work RVU: 0.85
2022 NF PE RVU: 1.78
2022 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 **2020 Medicare Utilization:** 192

2022 Work RVU: 0.90
2022 NF PE RVU: 3.40
2022 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 **2020 Medicare Utilization:** 1,976

2022 Work RVU: 1.20
2022 NF PE RVU: 11.00
2022 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 **2020 Medicare Utilization:** 78,847

2022 Work RVU: 0.93
2022 NF PE RVU: 1.71
2022 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 **2020 Medicare Utilization:** 1,584

2022 Work RVU: 1.28
2022 NF PE RVU: 9.79
2022 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 **2020 Medicare Utilization:** 537

2022 Work RVU: 1.74
2022 NF PE RVU: 17.89
2022 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 **2020 Medicare Utilization:** 172,583

2022 Work RVU: 2.50
2022 NF PE RVU: 15.27
2022 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 **2020 Medicare Utilization:** 187,980

2022 Work RVU: 2.60
2022 NF PE RVU: 15.95
2022 Fac PE RVU: NA

RUC Recommendation: 2.60 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 19,920

2022 Work RVU: 1.08
2022 NF PE RVU: 9.11
2022 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

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 **2020 Medicare Utilization:** 20,770

2022 Work RVU: 1.63
2022 NF PE RVU: 10.96
2022 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 **2020 Medicare Utilization:** 227,325

2022 Work RVU: 1.08
2022 NF PE RVU: 10.17
2022 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 **2020 Medicare Utilization:** 162,443

2022 Work RVU: 1.08
2022 NF PE RVU: 12.13
2022 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 23,964

2022 Work RVU: 1.08
2022 NF PE RVU: 11.19
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 1,867

2022 Work RVU: 0.96
2022 NF PE RVU: 2.38
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 44,130

2022 Work RVU: 1.54
2022 NF PE RVU: 3.27
2022 Fac PE RVU: NA

RUC Recommendation: 1.54 **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **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 **2020 Medicare Utilization:** 106

2022 Work RVU: 1.87
2022 NF PE RVU: 4.44
2022 Fac PE RVU: NA

RUC Recommendation: 1.87 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **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 **2020 Medicare Utilization:** 2,015

2022 Work RVU: 1.99
2022 NF PE RVU: 5.05
2022 Fac PE RVU: NA

RUC Recommendation: 1.99 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** **2020 Medicare Utilization:** 1,124

2022 Work RVU: 0.79
2022 NF PE RVU: 2.39
2022 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 3,767

2022 Work RVU: 1.18
2022 NF PE RVU: 3.04
2022 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 564

2022 Work RVU: 0.37
2022 NF PE RVU: 2.57
2022 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 52,768

2022 Work RVU: 0.37
2022 NF PE RVU: 2.17
2022 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 113,196

2022 Work RVU: 0.35
2022 NF PE RVU: 1.56
2022 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 **2020 Medicare Utilization:** 784,971

2022 Work RVU: 0.86
2022 NF PE RVU: 2.08
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (list separately in addition to code for primary procedure)**

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 **2020 Medicare Utilization:** 13,124

2022 Work RVU: 0.71
2022 NF PE RVU: 1.82
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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:** **2020 Medicare Utilization:** 4,952

2022 Work RVU: 1.00
2022 NF PE RVU: 1.67
2022 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:** **2020 Medicare Utilization:** 44,418

2022 Work RVU: 1.25
2022 NF PE RVU: 2.08
2022 Fac PE RVU: NA

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** **2020 Medicare Utilization:** 104,301

2022 Work RVU: 1.50
2022 NF PE RVU: 2.49
2022 Fac PE RVU: NA

RUC Recommendation: 1.77 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 123,612

2022 Work RVU: 2.00
2022 NF PE RVU: 3.22
2022 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:** **2020 Medicare Utilization:** 143,752

2022 Work RVU: 2.50
2022 NF PE RVU: 3.79
2022 Fac PE RVU: NA

RUC Recommendation: 3.34 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** **2020 Medicare Utilization:** 63,156

2022 Work RVU: 3.00
2022 NF PE RVU: 4.32
2022 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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:** **2020 Medicare Utilization:** 69,761

2022 Work RVU: 3.56
2022 NF PE RVU: 4.90
2022 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 **2020 Medicare Utilization:** 42,319

2022 Work RVU: 0.90
2022 NF PE RVU: 1.69
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,937

2022 Work RVU: 0.96
2022 NF PE RVU: 1.99
2022 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

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 **2020 Medicare Utilization:** 88,442

2022 Work RVU: 0.90
2022 NF PE RVU: 2.80
2022 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:** **2020 Medicare Utilization:** 15,254

2022 Work RVU: 1.73
2022 NF PE RVU: 2.62
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 4,511

2022 Work RVU: 0.54
2022 NF PE RVU: 4.87
2022 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 3,888

2022 Work RVU: 0.54
2022 NF PE RVU: 4.15
2022 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 306

2022 Work RVU: 1.50
2022 NF PE RVU: 5.45
2022 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,340

2022 Work RVU: 1.50
2022 NF PE RVU: 5.66
2022 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 **2020 Medicare Utilization:** 38,305

2022 Work RVU: 0.35
2022 NF PE RVU: 1.57
2022 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** May 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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:** **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 90,197

2022 Work RVU: 0.86
2022 NF PE RVU: 9.84
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 42,469

2022 Work RVU: 2.25
2022 NF PE RVU: 13.89
2022 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:**

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 **2020 Medicare Utilization:** 25,219

2022 Work RVU: 0.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.31

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 15,809

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 449

2022 Work RVU: 2.45
2022 NF PE RVU: 9.40
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 32,186

2022 Work RVU: 1.98
2022 NF PE RVU: 5.61
2022 Fac PE RVU: NA

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 25,427

2022 Work RVU: 0.35
2022 NF PE RVU: 0.17
2022 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 **2020 Medicare Utilization:** 15,859

2022 Work RVU: 0.78
2022 NF PE RVU: 0.58
2022 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 **2020 Medicare Utilization:** 36,946

2022 Work RVU: 0.80
2022 NF PE RVU: 0.76
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 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 **2020 Medicare Utilization:** 6,654

2022 Work RVU: 0.73
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.36

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 **2020 Medicare Utilization:** 5,033

2022 Work RVU: 0.97
2022 NF PE RVU: 0.50
2022 Fac PE RVU: 0.47

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 431

2022 Work RVU: 0.80
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.35

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 562

2022 Work RVU: 0.30
2022 NF PE RVU: 0.78
2022 Fac PE RVU: 0.17

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

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 **2020 Medicare Utilization:** 1,011

2022 Work RVU: 0.65
2022 NF PE RVU: 0.97
2022 Fac PE RVU: 0.31

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 **2020 Medicare Utilization:** 32,970

2022 Work RVU: 0.91
2022 NF PE RVU: 0.49
2022 Fac PE RVU: 0.46

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 **2020 Medicare Utilization:** 45,873

2022 Work RVU: 0.80
2022 NF PE RVU: 0.42
2022 Fac PE RVU: 0.40

RUC Recommendation: 1.00 and Refer to CPT Assistant **Referred to CPT** June 2017 **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 **2020 Medicare Utilization:** 947

2022 Work RVU: 0.00
2022 NF PE RVU: 2.65
2022 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 7,441

2022 Work RVU: 0.77
2022 NF PE RVU: 2.40
2022 Fac PE RVU: 0.32

RUC Recommendation: 0.77 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95992 **Canalith repositioning procedure(s) (eg, epley maneuver, semont maneuver), per day**

Global: XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2020 Medicare Utilization:** 96,107

2022 Work RVU: 0.75
2022 NF PE RVU: 0.49
2022 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 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,402

2022 Work RVU: 1.75
2022 NF PE RVU: 1.04
2022 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96110 **Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument**

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:** January 2017 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.30
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,685

2022 Work RVU: 2.56
2022 NF PE RVU: 1.05
2022 Fac PE RVU: 1.01

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 448

2022 Work RVU: 1.16
2022 NF PE RVU: 0.53
2022 Fac PE RVU: 0.42

RUC Recommendation: 1.10 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 129,367

2022 Work RVU: 1.86
2022 NF PE RVU: 0.82
2022 Fac PE RVU: 0.44

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

96120 **Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 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 **2020 Medicare Utilization:** 39,411

2022 Work RVU: 1.71
2022 NF PE RVU: 0.52
2022 Fac PE RVU: 0.28

RUC Recommendation: 1.71 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 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:** January 2016 **2020 Medicare Utilization:** 3,828

2022 Work RVU: 1.70
2022 NF PE RVU: 1.27
2022 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 436,595

2022 Work RVU: 0.00
2022 NF PE RVU: 0.13
2022 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 **2020 Medicare Utilization:** 98,966

2022 Work RVU: 2.56
2022 NF PE RVU: 0.84
2022 Fac PE RVU: 0.49

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 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 **2020 Medicare Utilization:** 64,986

2022 Work RVU: 1.96
2022 NF PE RVU: 0.56
2022 Fac PE RVU: 0.27

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 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 **2020 Medicare Utilization:** 174,666

2022 Work RVU: 2.56
2022 NF PE RVU: 1.16
2022 Fac PE RVU: 0.42

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 286,541

2022 Work RVU: 1.96
2022 NF PE RVU: 0.93
2022 Fac PE RVU: 0.26

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 **2020 Medicare Utilization:** 158,948

2022 Work RVU: 0.55
2022 NF PE RVU: 0.71
2022 Fac PE RVU: 0.11

RUC Recommendation: 0.55 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 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 **2020 Medicare Utilization:** 300,973

2022 Work RVU: 0.46
2022 NF PE RVU: 0.69
2022 Fac PE RVU: 0.06

RUC Recommendation: 0.46 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 175,273

2022 Work RVU: 0.00
2022 NF PE RVU: 1.01
2022 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 **2020 Medicare Utilization:** 302,550

2022 Work RVU: 0.00
2022 NF PE RVU: 1.03
2022 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

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 **2020 Medicare Utilization:** 13,403

2022 Work RVU: 0.00
2022 NF PE RVU: 0.05
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 **2020 Medicare Utilization:** 25,244

2022 Work RVU: 2.10
2022 NF PE RVU: 0.63
2022 Fac PE RVU: 0.32

RUC Recommendation: 2.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 36,724

2022 Work RVU: 1.45
2022 NF PE RVU: 0.42
2022 Fac PE RVU: 0.20

RUC Recommendation: 1.45 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 34,164

2022 Work RVU: 0.50
2022 NF PE RVU: 0.14
2022 Fac PE RVU: 0.06

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 11,810

2022 Work RVU: 0.21
2022 NF PE RVU: 0.07
2022 Fac PE RVU: 0.04

RUC Recommendation: 0.21 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 29,356

2022 Work RVU: 0.10
2022 NF PE RVU: 0.03
2022 Fac PE RVU: 0.02

RUC Recommendation: 0.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,487

2022 Work RVU: 1.55
2022 NF PE RVU: 0.44
2022 Fac PE RVU: 0.21

RUC Recommendation: 1.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,433

2022 Work RVU: 0.55
2022 NF PE RVU: 0.16
2022 Fac PE RVU: 0.07

RUC Recommendation: 0.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 1.50
2022 NF PE RVU: 0.71
2022 Fac PE RVU: 0.58

RUC Recommendation: 1.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96171 **Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.54
2022 NF PE RVU: 0.26
2022 Fac PE RVU: 0.21

RUC Recommendation: 0.54 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 211,384

2022 Work RVU: 0.17
2022 NF PE RVU: 0.82
2022 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 **2020 Medicare Utilization:** 367,462

2022 Work RVU: 0.09
2022 NF PE RVU: 0.28
2022 Fac PE RVU: NA

RUC Recommendation: 0.09 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,196,817

2022 Work RVU: 0.21
2022 NF PE RVU: 1.75
2022 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 549,123

2022 Work RVU: 0.18
2022 NF PE RVU: 0.43
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,231,930

2022 Work RVU: 0.19
2022 NF PE RVU: 0.68
2022 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 132,910

2022 Work RVU: 0.17
2022 NF PE RVU: 0.42
2022 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 7,679,555

2022 Work RVU: 0.17
2022 NF PE RVU: 0.24
2022 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 **2020 Medicare Utilization:** 231,198

2022 Work RVU: 0.18
2022 NF PE RVU: 0.96
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 1,377,521

2022 Work RVU: 0.10
2022 NF PE RVU: 0.36
2022 Fac PE RVU: NA

RUC Recommendation: 0.10 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 62,528

2022 Work RVU: 0.17
2022 NF PE RVU: 0.38
2022 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 **2020 Medicare Utilization:** 750,708

2022 Work RVU: 0.21
2022 NF PE RVU: 1.99
2022 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 394,519

2022 Work RVU: 0.19
2022 NF PE RVU: 0.77
2022 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 13,682

2022 Work RVU: 0.52
2022 NF PE RVU: 1.95
2022 Fac PE RVU: 0.28

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 **2020 Medicare Utilization:** 608

2022 Work RVU: 0.80
2022 NF PE RVU: 3.10
2022 Fac PE RVU: 0.44

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 **2020 Medicare Utilization:** 65,537

2022 Work RVU: 0.24
2022 NF PE RVU: 2.80
2022 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 149,102

2022 Work RVU: 0.20
2022 NF PE RVU: 1.46
2022 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 1,833,479

2022 Work RVU: 0.28
2022 NF PE RVU: 3.68
2022 Fac PE RVU: NA

RUC Recommendation: 0.28 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 844,948

2022 Work RVU: 0.19
2022 NF PE RVU: 0.65
2022 Fac PE RVU: NA

RUC Recommendation: 0.19 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

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 **2020 Medicare Utilization:** 26,235

2022 Work RVU: 0.21
2022 NF PE RVU: 3.68
2022 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 371,277

2022 Work RVU: 0.21
2022 NF PE RVU: 1.72
2022 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 **2020 Medicare Utilization:** 29

2022 Work RVU: 2.12
2022 NF PE RVU: 21.03
2022 Fac PE RVU: 1.65

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

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 **2020 Medicare Utilization:** 45,056

2022 Work RVU: 0.00
2022 NF PE RVU: 4.28
2022 Fac PE RVU: NA

RUC Recommendation: 0.00 PE Only

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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 **2020 Medicare Utilization:** 30,156

2022 Work RVU: 0.48
2022 NF PE RVU: 6.47
2022 Fac PE RVU: NA

RUC Recommendation: 0.48

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

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 **2020 Medicare Utilization:** 42,444

2022 Work RVU: 1.01
2022 NF PE RVU: 7.46
2022 Fac PE RVU: NA

RUC Recommendation: 1.01

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 284,327

2022 Work RVU: 0.00
2022 NF PE RVU: 3.48
2022 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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?** No

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2020 Medicare Utilization:** 79,671

2022 Work RVU: 1.15
2022 NF PE RVU: 3.47
2022 Fac PE RVU: 0.66

RUC Recommendation: Survey. 1.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

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?** No

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2020 Medicare Utilization:** 21,553

2022 Work RVU: 1.30
2022 NF PE RVU: 3.75
2022 Fac PE RVU: 0.74

RUC Recommendation: Survey 1.30 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Status Report: CMS Requests and Relativity Assessment Issues

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?** No

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2020 Medicare Utilization:** 11,568

2022 Work RVU: 2.10
2022 NF PE RVU: 4.75
2022 Fac PE RVU: 1.19

RUC Recommendation: Survey 2.10 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96X70 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** AACAP, AND, APA (psychology) **First Identified:** April 2021 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

96X71 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** April 2021 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU:

2022 NF PE RVU:

2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.06
2022 NF PE RVU: 0.11
2022 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 **2020 Medicare Utilization:** 417,188

2022 Work RVU: 0.25
2022 NF PE RVU: 0.16
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.18
2022 NF PE RVU: 0.18
2022 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 **2020 Medicare Utilization:** 804,443

2022 Work RVU: 0.18
2022 NF PE RVU: 0.16
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 122,539

2022 Work RVU: 0.06
2022 NF PE RVU: 0.10
2022 Fac PE RVU: NA

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 127,796

2022 Work RVU: 0.17
2022 NF PE RVU: 0.33
2022 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

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 **2020 Medicare Utilization:** 687,061

2022 Work RVU: 0.25
2022 NF PE RVU: 0.17
2022 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 **2020 Medicare Utilization:** 39,200

2022 Work RVU: 0.26
2022 NF PE RVU: 0.31
2022 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 **2020 Medicare Utilization:** 6,669

2022 Work RVU: 0.21
2022 NF PE RVU: 0.21
2022 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 **2020 Medicare Utilization:** 1,417,772

2022 Work RVU: 0.21
2022 NF PE RVU: 0.20
2022 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **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 **2020 Medicare Utilization:** 48,673,226

2022 Work RVU: 0.45
2022 NF PE RVU: 0.40
2022 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **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 **2020 Medicare Utilization:** 16,195,152

2022 Work RVU: 0.50
2022 NF PE RVU: 0.49
2022 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **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 **2020 Medicare Utilization:** 1,219,859

2022 Work RVU: 0.48
2022 NF PE RVU: 0.59
2022 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 **2020 Medicare Utilization:** 2,665,806

2022 Work RVU: 0.45
2022 NF PE RVU: 0.40
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

2020 Medicare Utilization: 22,945,736

2022 Work RVU: 0.43
2022 NF PE RVU: 0.35
2022 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

2020 Medicare Utilization: 999,305

2022 Work RVU: 0.29
2022 NF PE RVU: 0.22
2022 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

2020 Medicare Utilization: 1,188,088

2022 Work RVU: 1.54
2022 NF PE RVU: 1.35
2022 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 **2020 Medicare Utilization:** 1,052,427

2022 Work RVU: 1.54
2022 NF PE RVU: 1.35
2022 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 **2020 Medicare Utilization:** 234,585

2022 Work RVU: 1.54
2022 NF PE RVU: 1.35
2022 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 **2020 Medicare Utilization:** 443,064

2022 Work RVU: 0.96
2022 NF PE RVU: 1.04
2022 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 **2020 Medicare Utilization:** 124,556

2022 Work RVU: 1.54
2022 NF PE RVU: 1.37
2022 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 **2020 Medicare Utilization:** 92,211

2022 Work RVU: 1.54
2022 NF PE RVU: 1.37
2022 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 **2020 Medicare Utilization:** 19,455

2022 Work RVU: 1.54
2022 NF PE RVU: 1.37
2022 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 **2020 Medicare Utilization:** 28,565

2022 Work RVU: 0.96
2022 NF PE RVU: 1.05
2022 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 **2020 Medicare Utilization:** 17,002,856

2022 Work RVU: 0.44
2022 NF PE RVU: 0.64
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 35,300

2022 Work RVU: 0.48
2022 NF PE RVU: 1.41
2022 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 **2020 Medicare Utilization:** 2,035,438

2022 Work RVU: 0.45
2022 NF PE RVU: 0.50
2022 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 **2020 Medicare Utilization:** 15,016

2022 Work RVU: 0.48
2022 NF PE RVU: 0.44
2022 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 **2020 Medicare Utilization:** 63,616

2022 Work RVU: 0.48
2022 NF PE RVU: 0.44
2022 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 **2020 Medicare Utilization:** 768,106

2022 Work RVU: 0.77
2022 NF PE RVU: 2.19
2022 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 **2020 Medicare Utilization:** 148,930

2022 Work RVU: 0.50
2022 NF PE RVU: 0.78
2022 Fac PE RVU: 0.17

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 48,547

2022 Work RVU: 0.55
2022 NF PE RVU: 0.68
2022 Fac PE RVU: 0.16

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 **2020 Medicare Utilization:** 17,066

2022 Work RVU: 0.60
2022 NF PE RVU: 0.86
2022 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 **2020 Medicare Utilization:** 6,061

2022 Work RVU: 0.41
2022 NF PE RVU: 10.98
2022 Fac PE RVU: 0.17

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 **2020 Medicare Utilization:** 1,379

2022 Work RVU: 0.46
2022 NF PE RVU: 10.77
2022 Fac PE RVU: 0.19

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 **2020 Medicare Utilization:** 16,743

2022 Work RVU: 0.40
2022 NF PE RVU: 13.14
2022 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 **2020 Medicare Utilization:** 2,577

2022 Work RVU: 0.62
2022 NF PE RVU: 0.48
2022 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 **2020 Medicare Utilization:** 47,325

2022 Work RVU: 0.50
2022 NF PE RVU: 0.92
2022 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 **2020 Medicare Utilization:** 3,036

2022 Work RVU: 0.50
2022 NF PE RVU: 0.71
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 30,959

2022 Work RVU: 0.48
2022 NF PE RVU: 1.10
2022 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 **2020 Medicare Utilization:** 173,453

2022 Work RVU: 0.53
2022 NF PE RVU: 0.53
2022 Fac PE RVU: 0.40

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 **2020 Medicare Utilization:** 179,999

2022 Work RVU: 0.45
2022 NF PE RVU: 0.47
2022 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 **2020 Medicare Utilization:** 42,085

2022 Work RVU: 0.46
2022 NF PE RVU: 0.43
2022 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 **2020 Medicare Utilization:** 78,183

2022 Work RVU: 0.71
2022 NF PE RVU: 0.56
2022 Fac PE RVU: 0.28

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 **2020 Medicare Utilization:** 69,362

2022 Work RVU: 0.96
2022 NF PE RVU: 0.70
2022 Fac PE RVU: 0.35

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 **2020 Medicare Utilization:** 75,202

2022 Work RVU: 1.21
2022 NF PE RVU: 0.82
2022 Fac PE RVU: 0.44

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 **2020 Medicare Utilization:** 62,738

2022 Work RVU: 1.46
2022 NF PE RVU: 0.94
2022 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 **2020 Medicare Utilization:** 4,333,649

2022 Work RVU: 0.46
2022 NF PE RVU: 0.34
2022 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 **2020 Medicare Utilization:** 11,589,611

2022 Work RVU: 0.71
2022 NF PE RVU: 0.44
2022 Fac PE RVU: 0.27

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 **2020 Medicare Utilization:** 837,075

2022 Work RVU: 0.96
2022 NF PE RVU: 0.54
2022 Fac PE RVU: 0.36

RUC Recommendation: 0.96 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.46
2022 NF PE RVU: 0.28
2022 Fac PE RVU: 0.18

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** **2022 Work RVU:** **2022 NF PE RVU:** **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 11

2022 Work RVU: 0.50
2022 NF PE RVU: 1.52
2022 Fac PE RVU: 0.19

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99152 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older**

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 **2020 Medicare Utilization:** 1,657,403

2022 Work RVU: 0.25
2022 NF PE RVU: 1.22
2022 Fac PE RVU: 0.08

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 21

2022 Work RVU: 1.90
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.32

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99156 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older**

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 **2020 Medicare Utilization:** 7,350

2022 Work RVU: 1.65
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.40

RUC Recommendation: 1.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.16
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.13
2022 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99183 **Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session**

Global: XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACEP, ACP, ACS, APMA **First Identified:** April 2013 **2020 Medicare Utilization:** 325,694

2022 Work RVU: 2.11
2022 NF PE RVU: 0.78
2022 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 51,623

2022 Work RVU: 0.48
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.11

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 283,817

2022 Work RVU: 0.93
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.21

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 1,984,076

2022 Work RVU: 1.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.33

RUC Recommendation: 1.42 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 4,006,675

2022 Work RVU: 2.74
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.54

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

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 **2020 Medicare Utilization:** 9,263,820

2022 Work RVU: 4.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.75

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 - Without Direct Patient Contact **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 14 **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2019 **2020 Medicare Utilization:** 344,177

2022 Work RVU: 2.10
2022 NF PE RVU: 0.96
2022 Fac PE RVU: 0.96

RUC Recommendation: 1.80 **Referred to CPT** February 2021 **Result:** Decrease

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 - Without Direct Patient Contact **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 14 **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2019 **2020 Medicare Utilization:** 14,025

2022 Work RVU: 1.00
2022 NF PE RVU: 0.47
2022 Fac PE RVU: 0.47

RUC Recommendation: 0.75 **Referred to CPT** February 2021 **Result:** Decrease
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 1.73
2022 NF PE RVU: 1.14
2022 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 **2020 Medicare Utilization:**

2022 Work RVU: 1.73
2022 NF PE RVU: 1.14
2022 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

993X0

Global: **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** February 2021 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: 0.81 **Referred to CPT** February 2021 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

99415 **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient evaluation and management service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2020 Medicare Utilization:** 4,525

2022 Work RVU: 0.00
2022 NF PE RVU: 0.29
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** February 2022 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99416 **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (list separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2020 Medicare Utilization:** 2,214

2022 Work RVU: 0.00
2022 NF PE RVU: 0.17
2022 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** February 2022 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99417 **Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (list separately in addition to codes 99205, 99215 for office or other outpatient evaluation and management services)**

Global: XXX **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 15 **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2021 **2020 Medicare Utilization:**

2022 Work RVU: 0.61
2022 NF PE RVU: 0.27
2022 Fac PE RVU: 0.24

RUC Recommendation: 0.61 **Referred to CPT** February 2021 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99491 **Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.**

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 **2020 Medicare Utilization:** 136,555

2022 Work RVU: 1.50
2022 NF PE RVU: 0.89
2022 Fac PE RVU: 0.64

RUC Recommendation: 1.45. Refer to CPT Assistant **Referred to CPT** **Result:** Not part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2018

Status Report: CMS Requests and Relativity Assessment Issues

99492 **Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2020 Medicare Utilization:** 6,958

2022 Work RVU: 1.88
2022 NF PE RVU: 2.45
2022 Fac PE RVU: 0.73

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 23,187

2022 Work RVU: 2.05
2022 NF PE RVU: 2.13
2022 Fac PE RVU: 0.82

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 **2020 Medicare Utilization:** 13,820

2022 Work RVU: 0.82
2022 NF PE RVU: 0.97
2022 Fac PE RVU: 0.35

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

99495 **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.**

Global: XXX **Issue:** Transitional Care Management Services **Screen:** Codes Increased by CMS Independent of RUC Review **Complete?** No

Most Recent RUC Meeting: April 2022 **Tab:** **Specialty Developing Recommendation:** AGS, ANA **First Identified:** October 2021 **2020 Medicare Utilization:** 592,370

2022 Work RVU: 2.78
2022 NF PE RVU: 3.07
2022 Fac PE RVU: 1.21

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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**

Global: XXX **Issue:** Transitional Care Management Services **Screen:** Codes Increased by CMS Independent of RUC Review **Complete?** No

Most Recent RUC Meeting: April 2022 **Tab:** **Specialty Developing Recommendation:** AGS, ANA **First Identified:** October 2021 **2020 Medicare Utilization:** 593,324

2022 Work RVU: 3.79
2022 NF PE RVU: 4.11
2022 Fac PE RVU: 1.63

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2020 Medicare Utilization:** 1,918,106

2022 Work RVU: 1.50
2022 NF PE RVU: 0.87
2022 Fac PE RVU: 0.65

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

Status Report: CMS Requests and Relativity Assessment Issues

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: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2020 Medicare Utilization:** 56,902

2022 Work RVU: 1.40
2022 NF PE RVU: 0.65
2022 Fac PE RVU: 0.63

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

G0008 **Administration of influenza virus vaccine**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0009 **Administration of pneumococcal vaccine**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

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

G0010 **Administration of hepatitis b vaccine** **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2020 Medicare Utilization:**

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 728,456

2022 Work RVU: 0.45
2022 NF PE RVU: 0.63
2022 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:**

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 **2020 Medicare Utilization:** 29,742

2022 Work RVU: 0.18
2022 NF PE RVU: 0.49
2022 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 **2020 Medicare Utilization:** 2,061

2022 Work RVU: 0.84
2022 NF PE RVU: 4.72
2022 Fac PE RVU: 0.69

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 202,130

2022 Work RVU: 3.26
2022 NF PE RVU: 6.66
2022 Fac PE RVU: 1.74

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 **2020 Medicare Utilization:** 140,681

2022 Work RVU: 0.90
2022 NF PE RVU: 0.67
2022 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 39,815

2022 Work RVU: 0.25
2022 NF PE RVU: 0.20
2022 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 **2020 Medicare Utilization:** 136,530

2022 Work RVU: 3.26
2022 NF PE RVU: 6.66
2022 Fac PE RVU: 1.74

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0124 **Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017

2020 Medicare Utilization: 39,175

2022 Work RVU: 0.26
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.38

RUC Recommendation: 0.42

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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

2020 Medicare Utilization: 913,572

2022 Work RVU: 0.17
2022 NF PE RVU: 0.51
2022 Fac PE RVU: 0.04

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

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

2020 Medicare Utilization: 2,589

2022 Work RVU: 0.26
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.38

RUC Recommendation: 0.42

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 57,008

2022 Work RVU: 0.00
2022 NF PE RVU: 3.17
2022 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE Only) **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 35,030

2022 Work RVU: 0.31
2022 NF PE RVU: 3.39
2022 Fac PE RVU: 0.07

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 **2020 Medicare Utilization:** 770,216

2022 Work RVU: 0.45
2022 NF PE RVU: 0.71
2022 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

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 **2020 Medicare Utilization:** 1,101,665

2022 Work RVU: 0.67
2022 NF PE RVU: 0.83
2022 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:**

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 **2020 Medicare Utilization:** 388,445

2022 Work RVU: 1.73
2022 NF PE RVU: 1.22
2022 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. 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

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

2020 Medicare Utilization: 30,278

2022 Work RVU: 1.73
2022 NF PE RVU: 1.26
2022 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Assume CMS will delete

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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 12,117

2022 Work RVU: 0.00
2022 NF PE RVU: 0.29
2022 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:**

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 **2020 Medicare Utilization:** 18,715

2022 Work RVU: 0.00
2022 NF PE RVU: 0.29
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 34,614

2022 Work RVU: 0.00
2022 NF PE RVU: 1.87
2022 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:**

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 **2020 Medicare Utilization:** 1,234,315

2022 Work RVU: 0.00
2022 NF PE RVU: 1.39
2022 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 **2020 Medicare Utilization:** 167,183

2022 Work RVU: 0.18
2022 NF PE RVU: 0.05
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 130,857

2022 Work RVU: 0.61
2022 NF PE RVU: 0.84
2022 Fac PE RVU: 0.28

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 79,202

2022 Work RVU: 0.45
2022 NF PE RVU: 0.47
2022 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 **2020 Medicare Utilization:** 790,648

2022 Work RVU: 0.60
2022 NF PE RVU: 0.92
2022 Fac PE RVU: NA

RUC Recommendation: Recommend CMS delete **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2020 Medicare Utilization:** 5,317,417

2022 Work RVU: 0.18
2022 NF PE RVU: 0.17
2022 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0296 **Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)**

Global: XXX **Issue:** Counseling Visit for Lung Cancer **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2022 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2020 Medicare Utilization:** 43,859

2022 Work RVU: 0.52
2022 NF PE RVU: 0.28
2022 Fac PE RVU: 0.20

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0297 **Low dose ct scan (ldct) for lung cancer screening**

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:** October 2018 **2020 Medicare Utilization:** 255,085

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

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:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 50,764

2022 Work RVU: 0.65
2022 NF PE RVU: 0.34
2022 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT **Referred to CPT** Time Uncertain **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 106,622

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 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 **2020 Medicare Utilization:** 484,018

2022 Work RVU: 2.60
2022 NF PE RVU: 2.13
2022 Fac PE RVU: 1.13

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

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 **2020 Medicare Utilization:** 111,091

2022 Work RVU: 0.17
2022 NF PE RVU: 0.23
2022 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:**

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 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2020 Medicare Utilization:** 58,714

2022 Work RVU: 1.39
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.57

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 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2020 Medicare Utilization:** 40,924

2022 Work RVU: 2.00
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.82

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

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 **2020 Medicare Utilization:** 115,458

2022 Work RVU: 3.60
2022 NF PE RVU: 6.65
2022 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 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2020 Medicare Utilization:** 23,004

2022 Work RVU: 1.71
2022 NF PE RVU: 1.51
2022 Fac PE RVU: 1.51

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0423 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session** **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2020 Medicare Utilization:** 33,897

2022 Work RVU: 1.71
2022 NF PE RVU: 1.51
2022 Fac PE RVU: 1.51

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **2020 Medicare Utilization:** 838,315

2022 Work RVU: 2.60
2022 NF PE RVU: 2.13
2022 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:**

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 **2020 Medicare Utilization:** 8,154,820

2022 Work RVU: 1.92
2022 NF PE RVU: 1.80
2022 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 **2020 Medicare Utilization:** 759,928

2022 Work RVU: 0.18
2022 NF PE RVU: 0.36
2022 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

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 **2020 Medicare Utilization:** 1,939,323

2022 Work RVU: 0.18
2022 NF PE RVU: 0.35
2022 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:**

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 **2020 Medicare Utilization:** 261,551

2022 Work RVU: 0.45
2022 NF PE RVU: 0.28
2022 Fac PE RVU: 0.20

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 **2020 Medicare Utilization:** 280,549

2022 Work RVU: 0.45
2022 NF PE RVU: 0.28
2022 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:**

Status Report: CMS Requests and Relativity Assessment Issues

G0452 **Molecular pathology procedure; physician interpretation and report**

Global: XXX **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 **2020 Medicare Utilization:** 137,304

2022 Work RVU: 0.93
2022 NF PE RVU: 0.44
2022 Fac PE RVU: NA

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:** 396,662

2022 Work RVU: 0.60
2022 NF PE RVU: NA
2022 Fac PE RVU: 0.30

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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:**

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 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2020 Medicare Utilization:** 319,191

2022 Work RVU: 0.10
2022 NF PE RVU: 1.55
2022 Fac PE RVU: 0.04

RUC Recommendation: Maintain

Referred to CPT

Result: Remove from screen

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 Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2020 **2020 Medicare Utilization:** 113,010

2022 Work RVU: 0.87
2022 NF PE RVU: 0.87
2022 Fac PE RVU: 0.37

RUC Recommendation: Request CMS Delete

Referred to CPT

Result: Request CMS Delete

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G6001 **Ultrasonic guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AADA, ASTRO **First Identified:** October 2020 **2020 Medicare Utilization:** 125,385

2022 Work RVU: 0.58
2022 NF PE RVU: 4.69
2022 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2022 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G6002 **Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy** **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2020 Medicare Utilization:** 1,083,968

2022 Work RVU: 0.39
2022 NF PE RVU: 1.76
2022 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G6012 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev** **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2020 Medicare Utilization:** 309,318

2022 Work RVU: 0.00
2022 NF PE RVU: 7.10
2022 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

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 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2020 Medicare Utilization:** 184,134

2022 Work RVU: 0.00
2022 NF PE RVU: 7.12
2022 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

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 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2020 Medicare Utilization:** 16,498

2022 Work RVU: 0.00
2022 NF PE RVU: 7.08
2022 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 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2020 Medicare Utilization:** 1,167,880

2022 Work RVU: 0.00
2022 NF PE RVU: 10.79
2022 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

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 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2020 Medicare Utilization:** 81,098

2022 Work RVU: 0.00
2022 NF PE RVU: 0.00
2022 Fac PE RVU: 0.00

RUC Recommendation: Review action plan

Referred to CPT

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **2020 Medicare Utilization:**

2022 Work RVU:
2022 NF PE RVU:
2022 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 **2020 Medicare Utilization:** 1,296

2022 Work RVU: 0.26
2022 NF PE RVU: 0.38
2022 Fac PE RVU: 0.38

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

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 **2020 Medicare Utilization:** 410,577

2022 Work RVU: 0.37
2022 NF PE RVU: 0.86
2022 Fac PE RVU: 0.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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 2022

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
76998	**Ultrasonic guidance, intraoperative**	CMS-Other - Utilization over 20,000 Part1	October 2019	STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS	February 2022

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 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
99415	**Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient evaluation and management service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	February 2022

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99416	**Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (list separately in addition to code for prolonged service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	February 2022

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

		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	Time Uncertain

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.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G6001	**Ultrasonic guidance for placement of radiation therapy fields**	CMS-Other - Utilization over 20,000 Part2	January 2021	AADA, ASTRO	February 2022

Background: The RUC identified G6001 via the CMS/Other Source Utilization over 20,000 screen. In January 2021, the RUC recommended to refer to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology).

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
43762	**Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract**	CMS 000-Day Global Typically Reported with an E/M	January 2022	0.75. CPT Assistant article	ACEP, ACG, ACS, AGA, ASGE	

Background: In January 2018, the RUC recommends that these codes be reviewed by the Relativity Assessment Workgroup in two years to examine utilization data to determine if 90% of 43760 are directed toward 43762 and 10% to 43763, as predicted. The data should also examine if these codes are typically reported with E/M services and if the global period assignment should remain 000. In January 2022, the Workgroup reviewed these services and determined that the utilization split is as was projected. Additionally, these services are not typically reported with office visits, hospital visits or emergency department visits and the 000-day global period assignment is appropriate. The specialty society voiced concern with the utilization by providers that are not expected to perform this surgical procedure. It is possible that, because 2019 was the first year for this new low volume code, that there may be a misunderstanding of this procedure resulting in misreporting. Therefore, the specialty societies indicate they will develop a CPT Assistant article that describes correct reporting of 43763 and contrasts this procedure with 43762 and other codes for g-tube placement (eg, 43246, 49440). The Workgroup recommends that CPT codes 43762 and 43763 be maintained/removed from this screen and referred to CPT Assistant to describe scenarios when each of these services should be reported.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
43763	**Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract**	CMS 000-Day Global Typically Reported with an E/M	January 2022	1.41. CPT Assistant article.	ACEP, ACG, ACS, AGA, ASGE	

Background: In January 2018, the RUC recommends that these codes be reviewed by the Relativity Assessment Workgroup in two years to examine utilization data to determine if 90% of 43760 are directed toward 43762 and 10% to 43763, as predicted. The data should also examine if these codes are typically reported with E/M services and if the global period assignment should remain 000. In January 2022, the Workgroup reviewed these services and determined that the utilization split is as was projected. Additionally, these services are not typically reported with office visits, hospital visits or emergency department visits and the 000-day global period assignment is appropriate. The specialty society voiced concern with the utilization by providers that are not expected to perform this surgical procedure. It is possible that, because 2019 was the first year for this new low volume code, that there may be a misunderstanding of this procedure resulting in misreporting. Therefore, the specialty societies indicate they will develop a CPT Assistant article that describes correct reporting of 43763 and contrasts this procedure with 43762 and other codes for g-tube placement (eg, 43246, 49440). The Workgroup recommends that CPT codes 43762 and 43763 be maintained/removed from this screen and referred to CPT Assistant to describe scenarios when each of these services should be reported.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
63685	**Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**	Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7	January 2021	Review action plan in 2 years after CPT article published. 6.05	AAPM, AANS/CNS, ASA, ISIS, NASS	

Background: Oct 2010 re-reviewed site of service issue. In October 2020, the RUC identified six codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2014 through 2019e. CPT codes 00918, 63685, 75561, 75572, 75574 and 93655. The Workgroup requested that the specialty societies submit an action plan for codes CPT codes 00918, 63685, 75561, 75572, 75574 and 93655 for January 2021. In January 2021, the RUC recommended to refer to CPT Assistant. A CPT Assistant article has alread been submitted. The RUC will review after 2 years of data are available after article is published.

Physician Time from RUC Meeting:
January 2022 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
15851	10	3	10	15	15													53
30468	25	3	10	20	15													73
50080	36	3	10	90	40			2						0.5				244
50081	40	3	10	140	44			2						0.5				302
55821	33	3	10	120	25			2				1		1				315
55831	40	3	10	120	25			2				1		1				322
55866	40	15	12	180	50			2						0.5				362
63020	40	20	15	90	30			2	1		1	1		1				379
63030	40	15	15	90	40			2	1					0.5				305
63035	0	0	0	60	0													60
69714	25	10	8	30	15		1	1						0.5				146
69716	25	10	10	50	15		1	1						0.5				168
69717	25	10	7	44	15		1	1						0.5				159
69719	27	10	9	55	15		1	1						0.5				174
69726	25	10	7	35	15		1	1						0.5				150
69727	27	10	10	50	15		1	1						0.5				170
76881	5	0	0	20	5													30
76882	5	0	0	15	5													25
98980	0	0	0	20	0													20
98981	0	0	0	20	0													20
99221	0	0	0	40	0													40
99222	0	0	0	55	0													55
99223	0	0	0	74	0													74
99231	0	0	0	25	0													25
99232	0	0	0	36	0													36
99233	0	0	0	52	0													52
99234	0	0	0	45	5													50
99235	0	0	0	68	8													76
99236	0	0	0	85	12													97
99238	0	0	0	28	10													38
99239	0	0	0	45	19													64
99252	0	0	0	35	0													35
99253	0	0	0	45	0													45
99254	0	0	0	60	0													60
99255	0	0	0	80	0													80
99417	0	0	0	15	0													15
368X1	15	5	6	60	18													104
368X2	15	5	6	75	18													119
37X01	17	1	5	20	10													53
558XX	40	8	11	180	50			2						0.5				354
69XX0	29	10	9	60	15		1	1						0.5				181
69XX1	33	10	10	60	15		1	1						0.5				186
69XX2	27	10	8	60	15		1	1						0.5				178

Physician Time from RUC Meeting:
January 2022 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
76XX0	7	0	0	25	7													39
993X0	0	0	0	20	0													20

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
15851	15758
22857	22857
30468	30468
49436	49436
50080	50080
50081	50081
55821	55821
55831	55831
55866	55866
63020	63020
63030	63030
63035	63035
69714	69714
69716	69716
69717	69717
69719	69719
69726	69726
69727	69727
76881	76881
76882	76882
98975	98975
98976	98976
98977	98977
98980	98980
98981	98981
99221	99221
99222	99222
99223	99223
99231	99231
99232	99232
99233	99223
99234	99234
99235	99235
99236	99236
99238	99238
99239	99239
99252	99252
99253	99253
99254	99254
99255	99255
99417	99417

158X1	10080
158X2	11008
368X1	36901
368X2	36901
37X01	30140
558XX	55866
69XX0	69714
69XX1	69714
69XX2	69714
76XX0	95860
993X0	99233

CPT	BETOS Class	BETOS Subclass	BETOS Subclass2
15851	Procedures	Minor procedure	Skin
22857	Procedures	Major procedure	Other
30468	Procedures	Minor procedure	Skin
49436	Procedures	Major procedure	Other
50080	Procedures	Major procedure	Other
50081	Procedures	Major procedure	Other
55821	Procedures	Major procedure	Other
55831	Procedures	Major procedure	Other
55866	Procedures	Major procedure	Other
63020	Procedures	Major procedure	Explor/Decompr/Excis disc
63030	Procedures	Major procedure	Explor/Decompr/Excis disc
63035	Procedures	Major procedure	Explor/Decompr/Excis disc
69714	Procedures	Major procedure	Other
69716	Procedures	Major procedure	Other
69717	Procedures	Major procedure	Other
69719	Procedures	Major procedure	Other
69726	Procedures	Major procedure	Other
69727	Procedures	Major procedure	Other
76881	Imaging	Echography/ultrasonography	Other
76882	Imaging	Echography/ultrasonography	Other
98975	Tests	Other tests	Other
98976	Tests	Other tests	Other
98977	Tests	Other tests	Other
98980	Tests	Other tests	Other
98981	Tests	Other tests	Other
99221	Evaluation Management	Hospital visit	Initial
99222	Evaluation Management	Hospital visit	Initial
99223	Evaluation Management	Hospital visit	Initial
99231	Evaluation Management	Hospital visit	Subsequent
99232	Evaluation Management	Hospital visit	Subsequent
99233	Evaluation Management	Hospital visit	Subsequent
99234	Evaluation Management	Hospital visit	Initial
99235	Evaluation Management	Hospital visit	Initial
99236	Evaluation Management	Hospital visit	Initial
99238	Evaluation Management	Hospital visit	NA
99239	Evaluation Management	Hospital visit	NA
99252	Evaluation Management	Hospital visit	NA
99253	Evaluation Management	Hospital visit	NA
99254	Evaluation Management	Hospital visit	NA
99255	Evaluation Management	Hospital visit	NA
99417	Evaluation Management	NA	NA
158X1	Procedures	Minor procedure	Skin
158X2	Procedures	Minor procedure	Skin
368X1	Procedures	Minor procedure	Other
368X2	Procedures	Minor procedure	Other
37X01	Procedures	Minor procedure	Skin
558XX	Procedures	Major procedure	Other
69XX0	Procedures	Major procedure	Other

69XX1	Procedures	Major procedure	Other
69XX2	Procedures	Major procedure	Other
76XX0	Imaging	Echography/ultrasonography	Other
993X0	Evaluation Management	Hospital visit	NA

CPT Source	Deleted	Source 2020 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2020)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
15850	D	0	15851	0	1.000	0.78	1.10	04 Removal of Sutures or Staples	0	0
15851		2,200	15851	2,200	1.000	0.86	1.10	04 Removal of Sutures or Staples	2,420	1,892
N/A; was previously either not captured or bundled with other services		N/A	158X1	N/A	N/A	0.00	0.00	04 Removal of Sutures or Staples		
N/A; was previously either not captured or bundled with other services		N/A	158X2	N/A	N/A	0.00	0.00	04 Removal of Sutures or Staples		
22857		10	22857	10	1.000	27.13	27.13	05 Total Disc Arthroplasty	271	271
0163T	D	0	228XX	0	1.000	0.00	0.00	05 Total Disc Arthroplasty	0	0
G2170	D	217	368X1	217	1.000	0.00	7.50	06 Percutaneous Arteriovenous Fistula Creation	1,628	0
G2171	D	129	368X2	129	1.000	0.00	9.60	06 Percutaneous Arteriovenous Fistula Creation	1,238	0
30468		0	30468	0	1.000	2.80	2.80	07 Energy Based Repair of Nasal Valve Collaps	0	0
30999		485	37X01	200	0.412	0.00	2.70	07 Energy Based Repair of Nasal Valve Collaps	540	0
30999		485	30999	285	0.588	0.00	0.00	07 Energy Based Repair of Nasal Valve Collaps	0	0
50080		2,092	50080	2,092	1.000	15.74	13.50	08 Percutaneous Nephrolithotomy	28,242	32,928
50081		5,083	50081	5,083	1.000	23.50	22.00	08 Percutaneous Nephrolithotomy	111,826	119,451
76000		100,018	Savings (Bundled into 50080)	126	0.001	0.30	0.00	08 Percutaneous Nephrolithotomy	0	38
76000		100,018	Savings (Bundled into 50081)	264	0.003	0.30	0.00	08 Percutaneous Nephrolithotomy	0	79
76000		100,018	76000	99,628	0.996	0.30	0.30	08 Percutaneous Nephrolithotomy	29,888	29,888
50432		26,858	Savings (Bundled into 50080)	251	0.009	4.00	0.00	08 Percutaneous Nephrolithotomy	0	1,004
50423		26,858	Savings (Bundled into 50081)	1,169	0.044	4.00	0.00	08 Percutaneous Nephrolithotomy	0	4,676
50432		26,858	50432	25,438	0.947	4.00	4.00	08 Percutaneous Nephrolithotomy	101,752	101,752
55821		1,008	55821	1,008	1.000	15.76	15.18	09 Laparoscopic Simple Prostatectomy	15,301	15,886
55831		356	55831	356	1.000	17.19	15.60	09 Laparoscopic Simple Prostatectomy	5,554	6,120
55866		18,557	55866	18,557	1.000	26.80	22.46	09 Laparoscopic Simple Prostatectomy	416,790	497,328
55899		1,740	558XX	1,000	0.575	0.00	19.53	09 Laparoscopic Simple Prostatectomy	19,530	0
55899		1,740	55899	740	0.425	0.00	0.00	09 Laparoscopic Simple Prostatectomy	0	0
69714		652	69714	308	0.473	8.00	8.00	10 Transcutaneous Passive Implant - Temporal Bone	2,468	2,468
69716		0	69716	0	1.000	9.03	9.03	10 Transcutaneous Passive Implant - Temporal Bone	0	0
69714		652	69XX0	330	0.505	14.45	9.97	10 Transcutaneous Passive Implant - Temporal Bone	3,285	4,761
69717		52	69717	52	1.000	15.43	8.48	10 Transcutaneous Passive Implant - Temporal Bone	441	802
69719		0	69719	0	1.000	9.77	9.46	10 Transcutaneous Passive Implant - Temporal Bone	0	0

CPT Source	Deleted	Source 2020 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2020)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
69714		652	69XX1	7	0.011	14.45	10.25	10 Transcutaneous Passive Implant - Temporal Bone	72	101
69726		0	69726	0	1.000	5.93	7.50	10 Transcutaneous Passive Implant - Temporal Bone	0	0
69727		0	69727	0	1.000	7.13	7.38	10 Transcutaneous Passive Implant - Temporal Bone	0	0
69714		652	69XX2	7	0.011	14.45	8.50	10 Transcutaneous Passive Implant - Temporal Bone	60	101
76881		170,257	76881	161,744	0.950	0.63	0.90	11 Neuromuscular Ultrasound	145,570	101,899
76881		170,257	76XX0	8,513	0.050	0.63	1.21	11 Neuromuscular Ultrasound	10,301	5,363
76882		243,066	76882	230,913	0.950	0.49	0.69	11 Neuromuscular Ultrasound	159,330	113,147
76882		243,066	76XX0	12,153	0.050	0.49	1.21	11 Neuromuscular Ultrasound	14,705	5,955
98975		0	98975	0	1.000	0.00	0.00	12 Cognitive Behavioral Therapy Monitoring	0	0
98976		0	98976	0	1.000	0.00	0.00	12 Cognitive Behavioral Therapy Monitoring	0	0
98977		0	98977	0	1.000	0.00	0.00	12 Cognitive Behavioral Therapy Monitoring	0	0
N/A		N/A	989X6	N/A	N/A	0.00	0.00	12 Cognitive Behavioral Therapy Monitoring	N/A	N/A
98980		0	98980	0	1.000	0.62	0.62	12 Cognitive Behavioral Therapy Monitoring	0	0
98981		0	98981	0	1.000	0.61	0.61	12 Cognitive Behavioral Therapy Monitoring	0	0
99218	D	114,218	99221	114,218	1.000	1.92	1.92	13 Inpatient and Observation Care Services	219,299	219,299
99221		1,470,299	99221	1,470,299	1.000	1.92	1.92	13 Inpatient and Observation Care Services	2,822,974	2,822,974
99219	D	489,335	99222	489,335	1.000	2.60	2.61	13 Inpatient and Observation Care Services	1,277,164	1,272,271
99222		5,381,532	99222	5,381,532	1.000	2.61	2.61	13 Inpatient and Observation Care Services	14,045,799	14,045,799
99220	D	1,256,108	99223	1,256,108	1.000	3.56	3.86	13 Inpatient and Observation Care Services	4,848,577	4,471,744
99223		9,478,160	99223	9,478,160	1.000	3.86	3.86	13 Inpatient and Observation Care Services	36,585,698	36,585,698
99224		99,979	99231	99,979	1.000	0.76	1.00	13 Inpatient and Observation Care Services	99,979	75,984
99231		5,656,849	99231	5,656,849	1.000	0.76	1.00	13 Inpatient and Observation Care Services	5,656,849	4,299,205
99225	D	509,692	99232	509,692	1.000	1.39	1.59	13 Inpatient and Observation Care Services	810,410	708,472
99232		39,672,179	99232	39,672,179	1.000	1.39	1.59	13 Inpatient and Observation Care Services	63,078,765	55,144,329
99226	D	307,279	99233	307,279	1.000	2.00	2.40	13 Inpatient and Observation Care Services	737,470	614,558
99233		24,576,605	99233	24,576,605	1.000	2.00	2.40	13 Inpatient and Observation Care Services	58,983,852	49,153,210
99234		27,775	99234	27,775	1.000	2.56	2.00	13 Inpatient and Observation Care Services	55,550	71,104
99235		67,330	99235	67,330	1.000	3.24	3.24	13 Inpatient and Observation Care Services	218,149	218,149
99236		103,222	99236	103,222	1.000	4.20	4.30	13 Inpatient and Observation Care Services	443,855	433,532
99217	D	1,087,712	99238	358,945	0.330	1.28	1.50	13 Inpatient and Observation Care Services	538,418	459,450
99238		1,998,365	99238	1,998,365	1.000	1.28	1.50	13 Inpatient and Observation Care Services	2,997,548	2,557,907
99217	D	1,087,712	99239	728,767	0.670	1.28	2.15	13 Inpatient and Observation Care Services	1,566,849	932,822
99239		4,565,657	99239	4,565,657	1.000	1.90	2.15	13 Inpatient and Observation Care Services	9,816,163	8,674,748
99251	D	0	99252	0	1.000	1.00	1.50	14 Inpatient Consultations	0	0
99252		0	99252	0	1.000	1.50	1.50	14 Inpatient Consultations	0	0
99253		0	99253	0	1.000	2.27	2.00	14 Inpatient Consultations	0	0
99254		0	99254	0	1.000	3.29	2.72	14 Inpatient Consultations	0	0
99255		0	99255	0	1.000	4.00	3.86	14 Inpatient Consultations	0	0
G2212		974,392	99417	974,392	1.000	0.61	0.61	15 Prolonged Services – on the Date of an E/M	594,379	594,379
99354	D	280,660	99417	188,688	0.672	0.78	0.61	15 Prolonged Services – on the Date of an E/M	115,100	146,547

CPT Source	Deleted	Source 2020 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2020)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
99355	D	46,767	99417	5,556	0.119	0.89	0.61	15 Prolonged Services – on the Date of an E/M	3,389	4,917
99356	D	234,306	993X0	702,918	3.000	0.57	0.81	15 Prolonged Services – on the Date of an E/M	569,364	400,663
99357	D	20,390	993X0	40,780	2.000	0.86	0.81	15 Prolonged Services – on the Date of an E/M	33,032	34,867
99354	D	280,660	Savings	217,737	0.776	2.33	0.00	15 Prolonged Services – on the Date of an E/M	0	507,327
99355	D	46,767	Savings	37,033	0.792	1.77	0.00	15 Prolonged Services – on the Date of an E/M	0	65,549
49436		297	49436	297	1.000	2.72	2.72	16 Delayed Creation of Exit Site from Embedde	808	808
63020		1,043	63020	1,043	1.000	16.29	15.95	17 Lumbar Laminotomy with Decompression	16,636	16,990
63030		22,190	63030	22,190	1.000	13.18	13.18	17 Lumbar Laminotomy with Decompression	292,464	292,464
63035		5,431	63035	5,431	1.000	3.15	4.00	17 Lumbar Laminotomy with Decompression	21,724	17,108
									207,521,471	185,888,785

Total Source RVUs	1,754,249
Total New/Revised RVUs	1,315,263
RVU Difference	438,986
CF	34.6062
CF Redistribution	**15,191,639**

New Technology/New Services List

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
								☐
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, diluent reconstituted; first dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, diluent reconstituted; second dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; third dose	Aug 2021	Pfizer-SARS-CoV-2-IA		CPT 2021	January 2025		☐
0004A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; booster dose	Oct 2021	Pfizer-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 100 mcg/0.5 ml dosage; first dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 100 mcg/0.5 ml dosage; second dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; third dose	Aug 2021	Moderna-SARS-CoV-2-IA		CPT 2021	January 2025		☐
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, chimpanzee adenovirus oxford 1 (chadox1) vector, preservative free, 5x1010 viral particles/0.5 ml dosage; first dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, chimpanzee adenovirus oxford 1 (chadox1) vector, preservative free, 5x1010 viral particles/0.5 ml dosage; second dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, adenovirus type 26 (ad26) vector, preservative free, 5x1010 viral particles/0.5 ml dosage, single dose	Jan 2021	Janssen-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 ml dosage; first dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 ml dosage; second dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐
0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; first dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0052A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; second dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; third dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; booster dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, booster dose	Oct 2021	Moderna Booster-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose	Oct 2021	Pfizer Tris-Sucrose-Age5-11-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose	Oct 2021	Pfizer Tris-Sucrose-Age5-11-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
10011	Fine needle aspiration biopsy, including mr guidance; first lesion	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
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	January 2023		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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	April 2022		☐
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐
20561	Needle insertion(s) without injection(s); 3 or more muscles	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐
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	January 2024		☐
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	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	Survey April 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	Survey April 2021	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	April 2022	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	April 2022		☐
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
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	☑
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
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)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	January 2023		☐
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	January 2023		☐
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
33286	Removal, subcutaneous cardiac rhythm monitor	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
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	January 2023		☐
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	January 2023	Review in two years (January 2023); new FDA indication recently released, suggesting this service is still changing.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33361	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	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.	☐
33362	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	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	January 2024	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
33364	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	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.	☐
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	January 2024	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	January 2024	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
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (list separately in addition to code for primary procedure)	Jan 2021	Percutaneous Cerebral Embolic Protection	07	CPT 2022	January 2026		☐
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
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	January 2023	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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2023	Review in 3 years (January 2023); pediatric procedure with some CMS utilization.	☑
33509	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic	Jan 2021	Harvest of Upper Extremity Artery, Endoscopic and Open	09	CPT 2022	January 2026		☐
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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)	Oct 2018	Aortic Graft Procedures	06	CPT 2020	January 2024		☐
338X3		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X4		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X5		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X6		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X7		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	April 2022		☐
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	April 2022		☐
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	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2025		☐
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	January 2025		☐
34806	Code Deleted CPT 2008	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
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	April 2022		☐
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	April 2022		☐
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	April 2022	Review in January 2022 with the other codes in this family identified via the 2022 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	April 2022	Review in January 2022 with the other codes in this family identified via the 2022 new technology/new services screen (36475-36479).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022		☐
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	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
368X1		Jan 2022	Percutaneous Arteriovenous Fistula Creation	06	CPT 2023	January 2027		☐
368X2		Jan 2022	Percutaneous Arteriovenous Fistula Creation	06	CPT 2023	January 2027		☐
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.	☑
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
38221	Diagnostic bone marrow; biopsy(ies)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [poem])	Oct 2020	Per-Oral Endoscopic Myotomy (POEM)	07	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
43X21		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐
43X22		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐

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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐

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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐
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	January 2024		☐
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	January 2023		☐
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.	☑
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	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2025		☐
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	January 2025		☐
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	☑
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
61736	Laser interstitial thermal therapy (litt) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
61737	Laser interstitial thermal therapy (litt) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or ct guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	January 2024		☐
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	January 2024		☐
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure)	Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
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.	☑
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	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
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	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
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	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each	Jan 2021	Lacrimal Canaliculus Drug Eluting Implant Insertion	17	CPT 2022	January 2026		☐
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐
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	January 2025		☐
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 left ventricular [lv] cardiac function, right ventricular [rv] structure and function and evaluation of vascular 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	January 2023		☐

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	January 2022	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 after additional utilization data is available. These services were revised at the October 2021 CPT meeting and will be surveyed.	☑

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	January 2022	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 after additional utilization data is available. These services were revised at the October 2021 CPT meeting and will be surveyed.	☑
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	January 2023		☐

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	January 2023		☐
76981	Ultrasound, elastography; parenchyma (eg, organ)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76982	Ultrasound, elastography; first target lesion	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76983	Ultrasound, elastography; each additional target lesion (list separately in addition to code for primary procedure)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76XX0		Jan 2022	Neuromuscular Ultrasound	11	CPT 2023	January 2027		☐
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	January 2023		☐
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
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	January 2023		☐
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	January 2023		☐

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	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77062	Diagnostic digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77063	Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77089	Trabecular bone score (tbs), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (dxa) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture-risk	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77090	Trabecular bone score (tbs), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77091	Trabecular bone score (tbs), structural condition of the bone microarchitecture; technical calculation only	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77092	Trabecular bone score (tbs), structural condition of the bone microarchitecture; interpretation and report on fracture-risk only by other qualified health care professional	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
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	☑
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	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE 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).	☑
77520	Proton treatment delivery; simple, without compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77522	Proton treatment delivery; simple, with compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77523	Proton treatment delivery; intermediate	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77525	Proton treatment delivery; complex	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐

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 parathyroid scintigraphy as an	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							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 parathyroid scintigraphy as an	☑

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CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
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	January 2024		☐
78835	Radiopharmaceutical quantification measurement(s) single area (list separately in addition to code for primary procedure)	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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 (protocadherin-related 15) (eg, usher syndrome type 1f), r245x variant serpine1 (serpine peptidase	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
	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 ewsr1/erg (t(21;22)) (eg, ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and	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
	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 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							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	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 (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,							

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	y165c, g382d) nod2 (nucleotide-binding oligomerization domain containing 2) (eg, crohn's disease, blau syndrome), common variants (eg, snp 8, snp 12, snp 13) npm1/alk (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis pax8/pparg (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis prame (preferentially expressed antigen in melanoma) (eg, melanoma), expression analysis prss1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, n29i, a16v, r122h) pygm (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type v, mcardle disease), common variants (eg, r50x, g205s) runx1/runx1t1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed ss18/ssx1 (t(x;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed ss18/ssx2 (t(x;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed vwf (von willebrand factor) (eg, von willebrand disease type 2n), common variants (eg, t791m, r816w, r854q)							

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81402	Molecular pathology procedure, level 3 (eg, >10 snps, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and t-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [loh], uniparental disomy [upd]) chromosome 1p-/19q- (eg, 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.	☑

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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 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	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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	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), 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							

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	(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)							

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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-tooth), full gene sequence emd (emerin) (eg, emery-dreifuss	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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	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] dehydrogenase 2) (eg, mineralocorticoid excess syndrome), full gene sequence hspb1 (heat shock 27kda protein 1) (eg, charcot-marie-tooth disease),							

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	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-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							

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	young [mody]), full gene sequence phox2b (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence plp1 (proteolipid protein 1) (eg, pelizaeus-merzbacher disease, spastic paraplegia), duplication/deletion analysis pqbp1 (polyglutamine binding protein 1) (eg, renpenning syndrome), duplication/deletion analysis prnp (prion protein) (eg, genetic prion disease), full gene sequence prop1 (prop paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence prph2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence prss1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence raf1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, leopard syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) ret (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2b and familial medullary thyroid carcinoma), common variants (eg, m918t, 2647_2648delinstt, a883f) rho (rhodopsin) (eg, retinitis pigmentosa), full gene sequence rp1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence scn1b (sodium channel, voltage-gated, type i, beta) (eg, brugada syndrome), full gene sequence sco2 (sco cytochrome oxidase deficient homolog 2 [sco1l]) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence sdhc (succinate dehydrogenase complex, subunit c, integral membrane protein, 15kda) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis sdhd (succinate dehydrogenase complex, subunit d, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence sgcg (sarcoglycan, gamma [35kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), duplication/deletion analysis sh2d1a (sh2 domain containing 1a) (eg, x-linked lymphoproliferative syndrome), full gene sequence slc16a2 (solute carrier family 16, member 2							

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	[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 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							

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	analysis znf41 (zinc finger protein 41) (eg, x-linked mental retardation 89), full gene sequence							

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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 (cox10 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence cox15 (cox15	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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	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 cytogenomic [genome-wide] analysis for constitutional chromosomal abnormalities, see 81228, 81229, 81349) (do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (do not report 88271 when performing cytogenomic microarray analysis) dbt (dihydrolipoamide branched chain transacylase e2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis dcx (doublecortin) (eg, x-linked lissencephaly), full gene sequence des (desmin) (eg, myofibrillar myopathy), full gene sequence dfnb59 (deafness, autosomal recessive 59)(eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence dguok (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial dna depletion syndrome), full gene sequence dhcr7 (7-dehydrocholesterol reductase) (eg, smith-lemli-opitz syndrome), full gene sequence eif2b2 (eukaryotic translation initiation factor 2b, subunit 2 beta, 39kda)(eg, leukoencephalopathy with vanishing white matter),							

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	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 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								

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	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 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,							

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	type 2), duplication/deletion analysis nlgn3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence nlgn4x (neuroligin 4, x-linked) (eg, autism spectrum disorders), full gene sequence nphp1 (nephronophthisis 1 [juvenile]) (eg, joubert syndrome), deletion analysis, and duplication analysis, if performed nphs2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence nsd1 (nuclear receptor binding set domain protein 1) (eg, sotos syndrome), duplication/deletion analysis otc (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence pafah1b1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kda]) (eg, lissencephaly, miller-dieker syndrome), duplication/deletion analysis park2 (parkinson protein 2, e3 ubiquitin protein ligase [parkin]) (eg, parkinson disease), duplication/deletion analysis pcca (propionyl coa carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis pcdh19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence pdha1 (pyruvate dehydrogenase [lipoamide] alpha 1)(eg, lactic acidosis), duplication/deletion analysis pdhb (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence pink1 (pten induced putative kinase 1) (eg, parkinson disease), full gene sequence pklr (pyruvate kinase, liver and rbc) (eg, pyruvate kinase deficiency), full gene sequence plp1 (proteolipid protein 1) (eg, pelizaeus-merzbacher disease, spastic paraplegia), full gene sequence pou1f1 (pou class 1 homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence prx (periaxin) (eg, charcot-marie-tooth disease), full gene sequence 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								

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	acid induced 1) (eg, smith-magenis syndrome), full gene sequence reep1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence ret (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2a and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) rps19 (ribosomal protein s19) (eg, diamond-blackfan anemia), full gene sequence rrm2b (ribonucleotide reductase m2 b [tp53 inducible]) (eg, mitochondrial dna depletion), full gene sequence sco1 (sco cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence sdhb (succinate dehydrogenase complex, subunit b, iron sulfur) (eg, hereditary paraganglioma), full gene sequence sdhc (succinate dehydrogenase complex, subunit c, integral membrane protein, 15kda) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence sgca (sarcoglycan, alpha [50kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgcb (sarcoglycan, beta [43kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgcd (sarcoglycan, delta [35kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgce (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis sgcg (sarcoglycan, gamma [35kda dystrophin-associated glycoprotein])(eg, limb-girdle muscular dystrophy), full gene sequence shoc2 (soc-2 suppressor of clear homolog) (eg, noonan-like syndrome with loose anagen hair), full gene sequence shox (short stature homeobox)(eg, langer mesomelic dysplasia), full gene sequence sil1 (sil1 homolog, endoplasmic reticulum chaperone [s. cerevisiae]) (eg, ataxia), full gene sequence slc2a1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [glut 1] deficiency syndrome), full gene sequence slc16a2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg,							

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	specific thyroid hormone cell transporter deficiency, allan-herndon-dudley syndrome), full gene sequence slc22a5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence slc25a20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence smad4 (smad family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis spast (spastin) (eg, spastic paraplegia), duplication/deletion analysis spg7 (spastic paraplegia 7 [pure and complicated autosomal recessive])(eg, spastic paraplegia), duplication/deletion analysis spred1 (sprouty-related, evh1 domain containing 1) (eg, legius syndrome), full gene sequence stat3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-ige syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) stk11 (serine/threonine kinase 11) (eg, peutz-jeghers syndrome), full gene sequence surf1 (surfeit 1) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence tardbp (tar dna binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence tbx5 (t-box 5) (eg, holt-oram syndrome), full gene sequence tcf4 (transcription factor 4) (eg, pitt-hopkins syndrome), duplication/deletion analysis tgfbr1 (transforming growth factor, beta receptor 1) (eg, marfan syndrome), full gene sequence tgfbr2 (transforming growth factor, beta receptor 2) (eg, marfan syndrome), full gene sequence thrb (thyroid hormone receptor, beta) (eg, thyroid 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							

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	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							

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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), full gene sequence bscl2 (berardinelli-seip congenital lipodystrophy 2 [seipin]) (eg, berardinelli-seip congenital lipodystrophy), full	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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	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 gene sequence dsg2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence dsp (desmoplakin) (eg, arrhythmogenic right							

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	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 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							

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	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 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							

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	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 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							

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	syndrome), full gene sequence nsd1 (nuclear receptor binding set domain protein 1) (eg, sotos syndrome), full gene sequence opa1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis optn (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence pafah1b1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kda]) (eg, lissencephaly, miller-dieker syndrome), full gene sequence pah (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence park2 (parkinson protein 2, e3 ubiquitin protein ligase [parkin]) (eg, parkinson disease), full gene sequence pax2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence pc (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence pcca (propionyl coa carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence pccb (propionyl coa carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence pcdh15 (protocadherin-related 15) (eg, usher syndrome type 1f), duplication/deletion analysis pcsk9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence pdha1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence pdhx (pyruvate dehydrogenase complex, component x) (eg, lactic acidosis), full gene sequence phex (phosphate-regulating endopeptidase homolog, x-linked) (eg, hypophosphatemic rickets), full gene sequence pkd2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence pkp2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence pnkd (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence polg (polymerase [dna 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-							

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	brain disease, walker-warburg syndrome), full gene sequence pomt1 (protein-o-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [lgmd] type 2k, walker-warburg syndrome), full gene sequence pomt2 (protein-o-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [lgmd] type 2n, walker-warburg syndrome), full gene sequence ppox (protoporphyrinogen oxidase) (eg, variegate porphyria), full gene sequence prkag2 (protein kinase, amp-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic cardiomyopathy with wolff-parkinson-white syndrome, lethal congenital glycogen storage disease of heart), full gene sequence prkcg (protein kinase c, gamma) (eg, spinocerebellar ataxia), full gene sequence psen2 (presenilin 2 [alzheimer disease 4]) (eg, alzheimer disease), full gene sequence ptpn11 (protein tyrosine phosphatase, non-receptor type 11) (eg, noonan syndrome, leopard syndrome), full gene sequence pygm (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type v, mcardle disease), full gene sequence raf1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, leopard syndrome), full gene sequence ret (ret proto-oncogene) (eg, hirschsprung disease), full gene sequence rpe65 (retinal pigment epithelium-specific protein 65kda) (eg, retinitis pigmentosa, leber congenital amaurosis), full gene sequence ryr1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations scn4a (sodium channel, voltage-gated, type iv, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence scnn1a (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence 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							

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	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 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							

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	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 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	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
	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]) (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) (eg, malignant hyperthermia), full gene sequence ryr2 (ryanodine receptor 2 [cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia,	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
	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).	☑
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	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	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
90868	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐

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	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
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.	☑
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Jan 2021	Colon Capsule Endoscopy	21	CPT 2022	January 2026		☐
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.	☑
92065	Orthoptic training	Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
920XX		Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐
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	January 2025		☐
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	January 2025		☐
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.	☑

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	January 2025		☐
92284	Dark adaptation examination with interpretation and report	Apr 2021	Dark Adaption Eye Exam	20	CPT 2023	January 2024	The RUC will review the typical technology used to perform this service when it is next re-evaluated, acknowledging that the device included in proposed direct practice costs recently was very recently replaced with a newer technology.	☐
92517	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
92518	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; ocular (ovemp)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
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	January 2025		☐
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	April 2022	Review in 2 years (January 2022)	☐
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	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	January 2023		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑
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)	Oct 2020	3D Imaging of Cardiac Structures	09	CPT 2022	January 2026		☐
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.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
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.	☑
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	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
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	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
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	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
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	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
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)	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
93982	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
93XX0		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX1		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX2		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX3		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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.	☑
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

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	January 2023		☐

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	☑
959XX		Oct 2021	Quantitative Pupillometry Services	09	CPT 2023	January 2027		☐
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	January 2024	Review in 3 years (January 2024).	☐
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	January 2024	Review in 3 years (January 2024).	☐
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	January 2024	Review in 3 years (January 2024).	☐
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	January 2024	Review in 3 years (January 2024).	☐

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	January 2024	Review in 3 years (January 2024).	☐
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	January 2024	Review in 3 years (January 2024).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
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	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
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	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
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	January 2024		☐
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2027	Delayed review one year to be reviewed with 989X6 from Jan 2022 meeting, tab 12	☐
98976	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2027	Delayed review one year to be reviewed with 989X6 from Jan 2022 meeting, tab 12	☐
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2027	Delayed review one year to be reviewed with 989X6 from Jan 2022 meeting, tab 12	☐
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2027	Delayed review one year to be reviewed with 989X6 from Jan 2022 meeting, tab 12	☐
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (list separately in addition to code for primary procedure)	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2027	Delayed review one year to be reviewed with 989X6 from Jan 2022 meeting, tab 12	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
989X6		Jan 2022	Cognitive Behavioral Therapy Monitoring	12	CPT 2023	January 2027		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
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	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐
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	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; 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)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
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	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	☑
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	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
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	January 2023		☐
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	January 2023		☐
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	January 2023		☐
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	January 2024		☐
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	January 2024		☐
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	January 2024		☐

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	April 2022		☐
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 that 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.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
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 that 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)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
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 that 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.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2015	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

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	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, 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	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, 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	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

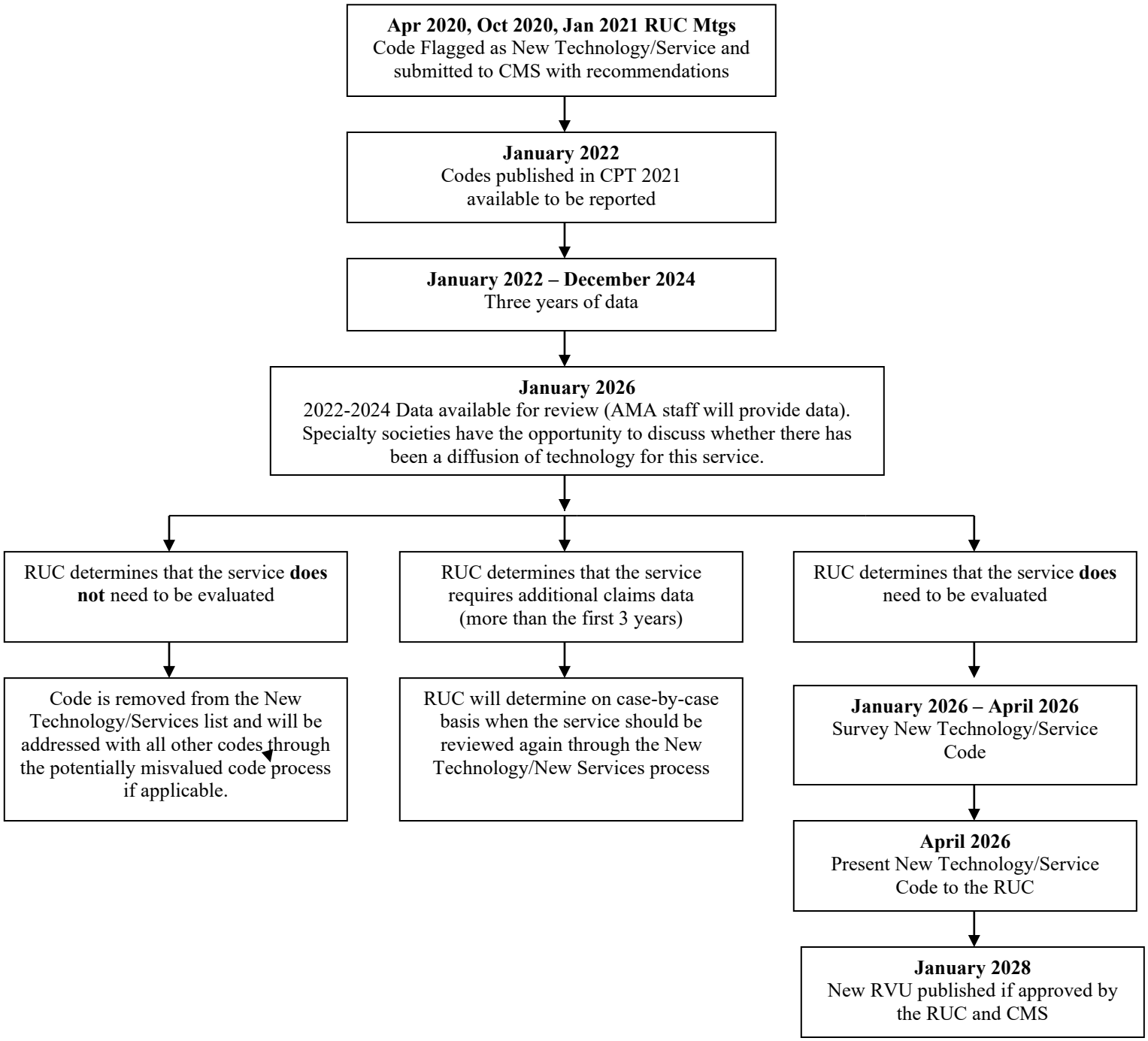
CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	
99495	Transitional care management services with the following required elements: communication (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	April 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐
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	April 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐

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



Society	Acronym
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
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 Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
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

Society	Acronym
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 Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Psychiatric Association	APA
American Rhinologic Society	ARS

Society	Acronym
American Roentgen Ray Society	ARRS
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 Cataract and Refractive Surgery	ASCRS(cat)
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

Society	Acronym
American Society of Retina Specialists	ASRS
American Society of Transplant Surgeons	ASTS
American Thoracic Society	ATS
American Urological Association	AUA
American Vein and Lymphatic Society	AVLS
American Women's Medical Association	AWMA
Association of University Radiologists	AUR
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 Medical Examiners	NAME
North American Neuromodulation Society	NANS
North American Spine Society	NASS
Obesity Medicine Association	OMA
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 Hospital Medicine	SHM
Society of Interventional Radiology	SIR

Society	Acronym
Society of Laparoscopic & Robotic Surgeons	SLS
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*	Long Descriptor	Global	Total CY2023 Physician Time - before applying post-op visit increase	Total CY2023 Physician Time with RUC Recommended Office Visit, Hospital Visit and Discharge Visit Times	Change in Total Physician Time	Percent Change - Total Time	CY2023 Work RVU before applying post-op visit increase	Surgical Global Work RVU After Incorporating RUC Recommendation for Bundled Office, Hospital and Discharge Visits	Change in Work RVU	Percent Change - Work RVU	Change in Clinical Staff Time	_99204	_99211	_99212	_99213	_99214	_99215	_99231	_99232	_99233	_99238	_99239
10040	Acne surgery (eg, marsupializa	010	34	36	2	6%	0.91	1.13	0.22	24%	0			1								
10060	Incision and drainage of absce	010	57	59	2	4%	1.22	1.44	0.22	18%	0			1								
10061	Incision and drainage of absce	010	83	87	4	5%	2.45	2.89	0.44	18%	0			2								
10080	Incision and drainage of pilon	010	47	49	2	4%	1.22	1.44	0.22	18%	0			1								
10081	Incision and drainage of pilon	010	61	63	2	3%	2.50	2.72	0.22	9%	0			1								
10120	Incision and removal of foreig	010	48	50	2	4%	1.22	1.44	0.22	18%	0			1								
10121	Incision and removal of foreig	010	88	90	2	2%	2.74	2.96	0.22	8%	0			1								
10140	Incision and drainage of hema	010	66	68	2	3%	1.58	1.80	0.22	14%	0			1								
10160	Puncture aspiration of absces	010	61	63	2	3%	1.25	1.47	0.22	18%	0			1								
10180	Incision and drainage, comple	010	52	54	2	4%	2.30	2.52	0.22	10%	0			1								
11004	Debridement of skin, subcutar	000	240	237	-3	-1%	10.80	11.20	0.40	4%	0									1		
11005	Debridement of skin, subcutar	000	265	262	-3	-1%	14.24	14.64	0.40	3%	0									1		
11006	Debridement of skin, subcutar	000	270	267	-3	-1%	13.10	13.50	0.40	3%	0									1		
11200	Removal of skin tags, multiple	010	29	31	2	7%	0.82	1.04	0.22	27%	0			1								
11400	Excision, benign lesion includi	010	36	38	2	6%	0.90	1.12	0.22	24%	0			1								
11401	Excision, benign lesion includi	010	51	53	2	4%	1.28	1.50	0.22	17%	0			1								
11402	Excision, benign lesion includi	010	56	58	2	4%	1.45	1.67	0.22	15%	0			1								
11403	Excision, benign lesion includi	010	76	78	2	3%	1.84	2.06	0.22	12%	0			1								
11404	Excision, benign lesion includi	010	86	88	2	2%	2.11	2.33	0.22	10%	0			1								
11406	Excision, benign lesion includi	010	113	120	7	6%	3.52	3.85	0.33	9%	0				1							
11420	Excision, benign lesion includi	010	36	38	2	6%	1.03	1.25	0.22	21%	0			1								
11421	Excision, benign lesion includi	010	51	53	2	4%	1.47	1.69	0.22	15%	0			1								
11422	Excision, benign lesion includi	010	56	58	2	4%	1.68	1.90	0.22	13%	0			1								
11423	Excision, benign lesion includi	010	76	78	2	3%	2.06	2.28	0.22	11%	0			1								
11424	Excision, benign lesion includi	010	86	88	2	2%	2.48	2.70	0.22	9%	0			1								
11426	Excision, benign lesion includi	010	113	120	7	6%	4.09	4.42	0.33	8%	0				1							
11440	Excision, other benign lesion i	010	36	38	2	6%	1.05	1.27	0.22	21%	0			1								
11441	Excision, other benign lesion i	010	51	53	2	4%	1.53	1.75	0.22	14%	0			1								
11442	Excision, other benign lesion i	010	56	58	2	4%	1.77	1.99	0.22	12%	0			1								
11443	Excision, other benign lesion i	010	76	78	2	3%	2.34	2.56	0.22	9%	0			1								
11444	Excision, other benign lesion i	010	86	88	2	2%	3.19	3.41	0.22	7%	0			1								
11446	Excision, other benign lesion i	010	113	120	7	6%	4.80	5.13	0.33	7%	0				1							
11450	Excision of skin and subcutane	090	93.5	104	10.5	11%	3.22	3.72	0.50	15%	0				1.5							
11451	Excision of skin and subcutane	090	99.5	110	10.5	11%	4.43	4.93	0.50	11%	0				1.5							
11462	Excision of skin and subcutane	090	98.5	109	10.5	11%	3.00	3.50	0.50	17%	0				1.5							
11463	Excision of skin and subcutane	090	109.5	120	10.5	10%	4.43	4.93	0.50	11%	0				1.5							
11470	Excision of skin and subcutane	090	100.5	111	10.5	10%	3.74	4.24	0.50	13%	0				1.5							
11471	Excision of skin and subcutane	090	107.5	118	10.5	10%	4.89	5.39	0.50	10%	0				1.5							
11600	Excision, malignant lesion incl	010	48	55	7	15%	1.63	1.96	0.33	20%	0				1							
11601	Excision, malignant lesion incl	010	63	70	7	11%	2.07	2.40	0.33	16%	0				1							
11602	Excision, malignant lesion incl	010	68	75	7	10%	2.27	2.60	0.33	15%	0				1							
11603	Excision, malignant lesion incl	010	93	100	7	8%	2.82	3.15	0.33	12%	0				1							
11604	Excision, malignant lesion incl	010	103	110	7	7%	3.17	3.50	0.33	10%	0				1							
11606	Excision, malignant lesion incl	010	153	160	7	5%	5.02	5.35	0.33	7%	0				1							
11620	Excision, malignant lesion incl	010	48	55	7	15%	1.64	1.97	0.33	20%	0				1							
11621	Excision, malignant lesion incl	010	63	70	7	11%	2.08	2.41	0.33	16%	0				1							
11622	Excision, malignant lesion incl	010	68	75	7	10%	2.41	2.74	0.33	14%	0				1							
11623	Excision, malignant lesion incl	010	93	100	7	8%	3.11	3.44	0.33	11%	0				1							
11624	Excision, malignant lesion incl	010	103	110	7	7%	3.62	3.95	0.33	9%	0				1							
11626	Excision, malignant lesion incl	010	123	130	7	6%	4.61	4.94	0.33	7%	0				1							
11640	Excision, malignant lesion incl	010	48	55	7	15%	1.67	2.00	0.33	20%	0				1							
11641	Excision, malignant lesion incl	010	63	70	7	11%	2.17	2.50	0.33	15%	0				1							
11642	Excision, malignant lesion incl	010	68	75	7	10%	2.62	2.95	0.33	13%	0				1							
11643	Excision, malignant lesion incl	010	93	100	7	8%	3.42	3.75	0.33	10%	0				1							
11644	Excision, malignant lesion incl	010	108	115	7	6%	4.34	4.67	0.33	8%	0				1							
11646	Excision, malignant lesion incl	010	128	135	7	5%	6.26	6.59	0.33	5%	0				1							
11750	Excision of nail and nail matrix	010	63	65	2	3%	1.58	1.80	0.22	14%	0			1								
11760	Repair of nail bed	010	63	65	2	3%	1.63	1.85	0.22	13%	0			1								
11762	Reconstruction of nail bed wit	010	111	113	2	2%	2.94	3.16	0.22	7%	0			1								
11765	Wedge excision of skin of nail	010	59	61	2	3%	1.22	1.44	0.22	18%	0			1								

11770	Excision of pilonidal cyst or sir	010	71	73	2	3%	2.66	2.88	0.22	8%	0			1								
11771	Excision of pilonidal cyst or sir	090	236	250.5	14.5	6%	6.09	7.44	1.35	22%	0			3.5				1.5			1	
11772	Excision of pilonidal cyst or sir	090	269	284.5	15.5	6%	7.35	8.81	1.46	20%	0			4				1.5			1	
11960	Insertion of tissue expander(s	090	357	408	51	14%	11.49	14.13	2.64	23%	0			1	7						0.5	
11970	Replacement of tissue expand	090	216	227	11	5%	7.49	8.37	0.88	12%	0			2	1						0.5	
11971	Removal of tissue expander w	090	215	228	13	6%	7.02	8.12	1.10	16%	0			3	1						0.5	
12020	Treatment of superficial wour	010	64	66	2	3%	2.67	2.89	0.22	8%	0			1								
12021	Treatment of superficial wour	010	51	53	2	4%	1.89	2.11	0.22	12%	0			1								
12031	Repair, intermediate, wounds	010	56	58	2	4%	2.00	2.22	0.22	11%	0			1								
12032	Repair, intermediate, wounds	010	68	70	2	3%	2.52	2.74	0.22	9%	0			1								
12034	Repair, intermediate, wounds	010	85	87	2	2%	2.97	3.19	0.22	7%	0			1								
12035	Repair, intermediate, wounds	010	124	126	2	2%	3.50	3.83	0.33	9%	0			1							0.5	
12036	Repair, intermediate, wounds	010	138	140	2	1%	4.23	4.56	0.33	8%	0			1							0.5	
12037	Repair, intermediate, wounds	010	158	160	2	1%	5.00	5.33	0.33	7%	0			1							0.5	
12041	Repair, intermediate, wounds	010	59	61	2	3%	2.10	2.32	0.22	10%	0			1								
12042	Repair, intermediate, wounds	010	69	71	2	3%	2.79	3.01	0.22	8%	0			1								
12044	Repair, intermediate, wounds	010	85	87	2	2%	3.19	3.41	0.22	7%	0			1								
12045	Repair, intermediate, wounds	010	146	155	9	6%	3.75	4.41	0.66	18%	0			1	1						0.5	
12046	Repair, intermediate, wounds	010	164	173	9	5%	4.30	4.96	0.66	15%	0			1	1						0.5	
12047	Repair, intermediate, wounds	010	185	194	9	5%	4.95	5.61	0.66	13%	0			1	1						0.5	
12051	Repair, intermediate, wounds	010	58	60	2	3%	2.33	2.55	0.22	9%	0			1								
12052	Repair, intermediate, wounds	010	70	72	2	3%	2.87	3.09	0.22	8%	0			1								
12053	Repair, intermediate, wounds	010	80	82	2	2%	3.17	3.39	0.22	7%	0			1								
12054	Repair, intermediate, wounds	010	96	98	2	2%	3.50	3.72	0.22	6%	0			1								
12055	Repair, intermediate, wounds	010	152	161	9	6%	4.50	5.16	0.66	15%	0			1	1						0.5	
12056	Repair, intermediate, wounds	010	162	171	9	6%	5.30	5.96	0.66	12%	0			1	1						0.5	
12057	Repair, intermediate, wounds	010	184	193	9	5%	6.00	6.66	0.66	11%	0			1	1						0.5	
13100	Repair, complex, trunk; 1.1 cn	010	69	71	2	3%	3.00	3.22	0.22	7%	0			1								
13101	Repair, complex, trunk; 2.6 cn	010	82	84	2	2%	3.50	3.72	0.22	6%	0			1								
13120	Repair, complex, scalp, arms,	010	74	76	2	3%	3.23	3.45	0.22	7%	0			1								
13121	Repair, complex, scalp, arms,	010	85	87	2	2%	4.00	4.22	0.22	5%	0			1								
13131	Repair, complex, forehead, ch	010	92	94	2	2%	3.73	3.95	0.22	6%	0			1								
13132	Repair, complex, forehead, ch	010	97	99	2	2%	4.78	5.00	0.22	5%	0			1								
13151	Repair, complex, eyelids, nose	010	95	97	2	2%	4.34	4.56	0.22	5%	0			1								
13152	Repair, complex, eyelids, nose	010	100	102	2	2%	5.34	5.56	0.22	4%	0			1								
13160	Secondary closure of surgical	090	363	403.5	40.5	11%	12.04	14.18	2.14	18%	0				4			2.5			1	
14000	Adjacent tissue transfer or rea	090	191.5	216	24.5	13%	6.37	7.53	1.16	18%	0				3.5							
14001	Adjacent tissue transfer or rea	090	291	319	28	10%	8.78	10.21	1.43	16%	0				4						0.5	
14020	Adjacent tissue transfer or rea	090	223	251	28	13%	7.22	8.54	1.32	18%	0				4							
14021	Adjacent tissue transfer or rea	090	288	316	28	10%	9.72	11.04	1.32	14%	0				4							
14040	Adjacent tissue transfer or rea	090	223	241	18	8%	8.60	9.70	1.10	13%	0			2	2							
14041	Adjacent tissue transfer or rea	090	303	331	28	9%	10.83	12.15	1.32	12%	0				4							
14060	Adjacent tissue transfer or rea	090	183	201	18	10%	9.23	10.33	1.10	12%	0			2	2							
14061	Adjacent tissue transfer or rea	090	341.5	373	31.5	9%	11.48	12.97	1.49	13%	0				4.5							
14301	Adjacent tissue transfer or rea	090	287	310	23	8%	12.65	13.97	1.32	10%	0			1	3						0.5	
14350	Filleted finger or toe flap, incl	090	318.5	350	31.5	10%	11.05	12.65	1.60	14%	0				4.5						0.5	
15050	Pinch graft, single or multiple,	090	190	218	28	15%	5.57	6.89	1.32	24%	0				4							
15100	Split-thickness autograft, trun	090	281	304	23	8%	9.90	11.46	1.56	16%	0			2	2			1			1	
15110	Epidermal autograft, trunk, ar	090	306	296	-10	-3%	10.97	12.43	1.46	13%	0			3					4			
15115	Epidermal autograft, face, sca	090	356	346	-10	-3%	11.28	12.96	1.68	15%	0			3					4		1	
15120	Split-thickness autograft, face	090	258	274	16	6%	10.15	11.14	0.99	10%	0			1	2						0.5	
15130	Dermal autograft, trunk, arms	090	215	219	4	2%	7.53	8.83	1.30	17%	0			4					1		1	
15135	Dermal autograft, face, scalp,	090	223	227	4	2%	11.03	12.33	1.30	12%	0			4					1		1	
15150	Tissue cultured skin autograft	090	326	320	-6	-2%	9.39	10.87	1.48	16%	0			3					3		1	
15155	Tissue cultured skin autograft	090	336	330	-6	-2%	10.14	11.62	1.48	15%	0			3					3		1	
15200	Full thickness graft, free, inclu	090	287.5	312	24.5	9%	9.15	10.53	1.38	15%	0				3.5						1	
15220	Full thickness graft, free, inclu	090	250	259	9	4%	8.09	9.19	1.10	14%	0			4.5							0.5	
15240	Full thickness graft, free, inclu	090	288	320	32	11%	10.41	12.28	1.87	18%	0			2	4						0.5	
15260	Full thickness graft, free, inclu	090	273	308	35	13%	11.64	13.29	1.65	14%	0				5							
15570	Formation of direct or tubed p	090	363	393	30	8%	10.21	11.97	1.76	17%	-2			1	2	1		1			1	
15572	Formation of direct or tubed p	090	297	320	23	8%	10.12	11.44	1.32	13%	0			1	3						0.5	
15574	Formation of direct or tubed p	090	314	337	23	7%	10.70	12.02	1.32	12%	0			1	3						0.5	
15576	Formation of direct or tubed p	090	271	287	16	6%	9.37	10.36	0.99	11%	0			1	2						0.5	
15600	Delay of flap or sectioning of f	090	179	183	4	2%	2.01	2.56	0.55	27%	0			2							0.5	
15610	Delay of flap or sectioning of f	090	179	183	4	2%	2.52	3.07	0.55	22%	0			2							0.5	
15620	Delay of flap or sectioning of f	090	175.5	193	17.5	10%	3.75	4.58	0.83	22%	0				2.5							
15630	Delay of flap or sectioning of f	090	181.5	199	17.5	10%	4.08	4.91	0.83	20%	0				2.5							

15650	Transfer, intermediate, of any	090	221.5	239	17.5	8%	4.77	5.71	0.94	20%	0				2.5						0.5	
15730	Midface flap (ie, zygomaticofa	090	255.5	268.5	13	5%	13.50	14.60	1.10	8%	0			3	1						0.5	
15731	Forehead flap with preservati	090	369	401	32	9%	14.38	16.12	1.74	12%	-2			1	3	1					0.5	
15733	Muscle, myocutaneous, or fas	090	305	323	18	6%	15.68	16.89	1.21	8%	0			2	2						0.5	
15734	Muscle, myocutaneous, or fas	090	596	617	21	4%	23.00	25.78	2.78	12%	-2			2	2	1		1	2	1	1	
15736	Muscle, myocutaneous, or fas	090	396	428	32	8%	17.04	18.78	1.74	10%	-2			1	3	1					0.5	
15738	Muscle, myocutaneous, or fas	090	516	548	32	6%	19.04	21.68	2.64	14%	0			1	4			2	2		1	
15740	Flap; island pedicle requiring i	090	365.5	402	36.5	10%	11.80	13.75	1.95	16%	0				4.5			1			1	
15750	Flap; neurovascular pedicle	090	400.5	437	36.5	9%	12.96	14.91	1.95	15%	0				4.5			1			1	
15756	Free muscle or myocutaneous	090	809	869	60	7%	36.94	40.40	3.46	9%	-2		1	3	2			8			1	
15757	Free skin flap with microvascu	090	829	880	51	6%	37.15	40.57	3.42	9%	-2		1	3	2			7	1		1	
15758	Free fascial flap with microvas	090	809	855	46	6%	36.90	40.08	3.18	9%	-2		1	3	2			6	1		1	
15760	Graft; composite (eg, full thick	090	278.5	303	24.5	9%	9.86	11.13	1.27	13%	0				3.5						0.5	
15769	Grafting of autologous soft tis	090	191	202	11	6%	6.68	7.67	0.99	15%	0			2	1						1	
15770	Graft; derma-fat-fascia	090	302.5	334	31.5	10%	8.96	10.56	1.60	18%	0				4.5						0.5	
15771	Grafting of autologous fat har	090	181	192	11	6%	6.73	7.50	0.77	11%	0			2	1							
15773	Grafting of autologous fat har	090	180	191	11	6%	6.83	7.60	0.77	11%	0			2	1							
15780	Dermabrasion; total face (eg,	090	244.5	276	31.5	13%	8.73	10.33	1.60	18%	0				4.5						0.5	
15781	Dermabrasion; segmental, fac	090	144	151	7	5%	5.02	5.79	0.77	15%	0			3.5								
15782	Dermabrasion; regional, other	090	123	128	5	4%	4.44	4.99	0.55	12%	0			2.5								
15783	Dermabrasion; superficial, any	090	117	122	5	4%	4.41	4.96	0.55	12%	0			2.5								
15786	Abrasion; single lesion (eg, ke	010	53	55	2	4%	2.08	2.30	0.22	11%	0			1								
15793	Chemical peel, nonfacial; derr	090	175	184	9	5%	3.96	4.95	0.99	25%	0			4.5								
15819	Cervicoplasty	090	316	344	28	9%	10.65	12.08	1.43	13%	0				4						0.5	
15820	Blepharoplasty, lower eyelid;	090	178.5	203	24.5	14%	6.27	7.43	1.16	18%	0				3.5							
15821	Blepharoplasty, lower eyelid;	090	191.5	216	24.5	13%	6.84	8.00	1.16	17%	0				3.5							
15822	Blepharoplasty, upper eyelid;	090	151	158	7	5%	4.62	5.39	0.77	17%	0			3.5								
15823	Blepharoplasty, upper eyelid;	090	161	174	13	8%	6.81	7.91	1.10	16%	0			3	1						0.5	
15830	Excision, excessive skin and su	090	429	455	26	6%	17.11	19.20	2.09	12%	0			2	3			1	1		1	
15832	Excision, excessive skin and su	090	364	392	28	8%	12.85	14.39	1.54	12%	0				4						1	
15833	Excision, excessive skin and su	090	342	370	28	8%	11.90	13.44	1.54	13%	0				4						1	
15834	Excision, excessive skin and su	090	352	382.5	30.5	9%	12.17	13.83	1.66	14%	0				4			0.5			1	
15835	Excision, excessive skin and su	090	344	374.5	30.5	9%	12.99	14.65	1.66	13%	0				4			0.5			1	
15836	Excision, excessive skin and su	090	302	330	28	9%	10.61	12.04	1.43	13%	0				4						0.5	
15837	Excision, excessive skin and su	090	239.5	264	24.5	10%	9.55	10.71	1.16	12%	0				3.5							
15838	Excision, excessive skin and su	090	205.5	230	24.5	12%	8.25	9.41	1.16	14%	0				3.5							
15839	Excision, excessive skin and su	090	274.5	299	24.5	9%	10.50	11.77	1.27	12%	0				3.5						0.5	
15840	Graft for facial nerve paralysis	090	443.5	487.5	44	10%	14.99	17.30	2.31	15%	0				4.5			2.5			1	
15841	Graft for facial nerve paralysis	090	769	846	77	10%	25.99	29.87	3.88	15%	0				6			7			1	
15842	Graft for facial nerve paralysis	090	963.5	1051.5	88	9%	41.01	45.42	4.41	11%	0				6.5			8.5			1	
15845	Graft for facial nerve paralysis	090	460.5	499	38.5	8%	14.32	16.36	2.04	14%	0				5.5						1	
15920	Excision, coccygeal pressure u	090	294	308	14	5%	8.29	9.74	1.45	17%	0			4.5				1			1	
15922	Excision, coccygeal pressure u	090	354	374	20	6%	10.38	12.18	1.80	17%	0			5				2			1	
15931	Excision, sacral pressure ulcer	090	334	368.5	34.5	10%	10.07	12.38	2.31	23%	0			3.5				5.5			1	
15933	Excision, sacral pressure ulcer	090	403	441.5	38.5	10%	11.77	14.52	2.75	23%	0			5.5				5.5			1	
15934	Excision, sacral pressure ulcer	090	441	482.5	41.5	9%	13.68	16.45	2.77	20%	0			4.5				6.5			1	
15935	Excision, sacral pressure ulcer	090	524	574.5	50.5	10%	15.78	19.23	3.45	22%	0			6.5				7.5			1	
15936	Excision, sacral pressure ulcer	090	399	432	33	8%	13.16	15.46	2.30	17%	0			4				5			1	
15937	Excision, sacral pressure ulcer	090	466	505	39	8%	15.14	17.79	2.65	18%	0			4.5				6			1	
15940	Excision, ischial pressure ulcer	090	340	376	36	11%	10.20	12.52	2.32	23%	0			3				6			1	
15941	Excision, ischial pressure ulcer	090	418	459	41	10%	12.41	15.28	2.87	23%	0			5.5				6			1	
15944	Excision, ischial pressure ulcer	090	441	482	41	9%	12.44	15.31	2.87	23%	0			5.5				6			1	
15945	Excision, ischial pressure ulcer	090	473	517.5	44.5	9%	13.75	16.85	3.10	23%	0			6				6.5			1	
15946	Excision, ischial pressure ulcer	090	650	723.5	73.5	11%	24.12	27.82	3.70	15%	-8					4		7.5			1	
15950	Excision, trochanteric pressur	090	282	302.5	20.5	7%	8.03	9.73	1.70	21%	0			4				2.5			1	
15951	Excision, trochanteric pressur	090	389	425	36	9%	11.58	14.21	2.63	23%	0			5.5				5			1	
15952	Excision, trochanteric pressur	090	430	468.5	38.5	9%	12.31	15.06	2.75	22%	0			5.5				5.5			1	
15953	Excision, trochanteric pressur	090	454	493.5	39.5	9%	13.57	16.43	2.86	21%	0			6				5.5			1	
15956	Excision, trochanteric pressur	090	568	621	53	9%	16.79	20.36	3.57	21%	0			6.5				8			1	
15958	Excision, trochanteric pressur	090	572	625	53	9%	16.75	20.32	3.57	21%	0			6.5				8			1	
17000	Destruction (eg, laser surgery	010	23	25	2	9%	0.61	0.83	0.22	36%	0			1								
17004	Destruction (eg, laser surgery	010	35	37	2	6%	1.37	1.59	0.22	16%	0			1								
17106	Destruction of cutaneous vasc	090	86	95	9	10%	3.69	4.24	0.55	15%	0			1	1							
17107	Destruction of cutaneous vasc	090	112	123	11	10%	4.79	5.56	0.77	16%	0			2	1							
17108	Destruction of cutaneous vasc	090	148	161	13	9%	7.49	8.48	0.99	13%	0			3	1							
17110	Destruction (eg, laser surgery	010	29	31	2	7%	0.70	0.92	0.22	31%	0			1								
17111	Destruction (eg, laser surgery	010	31	33	2	6%	0.97	1.19	0.22	23%	0			1								

17260	Destruction, malignant lesion	010	46	48	2	4%	0.96	1.18	0.22	23%	0			1								
17261	Destruction, malignant lesion	010	47	49	2	4%	1.22	1.44	0.22	18%	0			1								
17262	Destruction, malignant lesion	010	50	52	2	4%	1.63	1.85	0.22	13%	0			1								
17263	Destruction, malignant lesion	010	56	58	2	4%	1.84	2.06	0.22	12%	0			1								
17264	Destruction, malignant lesion	010	64	66	2	3%	1.99	2.21	0.22	11%	0			1								
17266	Destruction, malignant lesion	010	67	69	2	3%	2.39	2.61	0.22	9%	0			1								
17270	Destruction, malignant lesion	010	45	47	2	4%	1.37	1.59	0.22	16%	0			1								
17271	Destruction, malignant lesion	010	49	51	2	4%	1.54	1.76	0.22	14%	0			1								
17272	Destruction, malignant lesion	010	52	54	2	4%	1.82	2.04	0.22	12%	0			1								
17273	Destruction, malignant lesion	010	56	58	2	4%	2.10	2.32	0.22	10%	0			1								
17274	Destruction, malignant lesion	010	62	64	2	3%	2.64	2.86	0.22	8%	0			1								
17276	Destruction, malignant lesion	010	70	72	2	3%	3.25	3.47	0.22	7%	0			1								
17280	Destruction, malignant lesion	010	45	47	2	4%	1.22	1.44	0.22	18%	0			1								
17281	Destruction, malignant lesion	010	47	49	2	4%	1.77	1.99	0.22	12%	0			1								
17282	Destruction, malignant lesion	010	55	57	2	4%	2.09	2.31	0.22	11%	0			1								
17283	Destruction, malignant lesion	010	60	62	2	3%	2.69	2.91	0.22	8%	0			1								
17284	Destruction, malignant lesion	010	66	68	2	3%	3.20	3.42	0.22	7%	0			1								
17286	Destruction, malignant lesion	010	78	80	2	3%	4.48	4.70	0.22	5%	0			1								
17340	Cryotherapy (CO2 slush, liquid	010	16.5	16.5	0	0%	0.77	0.77	-	0%	-1		0.5									
17360	Chemical exfoliation for acne	010	29	30	1	3%	1.46	1.57	0.11	8%	0			0.5								
19020	Mastotomy with exploration c	090	177	183	6	3%	3.83	4.60	0.77	20%	0			3								0.5
19101	Biopsy of breast; open, incisio	010	116	118	2	2%	3.23	3.45	0.22	7%	0			1								
19110	Nipple exploration, with or wi	090	144	150	6	4%	4.44	5.10	0.66	15%	0			3								
19112	Excision of lactiferous duct fis	090	137	143	6	4%	3.81	4.47	0.66	17%	0			3								
19120	Excision of cyst, fibroadenoma	090	136	145	9	7%	5.92	6.47	0.55	9%	0			1	1							
19125	Excision of breast lesion ident	090	196	210	14	7%	6.69	7.35	0.66	10%	0				2							
19296	Placement of radiotherapy aft	000	119	119	0	0%	3.63	3.74	0.11	3%	0											0.5
19298	Placement of radiotherapy aft	000	164	164	0	0%	5.75	5.86	0.11	2%	0											0.5
19300	Mastectomy for gynecomastia	090	184	191	7	4%	5.31	6.19	0.88	17%	0			3.5								0.5
19301	Mastectomy, partial (eg, lump	090	216	232	16	7%	10.13	11.12	0.99	10%	0			1	2							0.5
19302	Mastectomy, partial (eg, lump	090	276	294	18	7%	13.99	15.07	1.08	8%	-2			1	1	1						0.5
19303	Mastectomy, simple, complet	090	283	306	23	8%	15.00	16.19	1.19	8%	-2				2	1						0.5
19305	Mastectomy, radical, including	090	463.5	517.5	54	12%	17.46	20.25	2.79	16%	0				4.5			4.5				1
19306	Mastectomy, radical, including	090	544.5	610.5	66	12%	18.13	21.49	3.36	19%	0				5.5			5.5				1
19307	Mastectomy, modified radical	090	343	373	30	9%	17.99	19.51	1.52	8%	-2				3	1						0.5
19316	Mastopexy	090	301	319	18	6%	11.09	12.30	1.21	11%	0			2	2							0.5
19318	Breast reduction	090	367	385	18	5%	16.03	17.24	1.21	8%	0			2	2							0.5
19325	Breast augmentation with imp	090	225	233	8	4%	8.12	9.11	0.99	12%	0			4								0.5
19328	Removal of intact breast impla	090	199	210	11	6%	7.44	8.32	0.88	12%	0			2	1							0.5
19330	Removal of ruptured breast in	090	229	240	11	5%	9.00	9.88	0.88	10%	0			2	1							0.5
19340	Insertion of breast implant on	090	261	279	18	7%	10.48	11.69	1.21	12%	0			2	2							0.5
19342	Insertion or replacement of br	090	252	265	13	5%	10.48	11.58	1.10	10%	0			3	1							0.5
19350	Nipple/areola reconstruction	090	229	237	8	3%	9.11	9.99	0.88	10%	0			4								
19355	Correction of inverted nipples	090	206	227	21	10%	8.52	9.51	0.99	12%	0				3							
19357	Tissue expander placement in	090	344	383	39	11%	14.84	17.04	2.20	15%	0			2	5							0.5
19361	Breast reconstruction; with la	090	552	578	26	5%	23.36	25.58	2.22	10%	0			3	2			2	1			1
19364	Breast reconstruction; with fr	090	767	775	8	1%	42.58	44.85	2.27	5%	-2		1	4	1			1	3			1
19367	Breast reconstruction; with sir	090	590	630	40	7%	26.80	29.04	2.24	8%	-2			1	2	1		3				1
19368	Breast reconstruction; with sir	090	770	824	54	7%	33.90	36.80	2.90	9%	-4			1	2	2		4				1
19369	Breast reconstruction; with bi	090	690	739	49	7%	31.31	33.97	2.66	8%	-4			1	2	2		3				1
19370	Revision of peri-implant capsu	090	255	276	21	8%	9.17	10.27	1.10	12%	0				3							0.5
19371	Peri-implant capsulectomy, br	090	261	277	16	6%	9.98	10.97	0.99	10%	0			1	2							0.5
19380	Revision of reconstructed bre	090	307	325	18	6%	11.17	12.38	1.21	11%	0			2	2							0.5
20100	Exploration of penetrating wo	010	266	283	17	6%	10.38	11.41	1.03	10%	0				1			2				1
20101	Exploration of penetrating wo	010	97	97	0	0%	3.23	3.23	-	0%	-2		1									
20102	Exploration of penetrating wo	010	106	108	2	2%	3.98	4.20	0.22	6%	0			1								
20103	Exploration of penetrating wo	010	136	138	2	1%	5.34	5.56	0.22	4%	0			1								
20150	Excision of epiphyseal bar, wit	090	337	363	26	8%	14.75	16.20	1.45	10%	0				3			1				1
20250	Biopsy, vertebral body, open;	010	248	255	7	3%	5.19	5.87	0.68	13%	0			1				1				1
20251	Biopsy, vertebral body, open;	010	238	245	7	3%	5.72	6.40	0.68	12%	0			1				1				1
20500	Injection of sinus tract; therap	010	56	58	2	4%	1.28	1.50	0.22	17%	0			1								
20520	Removal of foreign body in m	010	65	67	2	3%	1.90	2.12	0.22	12%	0			1								
20525	Removal of foreign body in m	010	136	138	2	1%	3.54	3.87	0.33	9%	0			1								0.5
20615	Aspiration and injection for tr	010	88	90	2	2%	2.33	2.55	0.22	9%	0			1								
20650	Insertion of wire or pin with a	010	114	116	2	2%	2.28	2.61	0.33	14%	0			1								0.5
20661	Application of halo, including	090	266	281.5	15.5	6%	5.26	6.72	1.46	28%	0			4				1.5				1
20662	Application of halo, including	090	285	298	13	5%	6.38	7.72	1.34	21%	0			4				1				1

20663	Application of halo, including	090	264	277	13	5%	5.74	7.08	1.34	23%	0			4				1			1	
20664	Application of halo, including	090	405	440	35	9%	10.06	12.48	2.42	24%	0				4			2		1	1	
20665	Removal of tongs or halo appl	010	57	59	2	4%	1.36	1.58	0.22	16%	0			1								
20670	Removal of implant; superfici	010	57	59	2	4%	1.79	2.01	0.22	12%	0			1								
20680	Removal of implant; deep (eg,	090	181	185	4	2%	5.96	6.51	0.55	9%	0			2							0.5	
20690	Application of a uniplane (pin	090	300	317	17	6%	8.78	10.32	1.54	18%	0			1	2			1	1		1	
20692	Application of a multiplane (p	090	474	518	44	9%	16.27	19.08	2.81	17%	0			4	3			3			1	
20693	Adjustment or revision of exte	090	208	216.5	8.5	4%	6.06	7.06	1.00	17%	0			3				0.5			1	
20694	Removal, under anesthesia, o	090	140	145	5	4%	4.28	4.94	0.66	15%	0			2.5							0.5	
20696	Application of multiplane (pin	090	468	505	37	8%	17.56	19.91	2.35	13%	0			3	3			2			1	
20802	Replantation, arm (includes su	090	1041	1107	66	6%	42.62	46.35	3.73	9%	-2			3	3	1		6			1	
20805	Replantation, forearm (includ	090	1012	1078	66	7%	51.46	55.19	3.73	7%	-2			3	3	1		6			1	
20808	Replantation, hand (includes h	090	1112	1173	61	5%	63.09	66.58	3.49	6%	-2			3	3	1		5			1	
20816	Replantation, digit, excluding	090	697	747	50	7%	31.95	34.80	2.85	9%	0			2	3			5			1	
20822	Replantation, digit, excluding	090	590	632	42	7%	26.66	29.25	2.59	10%	0			3	3			3			1	
20824	Replantation, thumb (includes	090	690	740	50	7%	31.95	34.80	2.85	9%	0			2	3			5			1	
20827	Replantation, thumb (includes	090	625	672	47	8%	27.48	30.31	2.83	10%	0			3	3			4			1	
20838	Replantation, foot, complete a	090	986	1062	76	8%	42.88	47.09	4.21	10%	-2			3	3	1		8			1	
20910	Cartilage graft; costochondral	090	227	235	8	4%	5.53	6.52	0.99	18%	0			4							0.5	
20912	Cartilage graft; nasal septum	090	256	264	8	3%	6.54	7.53	0.99	15%	0			4							0.5	
20920	Fascia lata graft; by stripper	090	195	203.5	8.5	4%	5.51	6.51	1.00	18%	0			3				0.5			1	
20922	Fascia lata graft; by incision a	090	224	237.5	13.5	6%	6.93	8.17	1.24	18%	0			3				1.5			1	
20924	Tendon graft, from a distance	090	194	202.5	8.5	4%	6.68	7.68	1.00	15%	0			3				0.5			1	
20955	Bone graft with microvascular	090	957	1014	57	6%	40.26	43.57	3.31	8%	0			3	3			6			1	
20956	Bone graft with microvascular	090	894	963	69	8%	41.18	45.32	4.14	10%	0			5	2			9			1	
20957	Bone graft with microvascular	090	930	1001	71	8%	42.61	46.97	4.36	10%	0			6	2			9			1	
20969	Free osteocutaneous flap with	090	1048	1124	76	7%	45.43	49.51	4.08	9%	-4			2	2	2		8			1	
20970	Free osteocutaneous flap with	090	988	1064	76	8%	44.58	48.66	4.08	9%	-4			2	2	2		8			1	
20972	Free osteocutaneous flap with	090	898	959	61	7%	44.51	47.87	3.36	8%	-4			2	2	2		5			1	
20973	Free osteocutaneous flap with	090	988	1049	61	6%	47.27	50.63	3.36	7%	-4			2	2	2		5			1	
21010	Arthrotomy, temporomandibu	090	337	351	14	4%	11.04	12.69	1.65	15%	0			3	1			1	1		1	
21011	Excision, tumor, soft tissue of	090	107	116	9	8%	2.99	3.54	0.55	18%	0			1	1							
21012	Excision, tumor, soft tissue of	090	148	157	9	6%	4.45	5.11	0.66	15%	0			1	1						0.5	
21013	Excision, tumor, soft tissue of	090	174	183	9	5%	5.42	6.08	0.66	12%	0			1	1						0.5	
21014	Excision, tumor, soft tissue of	090	217	233	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
21015	Radical resection of tumor (eg	090	277	300	23	8%	9.89	11.21	1.32	13%	0			1	3						0.5	
21016	Radical resection of tumor (eg	090	398	424	26	7%	15.26	17.22	1.96	13%	-2			1	2	1		1	1		1	
21025	Excision of bone (eg, for osteo	090	283	301	18	6%	10.03	11.13	1.10	11%	0			2	2							
21026	Excision of bone (eg, for osteo	090	261	284	23	9%	5.70	7.26	1.56	27%	0			2	2			1			1	
21029	Removal by contouring of ben	090	196	212	16	8%	8.39	9.38	0.99	12%	0			1	2						0.5	
21030	Excision of benign tumor or cy	090	133	144	11	8%	4.91	5.68	0.77	16%	0			2	1							
21031	Excision of torus mandibularis	090	93	95	2	2%	3.30	3.52	0.22	7%	-2		1	1								
21032	Excision of maxillary torus pal	090	125	129	4	3%	3.34	3.78	0.44	13%	0			2								
21034	Excision of malignant tumor o	090	365	395	30	8%	17.38	19.14	1.76	10%	-2			1	2	1		1			1	
21040	Excision of benign tumor or cy	090	137	148	11	8%	4.91	5.68	0.77	16%	0			2	1							
21044	Excision of malignant tumor o	090	325	350	25	8%	12.80	14.45	1.65	13%	-2			2	1	1		1			1	
21045	Excision of malignant tumor o	090	599	629	30	5%	18.37	21.19	2.82	15%	-2			2	2	1		2	1	1	1	
21046	Excision of benign tumor or cy	090	400	432	32	8%	14.21	16.32	2.11	15%	0			3	3			1			1	
21047	Excision of benign tumor or cy	090	565	602	37	7%	20.07	22.42	2.35	12%	0			3	3			2			1	
21048	Excision of benign tumor or cy	090	400	432	32	8%	14.71	16.82	2.11	14%	0			3	3			1			1	
21049	Excision of benign tumor or cy	090	550	587	37	7%	19.32	21.67	2.35	12%	0			3	3			2			1	
21050	Condylectomy, temporomand	090	377	404	27	7%	11.76	13.63	1.87	16%	-2			3	1	1		1			1	
21060	Meniscectomy, partial or com	090	334	357	23	7%	11.07	12.63	1.56	14%	0			2	2			1			1	
21070	Coronoidectomy (separate pr	090	246	257	11	4%	8.62	9.50	0.88	10%	-2		1	2	1						0.5	
21073	Manipulation of temporoman	090	134	142	8	6%	3.45	4.33	0.88	26%	0			4								
21100	Application of halo type appli	090	232	247	15	6%	4.73	6.05	1.32	28%	0			4	1						0.5	
21110	Application of interdental fixa	090	239	259	20	8%	5.99	7.31	1.32	22%	0			3	2							
21120	Genioplasty; augmentation (a	090	184	191	7	4%	5.10	5.87	0.77	15%	0			3.5								
21121	Genioplasty; sliding osteotom	090	193	200	7	4%	7.81	8.58	0.77	10%	0			3.5								
21122	Genioplasty; sliding osteotom	090	247	255	8	3%	8.71	9.70	0.99	11%	0			4							0.5	
21123	Genioplasty; sliding, augment	090	297	305	8	3%	11.34	12.44	1.10	10%	0			4							1	
21125	Augmentation, mandibular bo	090	297	305	8	3%	10.80	11.90	1.10	10%	0			4							1	
21127	Augmentation, mandibular bo	090	358	388.5	30.5	9%	12.44	14.10	1.66	13%	0				4			0.5			1	
21137	Reduction forehead; contouri	090	310	321	11	4%	10.24	11.23	0.99	10%	-2		1	2	1						1	
21138	Reduction forehead; contouri	090	400	416	16	4%	12.87	13.97	1.10	9%	-2		1	1	2						1	
21139	Reduction forehead; contouri	090	466	482	16	3%	15.02	16.25	1.23	8%	-2		1	2	1			1			1	
21141	Reconstruction midface, LeFo	090	474	515	41	9%	19.57	22.23	2.66	14%	-2			4	2	1		2			1	

21142	Reconstruction midface, LeFo	090	485	526	41	8%	20.28	22.94	2.66	13%	-2			4	2	1		2			1	
21143	Reconstruction midface, LeFo	090	497	538	41	8%	21.05	23.71	2.66	13%	-2			4	2	1		2			1	
21145	Reconstruction midface, LeFo	090	515	564.5	49.5	10%	23.94	26.50	2.56	11%	0				6			1.5			1	
21146	Reconstruction midface, LeFo	090	567.5	623	55.5	10%	24.87	27.72	2.85	11%	0				6.5			2			1	
21147	Reconstruction midface, LeFo	090	707.5	765.5	58	8%	26.47	29.44	2.97	11%	0				6.5			2.5			1	
21150	Reconstruction midface, LeFo	090	623	646	23	4%	25.96	27.52	1.56	6%	-4		2	2	2			1			1	
21151	Reconstruction midface, LeFo	090	686	714	28	4%	29.02	30.82	1.80	6%	-4		2	2	2			2			1	
21154	Reconstruction midface, LeFo	090	853	891.5	38.5	5%	31.29	33.57	2.28	7%	-5		2	2	1		1	2.5			1	
21155	Reconstruction midface, LeFo	090	939	975	36	4%	35.22	37.38	2.16	6%	-5		2	2	1		1	2			1	
21159	Reconstruction midface, LeFo	090	986	1027	41	4%	43.14	45.54	2.40	6%	-5		2	2	1		1	3			1	
21160	Reconstruction midface, LeFo	090	1121	1137	16	1%	47.19	49.37	2.18	5%	-5		2	2	1		1		2.5		1	
21172	Reconstruction superior-later	090	641	646	5	1%	28.20	29.49	1.29	5%	-4		2	2	1				1.5		1	
21175	Reconstruction, bifrontal, sup	090	731	738	7	1%	33.56	34.75	1.19	4%	-4		2	2	1				1		1	
21179	Reconstruction, entire or majo	090	590	601	11	2%	22.65	23.64	0.99	4%	-2		1	2	1						1	
21180	Reconstruction, entire or majo	090	670	681	11	2%	25.58	26.57	0.99	4%	-2		1	2	1						1	
21181	Reconstruction by contouring	090	396	410	14	4%	10.28	11.29	1.01	10%	-4		2	1	1			1			1	
21182	Reconstruction of orbital walls	090	801	808	7	1%	32.58	33.77	1.19	4%	-4		2	2	1				1		1	
21183	Reconstruction of orbital walls	090	891	894	3	0%	35.70	37.09	1.39	4%	-4		2	2	1				2		1	
21184	Reconstruction of orbital walls	090	996	999	3	0%	38.62	40.01	1.39	4%	-4		2	2	1				2		1	
21188	Reconstruction midface, oste	090	572	599	27	5%	23.15	24.63	1.48	6%	-5		2		1		1	1			1	
21193	Reconstruction of mandibular	090	386	428.5	42.5	11%	18.90	21.13	2.23	12%	0				5			1.5			1	
21194	Reconstruction of mandibular	090	482.5	531	48.5	10%	21.82	24.34	2.52	12%	0				5.5			2			1	
21195	Reconstruction of mandibular	090	384.5	430.5	46	12%	19.16	21.56	2.40	13%	0				5.5			1.5			1	
21196	Reconstruction of mandibular	090	411.5	457.5	46	11%	20.83	23.23	2.40	11%	0				5.5			1.5			1	
21198	Osteotomy, mandible, segme	090	359.5	396	36.5	10%	15.71	17.66	1.95	12%	0				4.5			1			1	
21199	Osteotomy, mandible, segme	090	283	290	7	2%	16.73	17.92	1.19	7%	0			2	1				1		1	
21206	Osteotomy, maxilla, segmenta	090	361.5	395.5	34	9%	15.59	17.42	1.83	12%	0				4.5			0.5			1	
21208	Osteoplasty, facial bones; aug	090	320	349	29	9%	11.42	13.27	1.85	16%	-2			3	2	1					0.5	
21209	Osteoplasty, facial bones; red	090	270	297	27	10%	7.82	9.58	1.76	23%	0			3	3						0.5	
21210	Graft, bone; nasal, maxillary c	090	318	352	34	11%	11.69	13.54	1.85	16%	-2			2	3	1						
21215	Graft, bone; mandible (includ	090	334	368	34	10%	12.23	14.08	1.85	15%	-2			2	3	1						
21230	Graft; rib cartilage, autogenou	090	342	353	11	3%	11.17	12.16	0.99	9%	0			2	1						1	
21235	Graft; ear cartilage, autogeno	090	265	285	20	8%	7.50	8.93	1.43	19%	0			3	2						0.5	
21240	Arthroplasty, temporomandib	090	425	472	47	11%	16.07	18.51	2.44	15%	0				6			1			1	
21242	Arthroplasty, temporomandib	090	402	432	30	7%	14.59	16.99	2.40	16%	-2			3	2	1		1	1		1	
21243	Arthroplasty, temporomandib	090	751	827	76	10%	24.53	28.73	4.20	17%	0				10			2	1		1	
21244	Reconstruction of mandible, e	090	387	422	35	9%	13.62	16.26	2.64	19%	-2			3	2	1		2	1		1	
21245	Reconstruction of mandible o	090	376	408	32	9%	13.12	15.10	1.98	15%	-2			2	2	1		1			1	
21246	Reconstruction of mandible o	090	369	382	13	4%	12.92	14.13	1.21	9%	0			3	1						1	
21247	Reconstruction of mandibular	090	544	590	46	8%	24.37	27.14	2.77	11%	-2			3	3	1		2			1	
21248	Reconstruction of mandible o	090	223	251	28	13%	12.74	14.06	1.32	10%	0				4							
21249	Reconstruction of mandible o	090	295	323	28	9%	18.77	20.09	1.32	7%	0				4							
21255	Reconstruction of zygomatic a	090	457	503	46	10%	18.46	21.23	2.77	15%	-2			3	3	1		2			1	
21256	Reconstruction of orbit with o	090	444	467	23	5%	17.66	19.38	1.72	10%	-2			2	2	1			1			
21260	Periorbital osteotomies for or	090	426	436	10	2%	17.90	19.62	1.72	10%	0			2	2				2		1	
21261	Periorbital osteotomies for or	090	674	697	23	3%	34.07	36.94	2.87	8%	-2			2	3	1			2	1	1	
21263	Periorbital osteotomies for or	090	639	662	23	4%	31.01	33.88	2.87	9%	-2			2	3	1			2	1	1	
21267	Orbital repositioning, periorbi	090	476	495	19	4%	20.69	22.83	2.14	10%	-2			2	2	1			2		1	
21268	Orbital repositioning, periorbi	090	614	637	23	4%	27.07	29.94	2.87	11%	-2			2	3	1			2	1	1	
21270	Malar augmentation, prosthe	090	362	373	11	3%	10.63	11.40	0.77	7%	0			2	1							
21275	Secondary revision of orbitocr	090	360	376	16	4%	11.76	12.99	1.23	10%	0			2	1			1			1	
21280	Medial canthopexy (separate	090	251	276	25	10%	7.13	8.43	1.30	18%	-2			1	2	1						
21282	Lateral canthopexy	090	209	227	18	9%	4.27	5.24	0.97	23%	-2			1	1	1						
21295	Reduction of masseter muscle	090	101	110	9	9%	1.90	2.45	0.55	29%	0			1	1							
21296	Reduction of masseter muscle	090	219	235	16	7%	4.78	6.01	1.23	26%	0			2	1			1			1	
21325	Open treatment of nasal fract	090	217	228	11	5%	4.18	5.17	0.99	24%	0			2	1						1	
21330	Open treatment of nasal fract	090	251	262	11	4%	5.79	6.78	0.99	17%	0			2	1						1	
21335	Open treatment of nasal fract	090	293	304	11	4%	9.02	10.01	0.99	11%	0			2	1						1	
21336	Open treatment of nasal septa	090	243	268	25	10%	6.77	8.20	1.43	21%	0			2	3							
21337	Closed treatment of nasal sep	090	154	170	16	10%	3.39	4.27	0.88	26%	0			1	2							
21338	Open treatment of nasoethmo	090	291	302	11	4%	6.87	7.86	0.99	14%	0			2	1						1	
21339	Open treatment of nasoethmo	090	315	326	11	3%	8.50	9.49	0.99	12%	0			2	1						1	
21340	Percutaneous treatment of na	090	347	365	18	5%	11.49	12.81	1.32	11%	0			2	2						1	
21343	Open treatment of depressed	090	389	410	21	5%	14.32	16.17	1.85	13%	0			2	3				1		1	
21344	Open treatment of complicate	090	519	537	18	3%	21.57	23.82	2.25	10%	0			2	3				1	1	1	
21345	Closed treatment of nasomax	090	312	337	25	8%	9.06	10.84	1.78	20%	0			3	2			1			1	
21346	Open treatment of nasomaxill	090	352	375	23	7%	11.45	13.01	1.56	14%	0			2	2			1			1	

21347	Open treatment of nasomaxill	090	393	416	23	6%	13.53	15.09	1.56	12%	0			2	2			1			1	
21348	Open treatment of nasomaxill	090	452	475	23	5%	17.52	19.08	1.56	9%	0			2	2			1			1	
21355	Percutaneous treatment of fra	010	176	192	16	9%	4.45	5.33	0.88	20%	0			1	2							
21356	Open treatment of depressed	010	185	201	16	9%	4.83	5.71	0.88	18%	0			1	2							
21360	Open treatment of depressed	090	273	291	18	7%	7.19	8.29	1.10	15%	0			2	2							
21365	Open treatment of complicate	090	432	477	45	10%	16.77	19.12	2.35	14%	0				5			2			1	
21366	Open treatment of complicate	090	467	490	23	5%	18.60	20.16	1.56	8%	0			2	2			1			1	
21385	Open treatment of orbital floo	090	324	335	11	3%	9.57	10.56	0.99	10%	0			2	1						1	
21386	Open treatment of orbital floo	090	320	331	11	3%	9.57	10.56	0.99	10%	0			2	1						1	
21387	Open treatment of orbital floo	090	335	346	11	3%	10.11	11.10	0.99	10%	0			2	1						1	
21390	Open treatment of orbital floo	090	346	360	14	4%	11.23	12.40	1.17	10%	-2			1	1	1			1			
21395	Open treatment of orbital floo	090	347	357	10	3%	14.70	15.91	1.21	8%	0			1	1			1	1		1	
21400	Closed treatment of fracture	090	102	106	4	4%	1.50	1.94	0.44	29%	0			2								
21401	Closed treatment of fracture	090	204	215	11	5%	3.68	4.67	0.99	27%	0			2	1						1	
21406	Open treatment of fracture of	090	284	295	11	4%	7.42	8.41	0.99	13%	0			2	1						1	
21407	Open treatment of fracture of	090	316	327	11	3%	9.02	10.01	0.99	11%	0			2	1						1	
21408	Open treatment of fracture of	090	385	396	11	3%	12.78	13.77	0.99	8%	0			2	1						1	
21421	Closed treatment of palatal or	090	256	278	22	9%	6.02	7.54	1.52	25%	-2			3	1	1					0.5	
21422	Open treatment of palatal or	090	319	330	11	3%	8.73	9.72	0.99	11%	0			2	1						1	
21423	Open treatment of palatal or	090	359	372	13	4%	10.85	12.06	1.21	11%	0			3	1						1	
21431	Closed treatment of craniofac	090	295	318	23	8%	7.90	9.46	1.56	20%	0			2	2			1			1	
21432	Open treatment of craniofacia	090	330	339	9	3%	8.82	9.72	0.90	10%	0			2				1			1	
21433	Open treatment of craniofacia	090	592	620	28	5%	26.29	28.09	1.80	7%	0			2	2			2			1	
21435	Open treatment of craniofacia	090	1001	1024	23	2%	20.26	23.68	3.42	17%	-2			2	2	1		2	2	2	1	
21436	Open treatment of craniofacia	090	644	671	27	4%	30.30	32.97	2.67	9%	-2			2	3	1			1	1	1	
21440	Closed treatment of mandibu	090	162	180	18	11%	3.44	4.54	1.10	32%	0			2	2							
21445	Open treatment of mandibula	090	252	274	22	9%	6.26	7.78	1.52	24%	-2			3	1	1					0.5	
21450	Closed treatment of mandibu	090	162	180	18	11%	3.71	4.81	1.10	30%	0			2	2							
21451	Closed treatment of mandibu	090	252	272	20	8%	5.65	7.08	1.43	25%	0			3	2						0.5	
21452	Percutaneous treatment of m	090	133	144	11	8%	2.40	3.28	0.88	37%	0			2	1						0.5	
21453	Closed treatment of mandibu	090	261	288	27	10%	6.64	8.40	1.76	27%	0			3	3						0.5	
21454	Open treatment of mandibula	090	288	313	25	9%	7.36	9.14	1.78	24%	0			3	2			1			1	
21461	Open treatment of mandibula	090	318	350	32	10%	9.31	11.42	2.11	23%	0			3	3			1			1	
21462	Open treatment of mandibula	090	342	374	32	9%	11.01	13.12	2.11	19%	0			3	3			1			1	
21465	Open treatment of mandibula	090	373	405	32	9%	13.12	15.23	2.11	16%	0			3	3			1			1	
21470	Open treatment of complicate	090	469	523.5	54.5	12%	17.54	20.34	2.80	16%	0				6			2.5			1	
21485	Closed treatment of temporo	090	203	223	20	10%	4.77	6.09	1.32	28%	0			3	2							
21490	Open treatment of temporom	090	368	395	27	7%	12.95	14.71	1.76	14%	0			3	3						0.5	
21497	Interdental wiring, for conditi	090	239	259	20	8%	4.64	6.07	1.43	31%	0			3	2						0.5	
21501	Incision and drainage, deep ab	090	176	183	7	4%	3.98	4.86	0.88	22%	0			3.5							0.5	
21502	Incision and drainage, deep ab	090	275	293	18	7%	7.55	9.13	1.58	21%	0			4				2			1	
21510	Incision, deep, with opening o	090	295	314	19	6%	6.20	7.89	1.69	27%	0			4.5				2			1	
21550	Biopsy, soft tissue of neck or t	010	89	91	2	2%	2.11	2.33	0.22	10%	0			1								
21552	Excision, tumor, soft tissue of	090	194	203	9	5%	6.49	7.15	0.66	10%	0			1	1						0.5	
21554	Excision, tumor, soft tissue of	090	320	341	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
21555	Excision, tumor, soft tissue of	090	138	147	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
21556	Excision, tumor, soft tissue of	090	234	250	16	7%	7.66	8.65	0.99	13%	0			1	2						0.5	
21557	Radical resection of tumor (eg	090	398	422	24	6%	14.75	16.62	1.87	13%	0			1	3			1	1		1	
21558	Radical resection of tumor (eg	090	502	524	22	4%	21.58	23.74	2.16	10%	-2			1	2	1		1	2		1	
21600	Excision of rib, partial	090	251	266.5	15.5	6%	7.26	8.72	1.46	20%	0			4				1.5			1	
21601	Excision of chest wall tumor in	090	510.5	565	54.5	11%	17.78	20.60	2.82	16%	0				3.5			6			1	
21602	Excision of chest wall tumor in	090	669.5	745	75.5	11%	22.19	26.00	3.81	17%	0				6.5			6			1	
21603	Excision of chest wall tumor in	090	760	846.5	86.5	11%	25.17	29.50	4.33	17%	0				7			7.5			1	
21610	Costotransversectomy (separ	090	440	476	36	8%	15.91	17.84	1.93	12%	0				3			3			1	
21615	Excision first and/or cervical r	090	334	358	24	7%	10.45	12.38	1.93	18%	0			4.5				3			1	
21616	Excision first and/or cervical r	090	393	420.5	27.5	7%	12.69	14.85	2.16	17%	0			5				3.5			1	
21620	Ostectomy of sternum, partia	090	285	305.5	20.5	7%	7.28	8.98	1.70	23%	0			4				2.5			1	
21627	Sternal debridement	090	264	284.5	20.5	8%	7.30	9.00	1.70	23%	0			4				2.5			1	
21630	Radical resection of sternum;	090	597	640.5	43.5	7%	19.18	22.17	2.99	16%	0			5.5				6.5			1	
21632	Radical resection of sternum;	090	602	645.5	43.5	7%	19.68	22.67	2.99	15%	0			5.5				6.5			1	
21685	Hyoid myotomy and suspensi	090	440	479	39	9%	15.26	17.82	2.56	17%	-6			1	2	3			1		1	
21700	Division of scalenus anticus; w	090	188	193	5	3%	6.31	7.08	0.77	12%	0			2.5							1	
21705	Division of scalenus anticus; w	090	273	286.5	13.5	5%	9.92	11.16	1.24	13%	0			3				1.5			1	
21720	Division of sternocleidomasto	090	157	162	5	3%	5.80	6.46	0.66	11%	0			2.5							0.5	
21725	Division of sternocleidomasto	090	258	266.5	8.5	3%	7.19	8.19	1.00	14%	0			3				0.5			1	
21740	Reconstructive repair of pectu	090	391	406	15	4%	17.57	18.89	1.32	8%	0				2			1	1		1	
21750	Closure of median sternotomy	090	306	309	3	1%	11.40	12.15	0.75	7%	0				1				1		1	

21820	Closed treatment of sternum	090	59	62	3	5%	1.36	1.69	0.33	24%	0			1.5								
21825	Open treatment of sternum fr	090	253	267.5	14.5	6%	7.76	9.11	1.35	17%	0			3.5				1.5			1	
21920	Biopsy, soft tissue of back or f	010	69	71	2	3%	2.11	2.33	0.22	10%	0			1								
21925	Biopsy, soft tissue of back or f	090	145	151	6	4%	4.63	5.40	0.77	17%	0			3							0.5	
21930	Excision, tumor, soft tissue of	090	165	174	9	5%	4.94	5.60	0.66	13%	0			1	1						0.5	
21931	Excision, tumor, soft tissue of	090	206	215	9	4%	6.88	7.54	0.66	10%	0			1	1						0.5	
21932	Excision, tumor, soft tissue of	090	276	292	16	6%	9.82	11.05	1.23	13%	0			2	1			1			1	
21933	Excision, tumor, soft tissue of	090	315	336	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
21935	Radical resection of tumor (eg	090	408	432	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
21936	Radical resection of tumor (eg	090	510	532	22	4%	22.55	24.71	2.16	10%	-2			1	2	1		1	2		1	
22010	Incision and drainage, open, d	090	378	412	34	9%	12.75	15.10	2.35	18%	0			1	3			3	1		1	
22015	Incision and drainage, open, d	090	373	407	34	9%	12.64	14.99	2.35	19%	0			1	3			3	1		1	
22100	Partial excision of posterior ve	090	372	410	38	10%	11.00	13.02	2.02	18%	0				4			2			1	
22101	Partial excision of posterior ve	090	387	430	43	11%	11.08	13.34	2.26	20%	0				4			3			1	
22102	Partial excision of posterior ve	090	387	430	43	11%	11.08	13.34	2.26	20%	0				4			3			1	
22110	Partial excision of vertebral bo	090	479	537	58	12%	14.00	16.98	2.98	21%	0				4			6			1	
22112	Partial excision of vertebral bo	090	530	590.5	60.5	11%	14.07	17.17	3.10	22%	0				4			6.5			1	
22114	Partial excision of vertebral bo	090	530	590.5	60.5	11%	14.07	17.17	3.10	22%	0				4			6.5			1	
22206	Osteotomy of spine, posterior	090	758	779	21	3%	37.18	39.69	2.51	7%	0			1	3			2	3		1	
22207	Osteotomy of spine, posterior	090	758	779	21	3%	36.68	39.19	2.51	7%	0			1	3			2	3		1	
22210	Osteotomy of spine, posterior	090	609	679	70	11%	25.38	28.93	3.55	14%	0				5			7			1	
22212	Osteotomy of spine, posterior	090	640	710	70	11%	20.99	24.54	3.55	17%	0				5			7			1	
22214	Osteotomy of spine, posterior	090	624	694	70	11%	21.02	24.57	3.55	17%	0				5			7			1	
22220	Osteotomy of spine, including	090	585	652.5	67.5	12%	22.94	26.37	3.43	15%	0				5			6.5			1	
22222	Osteotomy of spine, including	090	651	723.5	72.5	11%	23.09	26.76	3.67	16%	0				5			7.5			1	
22224	Osteotomy of spine, including	090	666	738.5	72.5	11%	23.09	26.76	3.67	16%	0				5			7.5			1	
22310	Closed treatment of vertebral	090	131	137	6	5%	3.45	4.22	0.77	22%	0			3							0.5	
22315	Closed treatment of vertebral	090	252	285	33	13%	10.11	11.89	1.78	18%	0				4			1			1	
22318	Open treatment and/or reduc	090	451	484	33	7%	22.72	24.63	1.91	8%	0			1	3			2			1	
22319	Open treatment and/or reduc	090	483	521	38	8%	25.33	27.48	2.15	8%	0			1	3			3			1	
22325	Open treatment and/or reduc	090	528	590.5	62.5	12%	19.87	23.06	3.19	16%	0				5			5.5			1	
22326	Open treatment and/or reduc	090	480	535.5	55.5	12%	20.84	23.70	2.86	14%	0				4			5.5			1	
22327	Open treatment and/or reduc	090	604	684	80	13%	20.77	24.80	4.03	19%	0				5			9			1	
22510	Percutaneous vertebroplasty	010	150	157	7	5%	7.90	8.34	0.44	6%	0				1						0.5	
22511	Percutaneous vertebroplasty	010	150	157	7	5%	7.33	7.77	0.44	6%	0				1						0.5	
22513	Percutaneous vertebral augm	010	155	162	7	5%	8.65	9.09	0.44	5%	0				1						0.5	
22514	Percutaneous vertebral augm	010	150	157	7	5%	7.99	8.43	0.44	6%	0				1						0.5	
22526	Percutaneous intradiscal elect	010	145	147	2	1%	5.85	6.18	0.33	6%	0			1							0.5	
22532	Arthrodesis, lateral extracavit	090	583	613	30	5%	25.99	28.54	2.55	10%	0			1	3			3	2		1	
22533	Arthrodesis, lateral extracavit	090	549	583	34	6%	24.79	27.14	2.35	9%	0			1	3			3	1		1	
22548	Arthrodesis, anterior transora	090	673	741	68	10%	27.06	30.52	3.46	13%	0				4			8			1	
22551	Arthrodesis, anterior interbod	090	395	412	17	4%	25.00	26.41	1.41	6%	0				3				1		1	
22554	Arthrodesis, anterior interbod	090	362	379	17	5%	17.69	19.10	1.41	8%	0				3				1		1	
22556	Arthrodesis, anterior interbod	090	557	600	43	8%	24.70	26.96	2.26	9%	0				4			3			1	
22558	Arthrodesis, anterior interbod	090	525	563	38	7%	23.53	25.55	2.02	9%	0				4			2			1	
22586	Arthrodesis, pre-sacral interbo	090	500	534	34	7%	28.12	30.34	2.22	8%	0				4			2	1		1	
22590	Arthrodesis, posterior technic	090	501	544	43	9%	21.76	24.02	2.26	10%	0				4			3			1	
22595	Arthrodesis, posterior technic	090	521	579	58	11%	20.64	23.62	2.98	14%	0				4			6			1	
22600	Arthrodesis, posterior or post	090	490	548	58	12%	17.40	20.38	2.98	17%	0				4			6			1	
22610	Arthrodesis, posterior or post	090	549	614.5	65.5	12%	17.28	20.62	3.34	19%	0				4			7.5			1	
22612	Arthrodesis, posterior or post	090	482	500	18	4%	23.53	25.38	1.85	8%	0				3			1	2		1	
22630	Arthrodesis, posterior interbo	090	479	499	20	4%	22.09	24.03	1.94	9%	-2				2	1		1	2		1	
22633	Arthrodesis, combined poster	090	509	529	20	4%	26.80	28.74	1.94	7%	-2				2	1		1	2		1	
22800	Arthrodesis, posterior, for spi	090	571	634	63	11%	19.50	22.72	3.22	17%	0				4			7			1	
22802	Arthrodesis, posterior, for spi	090	538	586	48	9%	32.11	34.61	2.50	8%	0				4			4			1	
22804	Arthrodesis, posterior, for spi	090	595	648	53	9%	37.50	40.24	2.74	7%	0				4			5			1	
22808	Arthrodesis, anterior, for spin	090	530	583	53	10%	27.51	30.25	2.74	10%	0				4			5			1	
22810	Arthrodesis, anterior, for spin	090	595	648	53	9%	31.50	34.24	2.74	9%	0				4			5			1	
22812	Arthrodesis, anterior, for spin	090	700	772.5	72.5	10%	34.25	37.92	3.67	11%	0				5			7.5			1	
22818	Kyphectomy, circumferential e	090	747	781	34	5%	34.33	37.34	3.01	9%	0				3			5	3		1	
22819	Kyphectomy, circumferential e	090	795	841	46	6%	39.38	42.96	3.58	9%	0				4			6	3		1	
22830	Exploration of spinal fusion	090	301	317	16	5%	11.22	12.58	1.36	12%	0			3				2			1	
22849	Reinsertion of spinal fixation d	090	397	425.5	28.5	7%	19.17	21.13	1.96	10%	0			3				4.5			1	
22850	Removal of posterior nonsegn	090	243	255.5	12.5	5%	9.82	10.95	1.13	12%	0			2.5				1.5			1	
22852	Removal of posterior segment	090	266	281	15	6%	9.37	10.62	1.25	13%	0			2.5				2			1	
22855	Removal of anterior instrume	090	418	449	31	7%	15.86	17.94	2.08	13%	0			3				5			1	
22856	Total disc arthroplasty (artific	090	367	393	26	7%	24.05	25.50	1.45	6%	0				3			1			1	

22857	Total disc arthroplasty (artific	090	550	575	25	5%	27.13	29.31	2.18	8%	0				4			1	2		1
22861	Revision including replacemer	090	477	490	13	3%	33.36	34.97	1.61	5%	0				3				2		1
22862	Revision including replacemer	090	620	645	25	4%	32.63	34.81	2.18	7%	0				4			1	2		1
22864	Removal of total disc arthropl	090	457	470	13	3%	29.40	31.01	1.61	5%	0				3				2		1
22865	Removal of total disc arthropl	090	600	630	30	5%	31.75	34.17	2.42	8%	0				4			2	2		1
22867	Insertion of interlaminar/inter	090	271	292	21	8%	15.00	16.10	1.10	7%	0				3						0.5
22869	Insertion of interlaminar/inter	090	175	184	9	5%	7.03	7.69	0.66	9%	0			1	1						0.5
22900	Excision, tumor, soft tissue of	090	244	260	16	7%	8.32	9.55	1.23	15%	0			2	1			1			1
22901	Excision, tumor, soft tissue of	090	284	300	16	6%	10.11	11.34	1.23	12%	0			2	1			1			1
22902	Excision, tumor, soft tissue of	090	148	157	9	6%	4.42	5.08	0.66	15%	0			1	1						0.5
22903	Excision, tumor, soft tissue of	090	179	188	9	5%	6.39	7.05	0.66	10%	0			1	1						0.5
22904	Radical resection of tumor (eg	090	396	420	24	6%	16.69	18.56	1.87	11%	0			1	3			1	1		1
22905	Radical resection of tumor (eg	090	463	494	31	7%	21.58	23.78	2.20	10%	-2			1	2	1		2	1		1
23000	Removal of subdeltoid calcare	090	153	158	5	3%	4.48	5.14	0.66	15%	0			2.5							0.5
23020	Capsular contracture release (	090	292	310	18	6%	9.36	10.94	1.58	17%	0			4				2			1
23030	Incision and drainage, shoulde	010	152	154	2	1%	3.47	3.91	0.44	13%	0			1							1
23031	Incision and drainage, shoulde	010	94	96	2	2%	2.79	3.01	0.22	8%	0			1							
23035	Incision, bone cortex (eg, oste	090	300	323	23	8%	9.16	10.98	1.82	20%	0			4				3			1
23040	Arthrotomy, glenohumeral joi	090	305	328	23	8%	9.75	11.57	1.82	19%	0			4				3			1
23044	Arthrotomy, acromioclavicula	090	253	272.5	19.5	8%	7.59	9.18	1.59	21%	0			3.5				2.5			1
23065	Biopsy, soft tissue of shoulder	010	64	65	1	2%	2.30	2.41	0.11	5%	0			0.5							
23066	Biopsy, soft tissue of shoulder	090	133	139	6	5%	4.30	4.96	0.66	15%	0			3							
23071	Excision, tumor, soft tissue of	090	191	200	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5
23073	Excision, tumor, soft tissue of	090	285	306	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1
23075	Excision, tumor, soft tissue of	090	142	151	9	6%	4.21	4.87	0.66	16%	0			1	1						0.5
23076	Excision, tumor, soft tissue of	090	221	237	16	7%	7.41	8.40	0.99	13%	0			1	2						0.5
23077	Radical resection of tumor (eg	090	433	457	24	6%	17.66	19.53	1.87	11%	0			1	3			1	1		1
23078	Radical resection of tumor (eg	090	490	516	26	5%	22.55	24.51	1.96	9%	-2			1	2	1		1	1		1
23100	Arthrotomy, glenohumeral joi	090	216	223	7	3%	6.20	7.19	0.99	16%	0			3.5							1
23101	Arthrotomy, acromioclavicula	090	195	201	6	3%	5.72	6.60	0.88	15%	0			3							1
23105	Arthrotomy; glenohumeral joi	090	276	286.5	10.5	4%	8.48	9.70	1.22	14%	0			4				0.5			1
23106	Arthrotomy; sternoclavicular j	090	214	221	7	3%	6.13	7.12	0.99	16%	0			3.5							1
23107	Arthrotomy, glenohumeral joi	090	260	270.5	10.5	4%	8.87	10.09	1.22	14%	0			4				0.5			1
23120	Claviculectomy; partial	090	227	245	18	8%	7.39	8.60	1.21	16%	0			2	2						0.5
23125	Claviculectomy; total	090	279	289.5	10.5	4%	9.64	10.86	1.22	13%	0			4				0.5			1
23130	Acromioplasty or acromionect	090	231	240	9	4%	7.77	8.87	1.10	14%	0			4.5							0.5
23140	Excision or curettage of bone	090	242	251.5	9.5	4%	7.12	8.23	1.11	16%	0			3.5				0.5			1
23145	Excision or curettage of bone	090	307	320	13	4%	9.40	10.74	1.34	14%	0			4				1			1
23146	Excision or curettage of bone	090	269	279.5	10.5	4%	8.08	9.30	1.22	15%	0			4				0.5			1
23150	Excision or curettage of bone	090	296	314	18	6%	8.91	10.49	1.58	18%	0			4				2			1
23155	Excision or curettage of bone	090	355	376.5	21.5	6%	10.86	12.67	1.81	17%	0			4.5				2.5			1
23156	Excision or curettage of bone	090	310	328	18	6%	9.11	10.69	1.58	17%	0			4				2			1
23170	Sequestrectomy (eg, for osteo	090	247	261.5	14.5	6%	7.21	8.56	1.35	19%	0			3.5				1.5			1
23172	Sequestrectomy (eg, for osteo	090	277	294	17	6%	7.31	8.78	1.47	20%	0			3.5				2			1
23174	Sequestrectomy (eg, for osteo	090	352	374.5	22.5	6%	10.05	11.97	1.92	19%	0			5				2.5			1
23180	Partial excision (craterization,	090	299	318	19	6%	8.99	10.68	1.69	19%	0			4.5				2			1
23182	Partial excision (craterization,	090	314	333	19	6%	8.61	10.30	1.69	20%	0			4.5				2			1
23184	Partial excision (craterization,	090	339	360.5	21.5	6%	9.90	11.71	1.81	18%	0			4.5				2.5			1
23190	Ostectomy of scapula, partial	090	249	258.5	9.5	4%	7.47	8.58	1.11	15%	0			3.5				0.5			1
23195	Resection, humeral head	090	322	345	23	7%	10.36	12.18	1.82	18%	0			4				3			1
23200	Radical resection of tumor; cla	090	497	519	22	4%	22.71	24.87	2.16	10%	-2			1	2	1		1	2		1
23210	Radical resection of tumor; sc	090	560	582	22	4%	27.21	29.37	2.16	8%	-2			1	2	1		1	2		1
23220	Radical resection of tumor, pr	090	602	629	27	4%	30.21	32.61	2.40	8%	-2			1	2	1		2	2		1
23330	Removal of foreign body, shou	010	70	72	2	3%	1.90	2.12	0.22	12%	0			1							
23333	Removal of foreign body, shou	090	178	187	9	5%	6.00	6.66	0.66	11%	0			1	1						0.5
23334	Removal of prosthesis, include	090	418	433	15	4%	15.50	17.33	1.83	12%	0			1	3				2		1
23335	Removal of prosthesis, include	090	448	463	15	3%	19.00	20.83	1.83	10%	0			1	3				2		1
23395	Muscle transfer, any type, sho	090	423	463	40	9%	18.54	20.65	2.11	11%	0				5			1			1
23397	Muscle transfer, any type, sho	090	399	425.5	26.5	7%	16.76	18.81	2.05	12%	0			4.5				3.5			1
23400	Scapulopexy (eg, Sprengels de	090	315	329	14	4%	13.87	15.32	1.45	10%	0			4.5				1			1
23405	Tenotomy, shoulder area; sing	090	192	199	7	4%	8.54	9.42	0.88	10%	0			3.5							0.5
23406	Tenotomy, shoulder area; mu	090	239	248.5	9.5	4%	11.01	12.12	1.11	10%	0			3.5				0.5			1
23410	Repair of ruptured musculote	090	277	295	18	6%	11.39	12.60	1.21	11%	0			2	2						0.5
23412	Repair of ruptured musculote	090	287	305	18	6%	11.93	13.14	1.21	10%	0			2	2						0.5
23415	Coracoacromial ligament relea	090	247	265	18	7%	9.23	10.44	1.21	13%	0			2	2						0.5
23420	Reconstruction of complete sh	090	328	348	20	6%	13.54	14.97	1.43	11%	0			3	2						0.5
23430	Tenodesis of long tendon of b	090	237	255	18	8%	10.17	11.38	1.21	12%	0			2	2						0.5

23440	Resection or transplantation c	090	208	215	7	3%	10.64	11.52	0.88	8%	0			3.5							0.5
23450	Capsulorrhaphy, anterior; Put	090	287	300	13	5%	13.70	15.04	1.34	10%	0			4				1			1
23455	Capsulorrhaphy, anterior; wit	090	307	320	13	4%	14.67	16.01	1.34	9%	0			4				1			1
23460	Capsulorrhaphy, anterior, any	090	344	363	19	6%	15.82	17.51	1.69	11%	0			4.5				2			1
23462	Capsulorrhaphy, anterior, any	090	327	345	18	6%	15.72	17.30	1.58	10%	0			4				2			1
23465	Capsulorrhaphy, glenohumera	090	356	375	19	5%	16.30	17.99	1.69	10%	0			4.5				2			1
23466	Capsulorrhaphy, glenohumera	090	348	383	35	10%	15.80	17.67	1.87	12%	0				5						1
23470	Arthroplasty, glenohumeral jo	090	390	421.5	31.5	8%	17.89	20.18	2.29	13%	0			4.5				4.5			1
23472	Arthroplasty, glenohumeral jo	090	448	477	29	6%	22.13	24.24	2.11	10%	0			1	3			2	1		1
23473	Revision of total shoulder arth	090	488	517	29	6%	25.00	27.11	2.11	8%	0			1	3			2	1		1
23474	Revision of total shoulder arth	090	513	542	29	6%	27.21	29.32	2.11	8%	0			1	3			2	1		1
23480	Osteotomy, clavicle, with or w	090	275	290.5	15.5	6%	11.54	13.00	1.46	13%	0			4				1.5			1
23485	Osteotomy, clavicle, with or w	090	331	351.5	20.5	6%	13.91	15.61	1.70	12%	0			4				2.5			1
23490	Prophylactic treatment (nailin	090	291	304	13	4%	12.16	13.50	1.34	11%	0			4				1			1
23491	Prophylactic treatment (nailin	090	315	329	14	4%	14.54	15.99	1.45	10%	0			4.5				1			1
23500	Closed treatment of clavicular	090	79	84	5	6%	2.21	2.76	0.55	25%	0			2.5							
23505	Closed treatment of clavicular	090	121	127	6	5%	3.83	4.49	0.66	17%	0			3							
23515	Open treatment of clavicular f	090	287	305	18	6%	9.69	10.90	1.21	12%	0			2	2						0.5
23520	Closed treatment of sternocla	090	82	87	5	6%	2.29	2.84	0.55	24%	0			2.5							
23525	Closed treatment of sternocla	090	130	138	8	6%	3.79	4.67	0.88	23%	0			4							
23530	Open treatment of sternoclav	090	210	217	7	3%	7.48	8.36	0.88	12%	0			3.5							0.5
23532	Open treatment of sternoclav	090	280	288	8	3%	8.20	9.30	1.10	13%	0			4							1
23540	Closed treatment of acromioc	090	82	87	5	6%	2.36	2.91	0.55	23%	0			2.5							
23545	Closed treatment of acromioc	090	115	122	7	6%	3.43	4.20	0.77	22%	0			3.5							
23550	Open treatment of acromiocla	090	267	281.5	14.5	5%	7.59	8.94	1.35	18%	0			3.5				1.5			1
23552	Open treatment of acromiocla	090	299	314.5	15.5	5%	8.82	10.28	1.46	17%	0			4				1.5			1
23570	Closed treatment of scapular	090	82	87	5	6%	2.36	2.91	0.55	23%	0			2.5							
23575	Closed treatment of scapular	090	138	145	7	5%	4.23	5.00	0.77	18%	0			3.5							
23585	Open treatment of scapular fr	090	407	435	28	7%	14.23	16.03	1.80	13%	0			2	2			2			1
23600	Closed treatment of proximal	090	100	113	13	13%	3.00	3.99	0.99	33%	0			3	1						
23605	Closed treatment of proximal	090	172	180	8	5%	5.06	6.05	0.99	20%	0			4							0.5
23615	Open treatment of proximal h	090	338	366	28	8%	12.30	13.97	1.67	14%	0			1	3			1			1
23616	Open treatment of proximal h	090	413	437	24	6%	18.37	20.24	1.87	10%	0			1	3			1	1		1
23620	Closed treatment of greater h	090	92	98	6	7%	2.55	3.21	0.66	26%	0			3							
23625	Closed treatment of greater h	090	151	158	7	5%	4.10	4.98	0.88	21%	0			3.5							0.5
23630	Open treatment of greater hu	090	306	334	28	9%	10.57	12.24	1.67	16%	0			1	3			1			1
23650	Closed treatment of shoulder	090	133	139	6	5%	3.53	4.19	0.66	19%	0			3							
23655	Closed treatment of shoulder	090	165	173	8	5%	4.76	5.75	0.99	21%	0			4							0.5
23660	Open treatment of acute shou	090	245	252	7	3%	7.66	8.65	0.99	13%	0			3.5							1
23665	Closed treatment of shoulder	090	165	173	8	5%	4.66	5.65	0.99	21%	0			4							0.5
23670	Open treatment of shoulder d	090	326	349	23	7%	12.28	13.84	1.56	13%	0			2	2			1			1
23675	Closed treatment of shoulder	090	222	231	9	4%	6.27	7.48	1.21	19%	0			4.5							1
23680	Open treatment of shoulder d	090	361	384	23	6%	13.15	14.71	1.56	12%	0			2	2			1			1
23700	Manipulation under anesthes	010	65	67	2	3%	2.57	2.79	0.22	9%	0			1							
23800	Arthrodesis, glenohumeral joi	090	378	402	24	6%	14.73	16.66	1.93	13%	0			4.5				3			1
23802	Arthrodesis, glenohumeral joi	090	448	493	45	10%	18.42	20.77	2.35	13%	0				5			2			1
23900	Interthoracoscapular amputat	090	537	579.5	42.5	8%	20.72	23.60	2.88	14%	0			5				6.5			1
23920	Disarticulation of shoulder;	090	475	518	43	9%	16.23	18.49	2.26	14%	0				4			3			1
23921	Disarticulation of shoulder; se	090	241	250.5	9.5	4%	5.72	6.83	1.11	19%	0			3.5				0.5			1
23930	Incision and drainage, upper a	010	92	94	2	2%	2.99	3.32	0.33	11%	0			1							0.5
23931	Incision and drainage, upper a	010	75	77	2	3%	1.84	2.17	0.33	18%	0			1							0.5
23935	Incision, deep, with opening o	090	233	245	12	5%	6.38	7.61	1.23	19%	0			3.5				1			1
24000	Arthrotomy, elbow, including	090	217	228	11	5%	6.08	7.20	1.12	18%	0			3				1			1
24006	Arthrotomy of the elbow, with	090	282	300	18	6%	9.74	11.32	1.58	16%	0			4				2			1
24065	Biopsy, soft tissue of upper ar	010	80	82	2	2%	2.13	2.35	0.22	10%	0			1							
24066	Biopsy, soft tissue of upper ar	090	172	178	6	3%	5.35	6.12	0.77	14%	0			3							0.5
24071	Excision, tumor, soft tissue of	090	183	192	9	5%	5.70	6.36	0.66	12%	0			1	1						0.5
24073	Excision, tumor, soft tissue of	090	283	304	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1
24075	Excision, tumor, soft tissue of	090	142	151	9	6%	4.24	4.90	0.66	16%	0			1	1						0.5
24076	Excision, tumor, soft tissue of	090	229	245	16	7%	7.41	8.40	0.99	13%	0			1	2						0.5
24077	Radical resection of tumor (eg	090	405	429	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1
24079	Radical resection of tumor (eg	090	472	503	31	7%	20.61	22.81	2.20	11%	-2			1	2	1		2	1		1
24100	Arthrotomy, elbow; with sync	090	157	163	6	4%	5.07	5.84	0.77	15%	0			3							0.5
24101	Arthrotomy, elbow; with joint	090	189	196	7	4%	6.30	7.18	0.88	14%	0			3.5							0.5
24102	Arthrotomy, elbow; with sync	090	251	260.5	9.5	4%	8.26	9.37	1.11	13%	0			3.5				0.5			1
24105	Excision, olecranon bursa	090	143	150	7	5%	3.78	4.55	0.77	20%	0			3.5							
24110	Excision or curettage of bone	090	224	232	8	4%	7.58	8.57	0.99	13%	0			4							0.5

24115	Excision or curettage of bone	090	339	359.5	20.5	6%	10.12	11.82	1.70	17%	0			4				2.5			1	
24116	Excision or curettage of bone	090	326	344	18	6%	12.23	13.81	1.58	13%	0			4				2			1	
24120	Excision or curettage of bone	090	195	202	7	4%	6.82	7.70	0.88	13%	0			3.5							0.5	
24125	Excision or curettage of bone	090	278	288.5	10.5	4%	8.14	9.36	1.22	15%	0			4				0.5			1	
24126	Excision or curettage of bone	090	272	285	13	5%	8.62	9.96	1.34	16%	0			4				1			1	
24130	Excision, radial head	090	192	199	7	4%	6.42	7.30	0.88	14%	0			3.5							0.5	
24134	Sequestrectomy (eg, for osteo	090	303	323.5	20.5	7%	10.22	11.92	1.70	17%	0			4				2.5			1	
24136	Sequestrectomy (eg, for osteo	090	263	280	17	6%	8.40	9.87	1.47	18%	0			3.5				2			1	
24138	Sequestrectomy (eg, for osteo	090	277	295.5	18.5	7%	8.50	10.29	1.79	21%	0			5.5				1.5			1	
24140	Partial excision (craterization,	090	284	299.5	15.5	5%	9.55	11.01	1.46	15%	0			4				1.5			1	
24145	Partial excision (craterization,	090	240	249.5	9.5	4%	7.81	8.92	1.11	14%	0			3.5				0.5			1	
24147	Partial excision (craterization,	090	252	264.5	12.5	5%	7.84	9.28	1.44	18%	0			5				0.5			1	
24149	Radical resection of capsule, s	090	456	503	47	10%	16.22	18.66	2.44	15%	0				6			1			1	
24150	Radical resection of tumor, sh	090	502	533	31	6%	23.46	25.66	2.20	9%	-2			1	2	1		2	1		1	
24152	Radical resection of tumor, ra	090	440	466	26	6%	19.99	21.95	1.96	10%	-2			1	2	1		1	1		1	
24155	Resection of elbow joint (arth	090	322	337.5	15.5	5%	12.09	13.55	1.46	12%	0			4				1.5			1	
24160	Removal of prosthesis, includ	090	405	429	24	6%	18.63	20.50	1.87	10%	0			1	3			1	1		1	
24164	Removal of prosthesis, includ	090	228	249	21	9%	10.00	11.10	1.10	11%	0				3						0.5	
24200	Removal of foreign body, upp	010	68	70	2	3%	1.81	2.03	0.22	12%	0			1								
24201	Removal of foreign body, upp	090	164	170	6	4%	4.70	5.47	0.77	16%	0			3							0.5	
24300	Manipulation, elbow, under a	090	205	217	12	6%	4.04	5.47	1.43	35%	0			6							0.5	
24301	Muscle or tendon transfer, an	090	266	274	8	3%	10.38	11.48	1.10	11%	0			4							1	
24305	Tendon lengthening, upper ar	090	209	216	7	3%	7.62	8.50	0.88	12%	0			3.5							0.5	
24310	Tenotomy, open, elbow to sho	090	171	177	6	4%	6.12	6.89	0.77	13%	0			3							0.5	
24320	Tenoplasty, with muscle trans	090	304	317	13	4%	10.86	12.20	1.34	12%	0			4				1			1	
24330	Flexor-plasty, elbow (eg, Stein	090	263	271	8	3%	9.79	10.89	1.10	11%	0			4							1	
24331	Flexor-plasty, elbow (eg, Stein	090	303	316	13	4%	10.95	12.29	1.34	12%	0			4				1			1	
24332	Tenolysis, triceps	090	230	243	13	6%	7.91	9.01	1.10	14%	0			3	1						0.5	
24340	Tenodesis of biceps tendon at	090	225	233	8	4%	8.08	9.07	0.99	12%	0			4							0.5	
24341	Repair, tendon or muscle, upp	090	318	353	35	11%	9.49	11.36	1.87	20%	0				5						1	
24342	Reinsertion of ruptured bicep	090	290	300.5	10.5	4%	10.86	12.08	1.22	11%	0			4				0.5			1	
24343	Repair lateral collateral ligam	090	281	296	15	5%	9.16	10.48	1.32	14%	0			4	1						0.5	
24344	Reconstruction lateral collate	090	385	417	32	8%	15.21	17.32	2.11	14%	0			3	3			1			1	
24345	Repair medial collateral ligam	090	284	299	15	5%	9.16	10.48	1.32	14%	0			4	1						0.5	
24346	Reconstruction medial collate	090	385	417	32	8%	15.21	17.32	2.11	14%	0			3	3			1			1	
24357	Tenotomy, elbow, lateral or m	090	168	176	8	5%	5.44	6.43	0.99	18%	0			4							0.5	
24358	Tenotomy, elbow, lateral or m	090	193	201	8	4%	6.66	7.65	0.99	15%	0			4							0.5	
24359	Tenotomy, elbow, lateral or m	090	213	221	8	4%	8.98	9.97	0.99	11%	0			4							0.5	
24360	Arthroplasty, elbow; with mer	090	320	334	14	4%	12.67	14.12	1.45	11%	0			4.5				1			1	
24361	Arthroplasty, elbow; with dist	090	322	336	14	4%	14.41	15.86	1.45	10%	0			4.5				1			1	
24362	Arthroplasty, elbow; with imp	090	350	364	14	4%	15.32	16.77	1.45	9%	0			4.5				1			1	
24363	Arthroplasty, elbow; with dist	090	435	464	29	7%	22.00	24.11	2.11	10%	0			1	3			2	1		1	
24365	Arthroplasty, radial head;	090	229	238.5	9.5	4%	8.62	9.73	1.11	13%	0			3.5				0.5			1	
24366	Arthroplasty, radial head; witl	090	243	252.5	9.5	4%	9.36	10.47	1.11	12%	0			3.5				0.5			1	
24370	Revision of total elbow arthro	090	470	499	29	6%	23.55	25.66	2.11	9%	0			1	3			2	1		1	
24371	Revision of total elbow arthro	090	505	534	29	6%	27.50	29.61	2.11	8%	0			1	3			2	1		1	
24400	Osteotomy, humerus, with or	090	288	299.5	11.5	4%	11.33	12.66	1.33	12%	0			4.5				0.5			1	
24410	Multiple osteotomies with rea	090	344	356.5	12.5	4%	15.11	16.55	1.44	10%	0			5				0.5			1	
24420	Osteoplasty, humerus (eg, sho	090	329	341.5	12.5	4%	13.73	15.17	1.44	10%	0			5				0.5			1	
24430	Repair of nonunion or maluni	090	343	376	33	10%	15.25	17.16	1.91	13%	0			1	3			2			1	
24435	Repair of nonunion or maluni	090	433	478	45	10%	14.99	17.34	2.35	16%	0				5			2			1	
24470	Hemiepiphyseal arrest (eg, cu	090	236	244	8	3%	8.93	10.03	1.10	12%	0			4							1	
24495	Decompression fasciotomy, fo	090	255	267	12	5%	8.41	9.64	1.23	15%	0			3.5				1			1	
24498	Prophylactic treatment (nailin	090	308	323.5	15.5	5%	12.28	13.74	1.46	12%	0			4				1.5			1	
24500	Closed treatment of humeral	090	121	129	8	7%	3.41	4.29	0.88	26%	0			4								
24505	Closed treatment of humeral	090	188	197	9	5%	5.39	6.49	1.10	20%	0			4.5							0.5	
24515	Open treatment of humeral sh	090	340	360	20	6%	12.12	13.92	1.80	15%	0			5				2			1	
24516	Treatment of humeral shaft fr	090	352	375	23	7%	12.19	14.01	1.82	15%	0			4				3			1	
24530	Closed treatment of supracon	090	136	144	8	6%	3.69	4.57	0.88	24%	0			4								
24535	Closed treatment of supracon	090	206	216	10	5%	7.11	8.32	1.21	17%	0			5							0.5	
24538	Percutaneous skeletal fixation	090	284	298	14	5%	9.77	11.22	1.45	15%	0			4.5				1			1	
24545	Open treatment of humeral su	090	361	384	23	6%	13.15	14.71	1.56	12%	0			2	2			1			1	
24546	Open treatment of humeral su	090	448	472	24	5%	14.91	16.78	1.87	13%	0			1	3			1	1		1	
24560	Closed treatment of humeral	090	118	125	7	6%	2.98	3.75	0.77	26%	0			3.5								
24565	Closed treatment of humeral	090	190	199	9	5%	5.78	6.88	1.10	19%	0			4.5							0.5	
24566	Percutaneous skeletal fixation	090	257	285	28	11%	9.06	10.38	1.32	15%	0				4							
24575	Open treatment of humeral e	090	308	336	28	9%	9.71	11.38	1.67	17%	0			1	3			1			1	

24576	Closed treatment of humeral	090	129	137	8	6%	3.06	3.94	0.88	29%	0			4								
24577	Closed treatment of humeral	090	192	201	9	5%	6.01	7.11	1.10	18%	0			4.5							0.5	
24579	Open treatment of humeral c	090	338	366	28	8%	11.44	13.11	1.67	15%	0			1	3			1			1	
24582	Percutaneous skeletal fixation	090	295	330	35	12%	10.14	11.79	1.65	16%	0				5							
24586	Open treatment of periarticul	090	375	399	24	6%	15.78	17.71	1.93	12%	0			4.5				3			1	
24587	Open treatment of periarticul	090	415	441.5	26.5	6%	15.79	17.84	2.05	13%	0			4.5				3.5			1	
24600	Treatment of closed elbow dis	090	121	127	6	5%	4.37	5.03	0.66	15%	0			3								
24605	Treatment of closed elbow dis	090	179	188	9	5%	5.64	6.74	1.10	20%	0			4.5							0.5	
24615	Open treatment of acute or ch	090	277	294	17	6%	9.83	11.30	1.47	15%	0			3.5				2			1	
24620	Closed treatment of Montegg	090	211	221	10	5%	7.22	8.43	1.21	17%	0			5							0.5	
24635	Open treatment of Monteggia	090	291	314	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
24640	Closed treatment of radial he	010	39	41	2	5%	1.25	1.47	0.22	18%	0			1								
24650	Closed treatment of radial he	090	87	93	6	7%	2.31	2.97	0.66	29%	0			3								
24655	Closed treatment of radial he	090	142	151	9	6%	4.62	5.61	0.99	21%	0			4.5								
24665	Open treatment of radial hea	090	256	265	9	4%	8.36	9.57	1.21	14%	0			4.5							1	
24666	Open treatment of radial hea	090	286	301.5	15.5	5%	9.86	11.32	1.46	15%	0			4				1.5			1	
24670	Closed treatment of ulnar fra	090	102	108	6	6%	2.69	3.35	0.66	25%	0			3								
24675	Closed treatment of ulnar fra	090	153	161	8	5%	4.91	5.79	0.88	18%	0			4								
24685	Open treatment of ulnar fract	090	252	270	18	7%	8.37	9.58	1.21	14%	0			2	2						0.5	
24800	Arthrodesis, elbow joint; local	090	290	299	9	3%	11.41	12.62	1.21	11%	0			4.5							1	
24802	Arthrodesis, elbow joint; with	090	399	425.5	26.5	7%	14.32	16.37	2.05	14%	0			4.5				3.5			1	
24900	Amputation, arm through hur	090	312	336	24	8%	10.18	12.11	1.93	19%	0			4.5				3			1	
24920	Amputation, arm through hur	090	282	306.5	24.5	9%	10.13	11.96	1.83	18%	0			3.5				3.5			1	
24925	Amputation, arm through hur	090	221	230.5	9.5	4%	7.30	8.41	1.11	15%	0			3.5				0.5			1	
24930	Amputation, arm through hur	090	294	318.5	24.5	8%	10.83	12.66	1.83	17%	0			3.5				3.5			1	
24931	Amputation, arm through hur	090	358	388.5	30.5	9%	13.44	15.62	2.18	16%	0			4				4.5			1	
24935	Stump elongation, upper extr	090	458	495.5	37.5	8%	16.45	19.09	2.64	16%	0			5				5.5			1	
25000	Incision, extensor tendon she	090	135	142	7	5%	3.55	4.32	0.77	22%	0			3.5								
25001	Incision, flexor tendon sheath	090	154	165	11	7%	3.79	4.67	0.88	23%	0			2	1						0.5	
25020	Decompression fasciotomy, fo	090	204	210	6	3%	6.06	6.94	0.88	15%	0			3							1	
25023	Decompression fasciotomy, fo	090	400	436.5	36.5	9%	13.83	16.36	2.53	18%	0			4.5				5.5			1	
25024	Decompression fasciotomy, fo	090	385	397	12	3%	10.79	12.86	2.07	19%	0			4	1			1	2		1	
25025	Decompression fasciotomy, fo	090	460	477	17	4%	17.94	20.25	2.31	13%	0			4	1			2	2		1	
25028	Incision and drainage, forearn	090	181	187	6	3%	5.39	6.27	0.88	16%	0			3							1	
25031	Incision and drainage, forearn	090	141	146	5	4%	4.26	4.92	0.66	15%	0			2.5							0.5	
25035	Incision, deep, bone cortex, fo	090	241	253	12	5%	7.65	8.88	1.23	16%	0			3.5				1			1	
25040	Arthrotomy, radiocarpal or mi	090	227	240.5	13.5	6%	7.50	8.74	1.24	17%	0			3				1.5			1	
25065	Biopsy, soft tissue of forearm	010	64	66	2	3%	2.04	2.26	0.22	11%	0			1								
25066	Biopsy, soft tissue of forearm	090	156	162	6	4%	4.27	5.04	0.77	18%	0			3							0.5	
25071	Excision, tumor, soft tissue of	090	178	187	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
25073	Excision, tumor, soft tissue of	090	221	237	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
25075	Excision, tumor, soft tissue of	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
25076	Excision, tumor, soft tissue of	090	206	222	16	8%	6.74	7.73	0.99	15%	0			1	2						0.5	
25077	Radical resection of tumor (eg	090	345	373	28	8%	12.93	14.60	1.67	13%	0			1	3			1			1	
25078	Radical resection of tumor (eg	090	422	448	26	6%	17.69	19.65	1.96	11%	-2			1	2	1		1	1		1	
25085	Capsulotomy, wrist (eg, contr	090	197	203	6	3%	5.64	6.52	0.88	16%	0			3							1	
25100	Arthrotomy, wrist joint; with b	090	142	147	5	4%	4.02	4.68	0.66	16%	0			2.5							0.5	
25101	Arthrotomy, wrist joint; with j	090	163	169	6	4%	4.83	5.60	0.77	16%	0			3							0.5	
25105	Arthrotomy, wrist joint; with s	090	201	208	7	3%	6.02	6.90	0.88	15%	0			3.5							0.5	
25107	Arthrotomy, distal radioulnar	090	257	285	28	11%	7.70	9.02	1.32	17%	0				4							
25109	Excision of tendon, forearm a	090	191	207	16	8%	6.94	7.93	0.99	14%	0			1	2						0.5	
25110	Excision, lesion of tendon she	090	132	137	5	4%	4.04	4.59	0.55	14%	0			2.5								
25111	Excision of ganglion, wrist (do	090	140	146	6	4%	3.53	4.19	0.66	19%	0			3								
25112	Excision of ganglion, wrist (do	090	148	154	6	4%	4.67	5.33	0.66	14%	0			3								
25115	Radical excision of bursa, syn	090	257	285	28	11%	10.09	11.41	1.32	13%	0				4							
25116	Radical excision of bursa, syn	090	249	272	23	9%	7.56	8.88	1.32	17%	0			1	3						0.5	
25118	Synovectomy, extensor tendo	090	158	164	6	4%	4.51	5.28	0.77	17%	0			3							0.5	
25119	Synovectomy, extensor tendo	090	214	221	7	3%	6.21	7.20	0.99	16%	0			3.5							1	
25120	Excision or curettage of bone	090	217	224	7	3%	6.27	7.26	0.99	16%	0			3.5							1	
25125	Excision or curettage of bone	090	270	278	8	3%	7.67	8.77	1.10	14%	0			4							1	
25126	Excision or curettage of bone	090	260	268	8	3%	7.74	8.84	1.10	14%	0			4							1	
25130	Excision or curettage of bone	090	167	174	7	4%	5.43	6.20	0.77	14%	0			3.5								
25135	Excision or curettage of bone	090	234	242	8	3%	7.08	8.07	0.99	14%	0			4							0.5	
25136	Excision or curettage of bone	090	204	211	7	3%	6.14	7.02	0.88	14%	0			3.5							0.5	
25145	Sequestrectomy (eg, for osteo	090	225	232	7	3%	6.54	7.53	0.99	15%	0			3.5							1	
25150	Partial excision (craterization,	090	257	269	12	5%	7.38	8.61	1.23	17%	0			3.5				1			1	
25151	Partial excision (craterization,	090	266	278	12	5%	7.68	8.91	1.23	16%	0			3.5				1			1	

25170	Radical resection of tumor, ra	090	470	496	26	6%	22.21	24.17	1.96	9%	-2			1	2	1		1	1		1	
25210	Carpectomy; 1 bone	090	194	201	7	4%	6.12	7.00	0.88	14%	0			3.5							0.5	
25215	Carpectomy; all bones of prox	090	269	279.5	10.5	4%	8.14	9.36	1.22	15%	0			4				0.5			1	
25230	Radial styloidectomy (separat	090	190	196	6	3%	5.37	6.25	0.88	16%	0			3							1	
25240	Excision distal ulna partial or	090	176	182	6	3%	5.31	6.08	0.77	15%	0			3							0.5	
25248	Exploration with removal of d	090	163	170	7	4%	5.31	6.08	0.77	15%	0			3.5								
25250	Removal of wrist prosthesis; (	090	205	212	7	3%	6.77	7.65	0.88	13%	0			3.5							0.5	
25251	Removal of wrist prosthesis; c	090	300	310.5	10.5	3%	9.82	11.04	1.22	12%	0			4				0.5			1	
25259	Manipulation, wrist, under an	090	201	213	12	6%	4.04	5.47	1.43	35%	0			6							0.5	
25260	Repair, tendon or muscle, flex	090	215	225	10	5%	8.04	9.25	1.21	15%	0			5							0.5	
25263	Repair, tendon or muscle, flex	090	229	238	9	4%	8.04	9.25	1.21	15%	0			4.5							1	
25265	Repair, tendon or muscle, flex	090	259	268	9	3%	10.10	11.20	1.10	11%	0			4.5							0.5	
25270	Repair, tendon or muscle, ext	090	176	183	7	4%	6.17	7.05	0.88	14%	0			3.5							0.5	
25272	Repair, tendon or muscle, ext	090	189	196	7	4%	7.21	8.09	0.88	12%	0			3.5							0.5	
25274	Repair, tendon or muscle, ext	090	242	250	8	3%	8.94	9.93	0.99	11%	0			4							0.5	
25275	Repair, tendon sheath, extens	090	223	236	13	6%	8.96	10.06	1.10	12%	0			3	1						0.5	
25280	Lengthening or shortening of	090	195	202	7	4%	7.39	8.27	0.88	12%	0			3.5							0.5	
25290	Tenotomy, open, flexor or ext	090	164	170	6	4%	5.43	6.20	0.77	14%	0			3							0.5	
25295	Tenolysis, flexor or extensor t	090	191	198	7	4%	6.72	7.60	0.88	13%	0			3.5							0.5	
25300	Tenodesis at wrist; flexors of	090	247	256	9	4%	9.02	10.12	1.10	12%	0			4.5							0.5	
25301	Tenodesis at wrist; extensors	090	235	243	8	3%	8.59	9.58	0.99	12%	0			4							0.5	
25310	Tendon transplantation or tra	090	235	248	13	6%	8.08	9.18	1.10	14%	0			3	1						0.5	
25312	Tendon transplantation or tra	090	284	294.5	10.5	4%	9.82	11.04	1.22	12%	0			4				0.5			1	
25315	Flexor origin slide (eg, for cer	090	300	320.5	20.5	7%	10.68	12.38	1.70	16%	0			4				2.5			1	
25316	Flexor origin slide (eg, for cer	090	356	380	24	7%	12.90	14.83	1.93	15%	0			4.5				3			1	
25320	Capsulorrhaphy or reconstruc	090	452	495	43	10%	12.75	14.76	2.01	16%	-8				1	4						
25332	Arthroplasty, wrist, with or wi	090	314	328	14	4%	11.74	13.19	1.45	12%	0			4.5				1			1	
25335	Centralization of wrist on ulna	090	370	391.5	21.5	6%	13.39	15.20	1.81	14%	0			4.5				2.5			1	
25337	Reconstruction for stabilizatio	090	353	387	34	10%	11.73	13.32	1.59	14%	-6				1	3						
25350	Osteotomy, radius; distal third	090	266	279	13	5%	9.09	10.43	1.34	15%	0			4				1			1	
25355	Osteotomy, radius; middle or	090	289	304.5	15.5	5%	10.53	11.99	1.46	14%	0			4				1.5			1	
25360	Osteotomy; ulna	090	259	272	13	5%	8.74	10.08	1.34	15%	0			4				1			1	
25365	Osteotomy; radius AND ulna	090	354	375.5	21.5	6%	12.91	14.72	1.81	14%	0			4.5				2.5			1	
25370	Multiple osteotomies, with re	090	424	455	31	7%	14.10	16.49	2.39	17%	0			5.5				4			1	
25375	Multiple osteotomies, with re	090	382	403.5	21.5	6%	13.55	15.36	1.81	13%	0			4.5				2.5			1	
25390	Osteoplasty, radius OR ulna; s	090	295	308	13	4%	10.70	12.04	1.34	13%	0			4				1			1	
25391	Osteoplasty, radius OR ulna; l	090	383	409.5	26.5	7%	14.28	16.33	2.05	14%	0			4.5				3.5			1	
25392	Osteoplasty, radius AND ulna;	090	390	416.5	26.5	7%	14.58	16.63	2.05	14%	0			4.5				3.5			1	
25393	Osteoplasty, radius AND ulna;	090	432	461	29	7%	16.56	18.73	2.17	13%	0			4.5				4			1	
25394	Osteoplasty, carpal bone, sho	090	250	263	13	5%	10.85	11.95	1.10	10%	0			3	1						0.5	
25400	Repair of nonunion or maluni	090	308	323.5	15.5	5%	11.28	12.74	1.46	13%	0			4				1.5			1	
25405	Repair of nonunion or maluni	090	387	413.5	26.5	7%	15.01	17.06	2.05	14%	0			4.5				3.5			1	
25415	Repair of nonunion or maluni	090	367	386	19	5%	13.80	15.49	1.69	12%	0			4.5				2			1	
25420	Repair of nonunion or maluni	090	444	474	30	7%	17.04	19.32	2.28	13%	0			5				4			1	
25425	Repair of defect with autograf	090	343	364.5	21.5	6%	13.72	15.53	1.81	13%	0			4.5				2.5			1	
25426	Repair of defect with autograf	090	411	437.5	26.5	6%	16.45	18.50	2.05	12%	0			4.5				3.5			1	
25430	Insertion of vascular pedicle in	090	270	283	13	5%	9.71	10.81	1.10	11%	0			3	1						0.5	
25431	Repair of nonunion of carpal b	090	278	291	13	5%	10.89	11.99	1.10	10%	0			3	1						0.5	
25440	Repair of nonunion, scaphoid	090	278	288.5	10.5	4%	10.68	11.90	1.22	11%	0			4				0.5			1	
25441	Arthroplasty with prosthetic r	090	358	374.5	16.5	5%	13.29	14.86	1.57	12%	0			4.5				1.5			1	
25442	Arthroplasty with prosthetic r	090	331	342.5	11.5	3%	11.12	12.45	1.33	12%	0			4.5				0.5			1	
25443	Arthroplasty with prosthetic r	090	307	318.5	11.5	4%	10.66	11.99	1.33	12%	0			4.5				0.5			1	
25444	Arthroplasty with prosthetic r	090	304	315.5	11.5	4%	11.42	12.75	1.33	12%	0			4.5				0.5			1	
25445	Arthroplasty with prosthetic r	090	283	291	8	3%	9.88	10.98	1.10	11%	0			4							1	
25446	Arthroplasty with prosthetic r	090	425	456.5	31.5	7%	17.30	19.59	2.29	13%	0			4.5				4.5			1	
25447	Arthroplasty, interposition, in	090	278	298	20	7%	11.14	12.57	1.43	13%	0			3	2						0.5	
25449	Revision of arthroplasty, inclu	090	369	388	19	5%	14.94	16.63	1.69	11%	0			4.5				2			1	
25450	Epiphyseal arrest by epiphysio	090	203	211	8	4%	8.06	8.94	0.88	11%	0			4								
25455	Epiphyseal arrest by epiphysio	090	260	269	9	3%	9.71	10.81	1.10	11%	0			4.5							0.5	
25490	Prophylactic treatment (nailin	090	280	288	8	3%	9.73	10.83	1.10	11%	0			4							1	
25491	Prophylactic treatment (nailin	090	271	279	8	3%	10.15	11.25	1.10	11%	0			4							1	
25492	Prophylactic treatment (nailin	090	343	357	14	4%	12.66	14.11	1.45	11%	0			4.5				1			1	
25500	Closed treatment of radial sha	090	84	90	6	7%	2.60	3.26	0.66	25%	0			3								
25505	Closed treatment of radial sha	090	171	181	10	6%	5.45	6.55	1.10	20%	0			5								
25515	Open treatment of radial shaf	090	247	265	18	7%	8.80	10.01	1.21	14%	0			2	2						0.5	
25520	Closed treatment of radial sha	090	219	229	10	5%	6.50	7.71	1.21	19%	0			5							0.5	
25525	Open treatment of radial shaf	090	303	331	28	9%	10.55	12.22	1.67	16%	0			1	3			1			1	

25526	Open treatment of radial shaf	090	367	392	25	7%	13.15	14.93	1.78	14%	0			3	2			1			1	
25530	Closed treatment of ulnar sha	090	88	94	6	7%	2.24	2.90	0.66	29%	0			3								
25535	Closed treatment of ulnar sha	090	163	172	9	6%	5.36	6.35	0.99	18%	0			4.5								
25545	Open treatment of ulnar shaft	090	286	309	23	8%	7.94	9.50	1.56	20%	0			2	2			1			1	
25560	Closed treatment of radial an	090	101	107	6	6%	2.59	3.25	0.66	25%	0			3								
25565	Closed treatment of radial an	090	182	191	9	5%	5.85	6.95	1.10	19%	0			4.5							0.5	
25574	Open treatment of radial AND	090	296	319	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
25575	Open treatment of radial AND	090	342	367	25	7%	12.29	14.07	1.78	14%	0			3	2			1			1	
25600	Closed treatment of distal rad	090	108	118	10	9%	2.78	3.88	1.10	40%	0			5								
25605	Closed treatment of distal rad	090	169	184	15	9%	6.25	7.57	1.32	21%	0			4	1						0.5	
25606	Percutaneous skeletal fixation	090	260	285	25	10%	8.31	9.85	1.54	19%	0			2	3						0.5	
25607	Open treatment of distal radi	090	275	300	25	9%	9.56	11.10	1.54	16%	0			2	3						0.5	
25608	Open treatment of distal radi	090	305	330	25	8%	11.07	12.61	1.54	14%	0			2	3						0.5	
25609	Open treatment of distal radi	090	358	390	32	9%	14.38	16.25	1.87	13%	0			2	4						0.5	
25622	Closed treatment of carpal sc	090	101	108	7	7%	2.79	3.56	0.77	28%	0			3.5								
25624	Closed treatment of carpal sc	090	155	165	10	6%	4.77	5.87	1.10	23%	0			5								
25628	Open treatment of carpal scaf	090	277	295	18	6%	9.67	10.88	1.21	13%	0			2	2						0.5	
25630	Closed treatment of carpal bo	090	91	97	6	7%	3.03	3.69	0.66	22%	0			3								
25635	Closed treatment of carpal bo	090	143	152	9	6%	4.61	5.60	0.99	21%	0			4.5								
25645	Open treatment of carpal bon	090	222	229	7	3%	7.42	8.41	0.99	13%	0			3.5							1	
25650	Closed treatment of ulnar styl	090	111	118	7	6%	3.23	4.00	0.77	24%	0			3.5								
25651	Percutaneous skeletal fixation	090	190	203	13	7%	5.82	6.92	1.10	19%	0			3	1						0.5	
25652	Open treatment of ulnar stylo	090	225	238	13	6%	8.06	9.16	1.10	14%	0			3	1						0.5	
25660	Closed treatment of radiocarp	090	145	154	9	6%	4.98	5.97	0.99	20%	0			4.5								
25670	Open treatment of radiocarpa	090	224	231	7	3%	8.09	9.08	0.99	12%	0			3.5							1	
25671	Percutaneous skeletal fixation	090	210	223	13	6%	6.46	7.56	1.10	17%	0			3	1						0.5	
25675	Closed treatment of distal rad	090	152	161	9	6%	4.89	5.88	0.99	20%	0			4.5								
25676	Open treatment of distal radi	090	242	252.5	10.5	4%	8.29	9.51	1.22	15%	0			4				0.5			1	
25680	Closed treatment of trans-sca	090	203	213	10	5%	6.23	7.44	1.21	19%	0			5							0.5	
25685	Open treatment of trans-scap	090	279	292	13	5%	10.09	11.43	1.34	13%	0			4				1			1	
25690	Closed treatment of lunate di	090	187	196	9	5%	5.72	6.82	1.10	19%	0			4.5							0.5	
25695	Open treatment of lunate disl	090	244	251	7	3%	8.51	9.50	0.99	12%	0			3.5							1	
25800	Arthrodesis, wrist; complete,	090	298	311	13	4%	10.07	11.41	1.34	13%	0			4				1			1	
25805	Arthrodesis, wrist; with sliding	090	351	370	19	5%	11.73	13.42	1.69	14%	0			4.5				2			1	
25810	Arthrodesis, wrist; with iliac o	090	370	403	33	9%	11.95	13.73	1.78	15%	0				4			1			1	
25820	Arthrodesis, wrist; limited, wi	090	222	230	8	4%	7.64	8.63	0.99	13%	0			4							0.5	
25825	Arthrodesis, wrist; with autog	090	321	338.5	17.5	5%	9.69	11.37	1.68	17%	0			5				1.5			1	
25830	Arthrodesis, distal radioulnar	090	310	330	20	6%	10.88	12.07	1.19	11%	-2			2	1	1						
25900	Amputation, forearm, through	090	345	370	25	7%	9.61	11.65	2.04	21%	0			5				3			1	
25905	Amputation, forearm, through	090	264	283.5	19.5	7%	9.59	11.18	1.59	17%	0			3.5				2.5			1	
25907	Amputation, forearm, through	090	235	247	12	5%	8.09	9.32	1.23	15%	0			3.5				1			1	
25909	Amputation, forearm, through	090	257	271.5	14.5	6%	9.31	10.66	1.35	15%	0			3.5				1.5			1	
25915	Krukenberg procedure	090	431	444	13	3%	17.52	18.51	0.99	6%	0			3	1							
25920	Disarticulation through wrist;	090	249	263.5	14.5	6%	9.03	10.38	1.35	15%	0			3.5				1.5			1	
25922	Disarticulation through wrist;	090	224	233.5	9.5	4%	7.65	8.76	1.11	15%	0			3.5				0.5			1	
25924	Disarticulation through wrist;	090	242	256.5	14.5	6%	8.81	10.16	1.35	15%	0			3.5				1.5			1	
25927	Transmetacarpal amputation;	090	242	254	12	5%	9.09	10.32	1.23	14%	0			3.5				1			1	
25929	Transmetacarpal amputation;	090	226	235.5	9.5	4%	7.82	8.93	1.11	14%	0			3.5				0.5			1	
25931	Transmetacarpal amputation;	090	233	242.5	9.5	4%	8.04	9.15	1.11	14%	0			3.5				0.5			1	
26010	Drainage of finger abscess; sir	010	51	53	2	4%	1.59	1.81	0.22	14%	0			1								
26011	Drainage of finger abscess; co	010	69	71	2	3%	2.24	2.46	0.22	10%	0			1								
26020	Drainage of tendon sheath, di	090	262	285	23	9%	6.84	8.53	1.69	25%	0			3	1			2			1	
26025	Drainage of palmar bursa; sin	090	200	211	11	5%	5.08	6.20	1.12	22%	0			3				1			1	
26030	Drainage of palmar bursa; mu	090	226	239.5	13.5	6%	6.25	7.49	1.24	20%	0			3				1.5			1	
26034	Incision, bone cortex, hand or	090	250	266.5	16.5	7%	6.63	8.20	1.57	24%	0			4.5				1.5			1	
26035	Decompression fingers and/o	090	351.5	400.5	49	14%	11.37	13.92	2.55	22%	0				4.5			3.5			1	
26037	Decompressive fasciotomy, ha	090	228	241.5	13.5	6%	7.57	8.81	1.24	16%	0			3				1.5			1	
26040	Fasciotomy, palmar (eg, Dupu	090	135	140	5	4%	3.46	4.12	0.66	19%	0			2.5							0.5	
26045	Fasciotomy, palmar (eg, Dupu	090	207	214	7	3%	5.73	6.61	0.88	15%	0			3.5							0.5	
26055	Tendon sheath incision (eg, fo	090	119	128	9	8%	3.11	3.77	0.66	21%	0			1	1						0.5	
26060	Tenotomy, percutaneous, sing	090	91	95	4	4%	2.91	3.35	0.44	15%	0			2								
26070	Arthrotomy, with exploration,	090	168	173	5	3%	3.81	4.58	0.77	20%	0			2.5							1	
26075	Arthrotomy, with exploration,	090	164	169	5	3%	3.91	4.68	0.77	20%	0			2.5							1	
26080	Arthrotomy, with exploration,	090	157	164	7	4%	4.47	5.35	0.88	20%	0			3.5							0.5	
26100	Arthrotomy with biopsy; carp	090	119	124	5	4%	3.79	4.34	0.55	15%	0			2.5								
26105	Arthrotomy with biopsy; meta	090	119	124	5	4%	3.83	4.38	0.55	14%	0			2.5								
26110	Arthrotomy with biopsy; inter	090	114	119	5	4%	3.65	4.20	0.55	15%	0			2.5								

26111	Excision, tumor or vascular ma	090	173	182	9	5%	5.42	6.08	0.66	12%	0			1	1						0.5
26113	Excision, tumor, soft tissue, or	090	214	230	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5
26115	Excision, tumor or vascular ma	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5
26116	Excision, tumor, soft tissue, or	090	201	217	16	8%	6.74	7.73	0.99	15%	0			1	2						0.5
26117	Radical resection of tumor (eg	090	271	294	23	8%	10.13	11.45	1.32	13%	0			1	3						0.5
26118	Radical resection of tumor (eg	090	368	400	32	9%	14.81	16.79	1.98	13%	-2			2	2	1		1			1
26121	Fasciectomy, palm only, with l	090	200	208	8	4%	7.73	8.61	0.88	11%	0			4							
26123	Fasciectomy, partial palmar w	090	308	343	35	11%	10.88	12.53	1.65	15%	0				5						
26130	Synovectomy, carpometacarp	090	180	187	7	4%	5.59	6.47	0.88	16%	0			3.5							0.5
26135	Synovectomy, metacarpophal	090	181	188	7	4%	7.13	8.01	0.88	12%	0			3.5							0.5
26140	Synovectomy, proximal interp	090	174	181	7	4%	6.34	7.22	0.88	14%	0			3.5							0.5
26145	Synovectomy, tendon sheath,	090	178	185	7	4%	6.49	7.37	0.88	14%	0			3.5							0.5
26160	Excision of lesion of tendon sh	090	121	130	9	7%	3.57	4.23	0.66	18%	0			1	1						0.5
26170	Excision of tendon, palm, flex	090	135	141	6	4%	4.91	5.57	0.66	13%	0			3							
26180	Excision of tendon, finger, flex	090	153	160	7	5%	5.35	6.12	0.77	14%	0			3.5							
26185	Sesamoidectomy, thumb or fi	090	202	230	28	14%	6.52	7.84	1.32	20%	0				4						
26200	Excision or curettage of bone	090	164	170	6	4%	5.65	6.42	0.77	14%	0			3							0.5
26205	Excision or curettage of bone	090	229	238.5	9.5	4%	7.93	9.04	1.11	14%	0			3.5				0.5			1
26210	Excision or curettage of bone	090	155	162	7	5%	5.32	6.09	0.77	14%	0			3.5							
26215	Excision or curettage of bone	090	199	206	7	4%	7.27	8.15	0.88	12%	0			3.5							0.5
26230	Partial excision (craterization,	090	186	192	6	3%	6.47	7.35	0.88	14%	0			3							1
26235	Partial excision (craterization,	090	185	191	6	3%	6.33	7.21	0.88	14%	0			3							1
26236	Partial excision (craterization,	090	171	177	6	4%	5.46	6.34	0.88	16%	0			3							1
26250	Radical resection of tumor, m	090	353	383	30	8%	15.21	16.97	1.76	12%	-2			1	2	1		1			1
26260	Radical resection of tumor, pr	090	256	274	18	7%	11.16	12.24	1.08	10%	-2			1	1	1					0.5
26262	Radical resection of tumor, di	090	212	230	18	8%	8.29	9.37	1.08	13%	-2			1	1	1					0.5
26320	Removal of implant from finge	090	150	155	5	3%	4.10	4.76	0.66	16%	0			2.5							0.5
26340	Manipulation, finger joint, und	090	170	182	12	7%	2.80	4.23	1.43	51%	0			6							0.5
26341	Manipulation, palmar fascial c	010	52	54	2	4%	0.91	1.13	0.22	24%	0			1							
26350	Repair or advancement, flexo	090	180	189	9	5%	6.21	7.20	0.99	16%	0			4.5							
26352	Repair or advancement, flexo	090	258	266	8	3%	7.87	8.97	1.10	14%	0			4							1
26356	Repair or advancement, flexo	090	277	299	22	8%	9.56	11.21	1.65	17%	0			4	2						0.5
26357	Repair or advancement, flexo	090	302	324	22	7%	11.00	12.65	1.65	15%	0			4	2						0.5
26358	Repair or advancement, flexo	090	327	349	22	7%	12.60	14.25	1.65	13%	0			4	2						0.5
26370	Repair or advancement of pro	090	221	228	7	3%	7.28	8.27	0.99	14%	0			3.5							1
26372	Repair or advancement of pro	090	278	288.5	10.5	4%	9.01	10.23	1.22	14%	0			4				0.5			1
26373	Repair or advancement of pro	090	258	268.5	10.5	4%	8.41	9.63	1.22	15%	0			4				0.5			1
26390	Excision flexor tendon, with in	090	220	228	8	4%	9.43	10.53	1.10	12%	0			4							1
26392	Removal of synthetic rod and	090	254	264.5	10.5	4%	10.50	11.72	1.22	12%	0			4				0.5			1
26410	Repair, extensor tendon, hand	090	162	168	6	4%	4.77	5.54	0.77	16%	0			3							0.5
26412	Repair, extensor tendon, hand	090	215	222	7	3%	6.48	7.47	0.99	15%	0			3.5							1
26415	Excision of extensor tendon, w	090	191	198	7	4%	8.51	9.39	0.88	10%	0			3.5							0.5
26416	Removal of synthetic rod and	090	216	224	8	4%	9.56	10.55	0.99	10%	0			4							0.5
26418	Repair, extensor tendon, finge	090	153	162	9	6%	4.47	5.46	0.99	22%	0			4.5							
26420	Repair, extensor tendon, finge	090	224	231	7	3%	6.94	7.93	0.99	14%	0			3.5							1
26426	Repair of extensor tendon, ce	090	190	197	7	4%	6.32	7.20	0.88	14%	0			3.5							0.5
26428	Repair of extensor tendon, ce	090	218	226	8	4%	7.40	8.39	0.99	13%	0			4							0.5
26432	Closed treatment of distal ext	090	134	140	6	4%	4.16	4.82	0.66	16%	0			3							
26433	Repair of extensor tendon, dis	090	148	154	6	4%	4.70	5.36	0.66	14%	0			3							
26434	Repair of extensor tendon, dis	090	190	197	7	4%	6.26	7.14	0.88	14%	0			3.5							0.5
26437	Realignment of extensor tend	090	183	190	7	4%	5.99	6.87	0.88	15%	0			3.5							0.5
26440	Tenolysis, flexor tendon; palm	090	162	168	6	4%	5.16	5.93	0.77	15%	0			3							0.5
26442	Tenolysis, flexor tendon; palm	090	280	315	35	13%	9.75	11.40	1.65	17%	0				5						
26445	Tenolysis, extensor tendon, ha	090	137	143	6	4%	4.45	5.11	0.66	15%	0			3							
26449	Tenolysis, complex, extensor t	090	275	310	35	13%	8.59	10.24	1.65	19%	0				5						
26450	Tenotomy, flexor, palm, open	090	111	116	5	5%	3.79	4.34	0.55	15%	0			2.5							
26455	Tenotomy, flexor, finger, oper	090	113	118	5	4%	3.76	4.31	0.55	15%	0			2.5							
26460	Tenotomy, extensor, hand or	090	107	112	5	5%	3.58	4.13	0.55	15%	0			2.5							
26471	Tenodesis; of proximal interph	090	171	178	7	4%	5.90	6.67	0.77	13%	0			3.5							
26474	Tenodesis; of distal joint, each	090	162	169	7	4%	5.49	6.26	0.77	14%	0			3.5							
26476	Lengthening of tendon, exten	090	153	160	7	5%	5.35	6.12	0.77	14%	0			3.5							
26477	Shortening of tendon, extenso	090	153	160	7	5%	5.32	6.09	0.77	14%	0			3.5							
26478	Lengthening of tendon, flexor	090	163	170	7	4%	5.97	6.74	0.77	13%	0			3.5							
26479	Shortening of tendon, flexor,	090	159	166	7	4%	5.91	6.68	0.77	13%	0			3.5							
26480	Transfer or transplant of tend	090	222	235	13	6%	6.90	8.00	1.10	16%	0			3	1						0.5
26483	Transfer or transplant of tend	090	242	250	8	3%	8.48	9.58	1.10	13%	0			4							1
26485	Transfer or transplant of tend	090	233	241	8	3%	7.89	8.99	1.10	14%	0			4							1

26489	Transfer or transplant of tend	090	282	295	13	5%	9.86	11.20	1.34	14%	0			4				1			1	
26490	Opponensplasty; superficialis	090	241	249	8	3%	8.60	9.70	1.10	13%	0			4							1	
26492	Opponensplasty; tendon trans	090	273	282	9	3%	9.84	11.05	1.21	12%	0			4.5							1	
26494	Opponensplasty; hypothenar	090	243	251	8	3%	8.66	9.76	1.10	13%	0			4							1	
26496	Opponensplasty; other metho	090	253	261	8	3%	9.78	10.88	1.10	11%	0			4							1	
26497	Transfer of tendon to restore	090	249	257	8	3%	9.76	10.86	1.10	11%	0			4							1	
26498	Transfer of tendon to restore	090	294	303	9	3%	14.21	15.42	1.21	9%	0			4.5							1	
26499	Correction claw finger, other	090	272	280	8	3%	9.17	10.27	1.10	12%	0			4							1	
26500	Reconstruction of tendon pull	090	179	186	7	4%	6.13	7.01	0.88	14%	0			3.5							0.5	
26502	Reconstruction of tendon pull	090	223	230	7	3%	7.31	8.30	0.99	14%	0			3.5							1	
26508	Release of thenar muscle(s) (e	090	206	213	7	3%	6.18	7.17	0.99	16%	0			3.5							1	
26510	Cross intrinsic transfer, each t	090	254	261	7	3%	5.60	6.59	0.99	18%	0			3.5							1	
26516	Capsulodesis, metacarpophala	090	217	224	7	3%	7.32	8.31	0.99	14%	0			3.5							1	
26517	Capsulodesis, metacarpophala	090	260	270.5	10.5	4%	9.08	10.30	1.22	13%	0			4				0.5			1	
26518	Capsulodesis, metacarpophala	090	283	293.5	10.5	4%	9.27	10.49	1.22	13%	0			4				0.5			1	
26520	Capsulectomy or capsulotomy	090	176	183	7	4%	5.47	6.35	0.88	16%	0			3.5							0.5	
26525	Capsulectomy or capsulotomy	090	175	182	7	4%	5.50	6.38	0.88	16%	0			3.5							0.5	
26530	Arthroplasty, metacarpophala	090	205	213	8	4%	6.88	7.87	0.99	14%	0			4							0.5	
26531	Arthroplasty, metacarpophala	090	215	224	9	4%	8.13	9.23	1.10	14%	0			4.5							0.5	
26535	Arthroplasty, interphalangeal	090	196	203	7	4%	5.41	6.29	0.88	16%	0			3.5							0.5	
26536	Arthroplasty, interphalangeal	090	211	219	8	4%	6.56	7.55	0.99	15%	0			4							0.5	
26540	Repair of collateral ligament,	090	204	211	7	3%	6.60	7.59	0.99	15%	0			3.5							1	
26541	Reconstruction, collateral liga	090	245	253	8	3%	8.81	9.91	1.10	12%	0			4							1	
26542	Reconstruction, collateral liga	090	220	227	7	3%	6.95	7.94	0.99	14%	0			3.5							1	
26545	Reconstruction, collateral liga	090	227	235	8	4%	7.11	8.21	1.10	15%	0			4							1	
26546	Repair non-union, metacarpal	090	341	383	42	12%	10.83	13.03	2.20	20%	0				6						1	
26548	Repair and reconstruction, fin	090	226	234	8	4%	8.22	9.32	1.10	13%	0			4							1	
26550	Pollicization of a digit	090	491	504	13	3%	21.68	22.67	0.99	5%	0			3	1							
26551	Transfer, toe-to-hand with mi	090	1004	1073	69	7%	48.48	52.62	4.14	9%	0			5	2			9			1	
26553	Transfer, toe-to-hand with mi	090	989	1058	69	7%	48.17	52.31	4.14	9%	0			5	2			9			1	
26554	Transfer, toe-to-hand with mi	090	1155	1231	76	7%	57.01	61.61	4.60	8%	0			6	2			10			1	
26555	Transfer, finger to another po	090	401	414	13	3%	17.08	18.07	0.99	6%	0			3	1							
26556	Transfer, free toe joint, with r	090	1004	1085	81	8%	49.75	54.33	4.58	9%	0			4	4			9			1	
26560	Repair of syndactyly (web fing	090	183	189	6	3%	5.52	6.18	0.66	12%	0			3								
26561	Repair of syndactyly (web fing	090	258	266	8	3%	11.10	12.20	1.10	10%	0			4							1	
26562	Repair of syndactyly (web fing	090	425	462	37	9%	16.68	18.64	1.96	12%	-2				4	1					1	
26565	Osteotomy; metacarpal, each	090	194	201	7	4%	6.91	7.79	0.88	13%	0			3.5							0.5	
26567	Osteotomy; phalanx of finger,	090	195	202	7	4%	6.99	7.87	0.88	13%	0			3.5							0.5	
26568	Osteoplasty, lengthening, met	090	239	247	8	3%	9.27	10.37	1.10	12%	0			4							1	
26580	Repair cleft hand	090	425	460	35	8%	19.75	21.40	1.65	8%	0				5							
26587	Reconstruction of polydactylo	090	401	414	13	3%	14.50	15.49	0.99	7%	0			3	1							
26590	Repair macrodactylia, each di	090	408	426	18	4%	18.67	19.77	1.10	6%	0			2	2							
26591	Repair, intrinsic muscles of ha	090	222	227	5	2%	3.38	4.15	0.77	23%	0			2.5							1	
26593	Release, intrinsic muscles of h	090	233	241	8	3%	5.50	6.60	1.10	20%	0			4							1	
26596	Excision of constricting ring of	090	210	218	8	4%	9.14	10.13	0.99	11%	0			4							0.5	
26600	Closed treatment of metacarp	090	93	101	8	9%	2.60	3.48	0.88	34%	0			4								
26605	Closed treatment of metacarp	090	107	114	7	7%	3.03	3.80	0.77	25%	0			3.5								
26607	Closed treatment of metacarp	090	149	154	5	3%	5.48	6.14	0.66	12%	0			2.5							0.5	
26608	Percutaneous skeletal fixation	090	191	199	8	4%	5.55	6.54	0.99	18%	0			4							0.5	
26615	Open treatment of metacarpa	090	217	235	18	8%	7.07	8.28	1.21	17%	0			2	2						0.5	
26641	Closed treatment of carpomet	090	138	146	8	6%	4.13	5.01	0.88	21%	0			4								
26645	Closed treatment of carpomet	090	131	138	7	5%	4.58	5.35	0.77	17%	0			3.5								
26650	Percutaneous skeletal fixation	090	197	215	18	9%	5.35	6.56	1.21	23%	0			2	2						0.5	
26665	Open treatment of carpometa	090	237	255	18	8%	7.94	9.15	1.21	15%	0			2	2						0.5	
26670	Closed treatment of carpomet	090	101	107	6	6%	3.83	4.49	0.66	17%	0			3								
26675	Closed treatment of carpomet	090	129	137	8	6%	4.83	5.71	0.88	18%	0			4								
26676	Percutaneous skeletal fixation	090	171	180	9	5%	5.74	6.73	0.99	17%	0			4.5								
26685	Open treatment of carpometa	090	227	245	18	8%	7.07	8.28	1.21	17%	0			2	2						0.5	
26686	Open treatment of carpometa	090	231	240.5	9.5	4%	8.17	9.28	1.11	14%	0			3.5				0.5			1	
26700	Closed treatment of metacarp	090	110	116	6	5%	3.83	4.49	0.66	17%	0			3								
26705	Closed treatment of metacarp	090	142	150	8	6%	4.38	5.26	0.88	20%	0			4								
26706	Percutaneous skeletal fixation	090	155	163	8	5%	5.31	6.19	0.88	17%	0			4								
26715	Open treatment of metacarpo	090	220	238	18	8%	7.03	8.24	1.21	17%	0			2	2						0.5	
26720	Closed treatment of phalange	090	63	67	4	6%	1.76	2.20	0.44	25%	0			2								
26725	Closed treatment of phalange	090	104	110	6	6%	3.48	4.14	0.66	19%	0			3								
26727	Percutaneous skeletal fixation	090	174	182	8	5%	5.42	6.41	0.99	18%	0			4							0.5	
26735	Open treatment of phalangea	090	237	255	18	8%	7.42	8.63	1.21	16%	0			2	2						0.5	

26740	Closed treatment of articular	090	78	83	5	6%	2.07	2.62	0.55	27%	0			2.5								
26742	Closed treatment of articular	090	104	110	6	6%	3.99	4.65	0.66	17%	0			3								
26746	Open treatment of articular fr	090	303	328	25	8%	9.80	11.34	1.54	16%	0			2	3						0.5	
26750	Closed treatment of distal pha	090	65	69	4	6%	1.80	2.24	0.44	24%	0			2								
26755	Closed treatment of distal pha	090	85	90	5	6%	3.23	3.78	0.55	17%	0			2.5								
26756	Percutaneous skeletal fixation	090	146	154	8	5%	4.58	5.46	0.88	19%	0			4								
26765	Open treatment of distal phal	090	217	235	18	8%	5.86	7.07	1.21	21%	0			2	2						0.5	
26770	Closed treatment of interphal	090	86	91	5	6%	3.15	3.70	0.55	17%	0			2.5								
26775	Closed treatment of interphal	090	142	150	8	6%	3.90	4.78	0.88	23%	0			4								
26776	Percutaneous skeletal fixation	090	152	160	8	5%	4.99	5.87	0.88	18%	0			4								
26785	Open treatment of interphala	090	227	245	18	8%	6.60	7.81	1.21	18%	0			2	2						0.5	
26820	Fusion in opposition, thumb,	090	254	262	8	3%	8.45	9.55	1.10	13%	0			4							1	
26841	Arthrodesis, carpometacarpal	090	222	231	9	4%	7.35	8.45	1.10	15%	0			4.5							0.5	
26842	Arthrodesis, carpometacarpal	090	258	268.5	10.5	4%	8.49	9.71	1.22	14%	0			4				0.5			1	
26843	Arthrodesis, carpometacarpal	090	232	239	7	3%	7.78	8.77	0.99	13%	0			3.5							1	
26844	Arthrodesis, carpometacarpal	090	275	285.5	10.5	4%	8.98	10.20	1.22	14%	0			4				0.5			1	
26850	Arthrodesis, metacarpophalar	090	237	244	7	3%	7.14	8.13	0.99	14%	0			3.5							1	
26852	Arthrodesis, metacarpophalar	090	272	282.5	10.5	4%	8.71	9.93	1.22	14%	0			4				0.5			1	
26860	Arthrodesis, interphalangeal j	090	163	171	8	5%	4.88	5.76	0.88	18%	0			4								
26862	Arthrodesis, interphalangeal j	090	227	235	8	4%	7.56	8.55	0.99	13%	0			4							0.5	
26910	Amputation, metacarpal, with	090	251	259	8	3%	7.79	8.89	1.10	14%	0			4							1	
26951	Amputation, finger or thumb,	090	203	223	20	10%	6.04	7.47	1.43	24%	0			3	2						0.5	
26952	Amputation, finger or thumb,	090	173	180	7	4%	6.48	7.36	0.88	14%	0			3.5							0.5	
26990	Incision and drainage, pelvis o	090	265	284.5	19.5	7%	7.95	9.54	1.59	20%	0			3.5				2.5			1	
26991	Incision and drainage, pelvis o	090	229	245	16	7%	7.06	8.42	1.36	19%	0			3				2			1	
26992	Incision, bone cortex, pelvis a	090	291	310.5	19.5	7%	13.48	15.07	1.59	12%	0			3.5				2.5			1	
27000	Tenotomy, adductor of hip, pe	090	147	152	5	3%	5.74	6.51	0.77	13%	0			2.5							1	
27001	Tenotomy, adductor of hip, op	090	189	197.5	8.5	4%	7.14	8.14	1.00	14%	0			3				0.5			1	
27003	Tenotomy, adductor, subcutar	090	267	286.5	19.5	7%	7.81	9.40	1.59	20%	0			3.5				2.5			1	
27005	Tenotomy, hip flexor(s), open	090	248	265	17	7%	10.07	11.54	1.47	15%	0			3.5				2			1	
27006	Tenotomy, abductors and/or	090	254	272	18	7%	10.11	11.69	1.58	16%	0			4				2			1	
27025	Fasciotomy, hip or thigh, any	090	392.5	436.5	44	11%	12.89	15.20	2.31	18%	0				4.5			2.5			1	
27027	Decompression fasciotomy(ie	090	359	383	24	7%	13.04	15.17	2.13	16%	0			3	1			3	1		1	
27030	Arthrotomy, hip, with drainag	090	302	329	27	9%	13.65	15.60	1.95	14%	0			3.5				4			1	
27033	Arthrotomy, hip, including exp	090	342	372.5	30.5	9%	14.11	16.29	2.18	15%	0			4				4.5			1	
27035	Denervation, hip joint, intrape	090	369	398	29	8%	17.37	19.54	2.17	12%	0			4.5				4			1	
27036	Capsulectomy or capsulotomy	090	380	418	38	10%	14.38	16.40	2.02	14%	0				4			2			1	
27040	Biopsy, soft tissue of pelvis an	010	106	108	2	2%	2.92	3.25	0.33	11%	0			1							0.5	
27041	Biopsy, soft tissue of pelvis an	090	250	262	12	5%	10.18	11.41	1.23	12%	0			3.5				1			1	
27043	Excision, tumor, soft tissue of	090	206	215	9	4%	6.88	7.54	0.66	10%	0			1	1						0.5	
27045	Excision, tumor, soft tissue of	090	320	341	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
27047	Excision, tumor, soft tissue of	090	160	169	9	6%	4.94	5.60	0.66	13%	0			1	1						0.5	
27048	Excision, tumor, soft tissue of	090	288	304	16	6%	8.85	10.08	1.23	14%	0			2	1			1			1	
27049	Radical resection of tumor (eg	090	496	516	20	4%	21.55	23.62	2.07	10%	0			1	3			1	2		1	
27050	Arthrotomy, with biopsy; sacr	090	260	276	16	6%	4.74	6.10	1.36	29%	0			3				2			1	
27052	Arthrotomy, with biopsy; hip j	090	327	358	31	9%	7.42	9.11	1.69	23%	0				3			2			1	
27054	Arthrotomy with synovectom	090	358	386	28	8%	9.21	11.27	2.06	22%	0			4				4			1	
27057	Decompression fasciotomy(ie	090	389	413	24	6%	14.91	17.04	2.13	14%	0			3	1			3	1		1	
27059	Radical resection of tumor (eg	090	608	640	32	5%	29.35	31.99	2.64	9%	-2			1	2	1		3	2		1	
27060	Excision; ischial bursa	090	254	272.5	18.5	7%	5.87	7.35	1.48	25%	0			3				2.5			1	
27062	Excision; trochanteric bursa o	090	185	191	6	3%	5.75	6.52	0.77	13%	0			3							0.5	
27065	Excision of bone cyst or benig	090	329	356	27	8%	6.55	8.50	1.95	30%	0			3.5				4			1	
27066	Excision of bone cyst or benig	090	406	442.5	36.5	9%	11.20	13.73	2.53	23%	0			4.5				5.5			1	
27067	Excision of bone cyst or benig	090	443	480.5	37.5	8%	14.72	17.36	2.64	18%	0			5				5.5			1	
27070	Partial excision, wing of ilium,	090	363	398.5	35.5	10%	11.56	13.98	2.42	21%	0			4				5.5			1	
27071	Partial excision, wing of ilium,	090	409	448	39	10%	12.39	15.04	2.65	21%	0			4.5				6			1	
27075	Radical resection of tumor; wi	090	633	656	23	4%	32.71	35.31	2.60	8%	-2			1	2	1		2	3		1	
27076	Radical resection of tumor; ili	090	840	864	24	3%	40.21	43.25	3.04	8%	-2			1	2	1		3	4		1	
27077	Radical resection of tumor; in	090	905	934	29	3%	45.21	48.49	3.28	7%	-2			1	2	1		4	4		1	
27078	Radical resection of tumor; isc	090	665	688	23	3%	32.21	34.81	2.60	8%	-2			1	2	1		2	3		1	
27080	Coccygectomy, primary	090	274	295	21	8%	6.89	8.49	1.60	23%	0			3				3			1	
27086	Removal of foreign body, pelv	010	82	84	2	2%	1.92	2.14	0.22	11%	0			1								
27087	Removal of foreign body, pelv	090	249	261	12	5%	8.83	10.06	1.23	14%	0			3.5				1			1	
27090	Removal of hip prosthesis; (se	090	317	340	23	7%	11.69	13.51	1.82	16%	0			4				3			1	
27091	Removal of hip prosthesis; co	090	577	645	68	12%	24.35	27.81	3.46	14%	0				4			8			1	
27097	Release or recession, hamstri	090	271	290.5	19.5	7%	9.27	10.86	1.59	17%	0			3.5				2.5			1	
27098	Transfer, adductor to ischium	090	303	323.5	20.5	7%	9.32	11.02	1.70	18%	0			4				2.5			1	

27100	Transfer external oblique mus	090	311	322.5	11.5	4%	11.35	12.68	1.33	12%	0			4.5				0.5			1	
27105	Transfer paraspinal muscle to	090	332	343.5	11.5	3%	12.04	13.37	1.33	11%	0			4.5				0.5			1	
27110	Transfer iliopsoas; to greater t	090	365	386.5	21.5	6%	13.77	15.58	1.81	13%	0			4.5				2.5			1	
27111	Transfer iliopsoas; to femoral	090	339	358	19	6%	12.60	14.29	1.69	13%	0			4.5				2			1	
27120	Acetabuloplasty; (eg, Whitma	090	515	567.5	52.5	10%	19.25	22.61	3.36	17%	0			5				8.5			1	
27122	Acetabuloplasty; resection, fe	090	436	482.5	46.5	11%	16.09	19.10	3.01	19%	0			4.5				7.5			1	
27125	Hemiarthroplasty, hip, partial	090	430.5	490	59.5	14%	16.64	19.70	3.06	18%	0				3.5			7			1	
27130	Arthroplasty, acetabular and p	090	377	390	13	3%	19.60	21.21	1.61	8%	0				3				2		1	
27132	Conversion of previous hip su	090	611	686.5	75.5	12%	25.69	29.51	3.82	15%	0				4			9.5			1	
27134	Revision of total hip arthropla	090	617	673	56	9%	30.28	33.17	2.89	10%	0				3			7			1	
27137	Revision of total hip arthropla	090	492	538	46	9%	22.70	25.11	2.41	11%	0				3			5			1	
27138	Revision of total hip arthropla	090	492	538	46	9%	23.70	26.11	2.41	10%	0				3			5			1	
27140	Osteotomy and transfer of gre	090	335	358	23	7%	12.78	14.60	1.82	14%	0			4				3			1	
27146	Osteotomy, iliac, acetabular o	090	443	481	38	9%	18.92	20.94	2.02	11%	0				4			2			1	
27147	Osteotomy, iliac, acetabular o	090	473	511	38	8%	22.07	24.09	2.02	9%	0				4			2			1	
27151	Osteotomy, iliac, acetabular o	090	523	566	43	8%	24.12	26.38	2.26	9%	0				4			3			1	
27156	Osteotomy, iliac, acetabular o	090	538	581	43	8%	26.23	28.49	2.26	9%	0				4			3			1	
27158	Osteotomy, pelvis, bilateral (e	090	562	617	55	10%	21.04	24.52	3.48	17%	0			5				9			1	
27161	Osteotomy, femoral neck (sep	090	489	539	50	10%	17.89	21.13	3.24	18%	0			5				8			1	
27165	Osteotomy, intertrochanteric	090	531.5	603	71.5	13%	20.29	23.92	3.63	18%	0				4.5			8			1	
27170	Bone graft, femoral head, neck	090	444	490	46	10%	17.61	20.02	2.41	14%	0				3			5			1	
27175	Treatment of slipped femoral	090	308	346.5	38.5	13%	9.38	11.82	2.44	26%	0			3				6.5			1	
27176	Treatment of slipped femoral	090	385	421.5	36.5	9%	12.92	15.45	2.53	20%	0			4.5				5.5			1	
27177	Open treatment of slipped fer	090	477	519.5	42.5	9%	16.09	18.97	2.88	18%	0			5				6.5			1	
27178	Open treatment of slipped fer	090	408	447	39	10%	12.92	15.57	2.65	21%	0			4.5				6			1	
27179	Open treatment of slipped fer	090	442	483.5	41.5	9%	13.97	16.74	2.77	20%	0			4.5				6.5			1	
27181	Open treatment of slipped fer	090	445	483	38	9%	16.18	18.20	2.02	12%	0				4			2			1	
27185	Epiphyseal arrest by epiphysio	090	320	345.5	25.5	8%	9.79	11.73	1.94	20%	0			4				3.5			1	
27187	Prophylactic treatment (nailin	090	396	425	29	7%	14.23	16.40	2.17	15%	0			4.5				4			1	
27200	Closed treatment of coccygea	090	63	66	3	5%	1.92	2.25	0.33	17%	0			1.5								
27202	Open treatment of coccygeal	090	216	227.5	11.5	5%	7.31	8.33	1.02	14%	0			2				1.5			1	
27215	Open treatment of iliac spine(	090	388	405	17	4%	10.45	12.12	1.67	16%	0			2	1			2	1		1	
27216	Percutaneous skeletal fixation	090	393	427	34	9%	15.73	18.08	2.35	15%	0			1	3			3	1		1	
27217	Open treatment of anterior p	090	443	477	34	8%	14.65	17.00	2.35	16%	0			1	3			3	1		1	
27218	Open treatment of posterior p	090	543	587	44	8%	20.93	23.76	2.83	14%	0			1	3			5	1		1	
27220	Closed treatment of acetabulu	090	184	191	7	4%	5.50	6.82	1.32	24%	0			3				1	1		1	
27222	Closed treatment of acetabulu	090	472	531	59	13%	14.11	17.72	3.61	26%	0			4.5				10			1	
27226	Open treatment of posterior c	090	412	440	28	7%	15.57	17.63	2.06	13%	0			4				4			1	
27227	Open treatment of acetabular	090	550	608	58	11%	25.41	28.39	2.98	12%	0				4			6			1	
27228	Open treatment of acetabular	090	680	729	49	7%	29.33	32.27	2.94	10%	0				4			5	1		1	
27230	Closed treatment of femoral f	090	205	218	13	6%	5.81	7.15	1.34	23%	0			4				1			1	
27232	Closed treatment of femoral f	090	353	397	44	12%	11.72	14.30	2.58	22%	0			2				8			1	
27235	Percutaneous skeletal fixation	090	360	395.5	35.5	10%	13.00	15.42	2.42	19%	0			4				5.5			1	
27236	Open treatment of femoral fra	090	418	438	20	5%	17.61	19.68	2.07	12%	0			1	3			1	2		1	
27238	Closed treatment of intertroc	090	207	216.5	9.5	5%	5.75	6.86	1.11	19%	0			3.5				0.5			1	
27240	Closed treatment of intertroc	090	454	509	55	12%	13.81	17.29	3.48	25%	0			5				9			1	
27244	Treatment of intertrochanteri	090	438	463	25	6%	18.18	20.49	2.31	13%	0			1	3			2	2		1	
27245	Treatment of intertrochanteri	090	443	468	25	6%	18.18	20.49	2.31	13%	0			1	3			2	2		1	
27246	Closed treatment of greater t	090	141	146	5	4%	4.83	5.60	0.77	16%	0			2.5							1	
27248	Open treatment of greater tro	090	384	394	10	3%	10.78	12.63	1.85	17%	0			3	1			1	2		1	
27252	Closed treatment of hip disloc	090	284	311	27	10%	11.03	12.98	1.95	18%	0			3.5				4			1	
27253	Open treatment of hip disloca	090	344	372	28	8%	13.58	15.64	2.06	15%	0			4				4			1	
27254	Open treatment of hip disloca	090	413	442	29	7%	18.94	21.11	2.17	11%	0			4.5				4			1	
27256	Treatment of spontaneous hip	010	154	161	7	5%	4.28	4.96	0.68	16%	0			1				1			1	
27257	Treatment of spontaneous hip	010	173	180	7	4%	5.38	6.06	0.68	13%	0			1				1			1	
27258	Open treatment of spontaneo	090	395	426.5	31.5	8%	16.18	18.47	2.29	14%	0			4.5				4.5			1	
27259	Open treatment of spontaneo	090	537	582	45	8%	23.26	25.61	2.35	10%	-2				3	1		3			1	
27265	Closed treatment of post hip a	090	150	158	8	5%	5.24	6.23	0.99	19%	0			4							0.5	
27266	Closed treatment of post hip a	090	202	214	12	6%	7.78	9.01	1.23	16%	0			3.5				1			1	
27267	Closed treatment of femoral f	090	171	189	18	11%	5.50	7.08	1.58	29%	0			4				2			1	
27268	Closed treatment of femoral f	090	196	214	18	9%	7.12	8.70	1.58	22%	0			4				2			1	
27269	Open treatment of femoral fra	090	404	423	19	5%	18.89	20.78	1.89	10%	0			3	1			2	1		1	
27275	Manipulation, hip joint, requir	010	110	112	2	2%	2.32	2.76	0.44	19%	0			1							1	
27279	Arthrodesis, sacroiliac joint, p	090	241	257	16	7%	12.13	13.12	0.99	8%	0			1	2						0.5	
27280	Arthrodesis, open, sacroiliac j	090	383	400	17	4%	20.00	21.54	1.54	8%	0			1	2			1	1		1	
27282	Arthrodesis, symphysis pubis	090	342	363.5	21.5	6%	11.85	13.66	1.81	15%	0			4.5				2.5			1	
27284	Arthrodesis, hip joint (includin	090	497	529	32	6%	25.06	27.19	2.13	8%	0				3			3	1		1	

27286	Arthrodesis, hip joint (includir	090	540	588	48	9%	25.17	27.67	2.50	10%	0				4			4			1	
27290	Interpelviabdominal amputati	090	615	668.5	53.5	9%	24.55	28.02	3.47	14%	0			5.5				8.5			1	
27295	Disarticulation of hip	090	499	542	43	9%	19.66	22.44	2.78	14%	0			4				7			1	
27301	Incision and drainage, deep ab	090	220	232	12	5%	6.78	8.01	1.23	18%	0			3.5				1			1	
27303	Incision, deep, with opening o	090	249	263.5	14.5	6%	8.63	9.98	1.35	16%	0			3.5				1.5			1	
27305	Fasciotomy, iliotibial (tenoton	090	207	218	11	5%	6.18	7.30	1.12	18%	0			3				1			1	
27306	Tenotomy, percutaneous, add	090	162	167	5	3%	4.74	5.51	0.77	16%	0			2.5							1	
27307	Tenotomy, percutaneous, add	090	206	217	11	5%	6.06	7.18	1.12	18%	0			3				1			1	
27310	Arthrotomy, knee, with explo	090	311	341.5	30.5	10%	10.00	12.18	2.18	22%	0			4				4.5			1	
27323	Biopsy, soft tissue of thigh or	010	74	76	2	3%	2.33	2.55	0.22	9%	0			1								
27324	Biopsy, soft tissue of thigh or	090	168	174	6	4%	5.04	5.81	0.77	15%	0			3							0.5	
27325	Neurectomy, hamstring musc	090	229	238.5	9.5	4%	7.20	8.31	1.11	15%	0			3.5				0.5			1	
27326	Neurectomy, popliteal (gastro	090	215	222	7	3%	6.47	7.46	0.99	15%	0			3.5							1	
27327	Excision, tumor, soft tissue of	090	140	149	9	6%	3.96	4.62	0.66	17%	0			1	1						0.5	
27328	Excision, tumor, soft tissue of	090	261	277	16	6%	8.85	10.08	1.23	14%	0			2	1			1			1	
27329	Radical resection of tumor (eg	090	413	437	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
27330	Arthrotomy, knee; with synov	090	165	171	6	4%	5.11	5.88	0.77	15%	0			3							0.5	
27331	Arthrotomy, knee; including j	090	200	206	6	3%	6.02	6.90	0.88	15%	0			3							1	
27332	Arthrotomy, with excision of s	090	235	243	8	3%	8.46	9.56	1.10	13%	0			4							1	
27333	Arthrotomy, with excision of s	090	263	273.5	10.5	4%	7.55	8.77	1.22	16%	0			4				0.5			1	
27334	Arthrotomy, with synovectom	090	294	314.5	20.5	7%	9.19	10.89	1.70	18%	0			4				2.5			1	
27335	Arthrotomy, with synovectom	090	329	352	23	7%	10.55	12.37	1.82	17%	0			4				3			1	
27337	Excision, tumor, soft tissue of	090	181	190	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
27339	Excision, tumor, soft tissue of	090	310	331	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
27340	Excision, prepatellar bursa	090	155	161	6	4%	4.32	5.09	0.77	18%	0			3							0.5	
27345	Excision of synovial cyst of po	090	204	211	7	3%	6.09	6.97	0.88	14%	0			3.5							0.5	
27347	Excision of lesion of meniscus	090	214	235	21	10%	6.73	7.72	0.99	15%	0				3							
27350	Patellectomy or hemipatellect	090	289	309.5	20.5	7%	8.66	10.36	1.70	20%	0			4				2.5			1	
27355	Excision or curettage of bone	090	258	272.5	14.5	6%	8.00	9.35	1.35	17%	0			3.5				1.5			1	
27356	Excision or curettage of bone	090	331	356.5	25.5	8%	10.09	12.03	1.94	19%	0			4				3.5			1	
27357	Excision or curettage of bone	090	361	387.5	26.5	7%	11.16	13.21	2.05	18%	0			4.5				3.5			1	
27360	Partial excision (craterization,	090	386	426.5	40.5	10%	11.46	14.12	2.66	23%	0			4				6.5			1	
27364	Radical resection of tumor (eg	090	550	577	27	5%	24.49	26.89	2.40	10%	-2			1	2	1		2	2		1	
27365	Radical resection of tumor, fe	090	633	656	23	4%	32.21	34.81	2.60	8%	-2			1	2	1		2	3		1	
27372	Removal of foreign body, dee	090	168	174	6	4%	5.21	5.98	0.77	15%	0			3							0.5	
27380	Suture of infrapatellar tendon	090	235	247	12	5%	7.45	8.68	1.23	17%	0			3.5				1			1	
27381	Suture of infrapatellar tendon	090	320	338	18	6%	10.76	12.34	1.58	15%	0			4				2			1	
27385	Suture of quadriceps or hams	090	237	250	13	5%	6.93	8.03	1.10	16%	0			3	1						0.5	
27386	Suture of quadriceps or hams	090	350	374	24	7%	11.13	13.06	1.93	17%	0			4.5				3			1	
27390	Tenotomy, open, hamstring, k	090	184	192.5	8.5	5%	5.53	6.53	1.00	18%	0			3				0.5			1	
27391	Tenotomy, open, hamstring, k	090	233	245	12	5%	7.49	8.72	1.23	16%	0			3.5				1			1	
27392	Tenotomy, open, hamstring, k	090	292	310	18	6%	9.63	11.21	1.58	16%	0			4				2			1	
27393	Lengthening of hamstring ten	090	197	205.5	8.5	4%	6.59	7.59	1.00	15%	0			3				0.5			1	
27394	Lengthening of hamstring ten	090	248	260	12	5%	8.79	10.02	1.23	14%	0			3.5				1			1	
27395	Lengthening of hamstring ten	090	348	369.5	21.5	6%	12.24	14.05	1.81	15%	0			4.5				2.5			1	
27396	Transplant or transfer (with m	090	254	266	12	5%	8.15	9.38	1.23	15%	0			3.5				1			1	
27397	Transplant or transfer (with m	090	360	393	33	9%	12.66	14.44	1.78	14%	0				4			1			1	
27400	Transfer, tendon or muscle, h	090	274	287	13	5%	9.33	10.67	1.34	14%	0			4				1			1	
27403	Arthrotomy with meniscus rep	090	257	269	12	5%	8.62	9.85	1.23	14%	0			3.5				1			1	
27405	Repair, primary, torn ligament	090	282	300	18	6%	9.08	10.66	1.58	17%	0			4				2			1	
27407	Repair, primary, torn ligament	090	349	373	24	7%	10.85	12.78	1.93	18%	0			4.5				3			1	
27409	Repair, primary, torn ligament	090	410	444	34	8%	13.71	16.12	2.41	18%	0			4.5				5			1	
27412	Autologous chondrocyte impla	090	484	510	26	5%	24.74	26.83	2.09	8%	0			2	3			1	1		1	
27415	Osteochondral allograft, knee	090	424	450	26	6%	20.00	22.09	2.09	10%	0			2	3			1	1		1	
27416	Osteochondral autograft(s), k	090	287	305	18	6%	14.16	15.37	1.21	9%	0			2	2						0.5	
27418	Anterior tibial tubercleplasty (	090	358	389.5	31.5	9%	11.60	13.89	2.29	20%	0			4.5				4.5			1	
27420	Reconstruction of dislocating	090	295	313	18	6%	10.26	11.84	1.58	15%	0			4				2			1	
27422	Reconstruction of dislocating	090	297	315	18	6%	10.21	11.79	1.58	15%	0			4				2			1	
27424	Reconstruction of dislocating	090	298	316	18	6%	10.24	11.82	1.58	15%	0			4				2			1	
27425	Lateral retinacular release, op	090	159	166	7	4%	5.39	6.16	0.77	14%	0			3.5								
27427	Ligamentous reconstruction (a	090	302	320	18	6%	9.79	11.37	1.58	16%	0			4				2			1	
27428	Ligamentous reconstruction (a	090	363	398	35	10%	15.58	17.45	1.87	12%	0				5						1	
27429	Ligamentous reconstruction (a	090	466	513	47	10%	17.54	19.98	2.44	14%	0				6			1			1	
27430	Quadricepsplasty (eg, Bennett	090	303	323.5	20.5	7%	10.16	11.86	1.70	17%	0			4				2.5			1	
27435	Capsulotomy, posterior capsu	090	340	373	33	10%	10.88	12.66	1.78	16%	0				4			1			1	
27437	Arthroplasty, patella; without	090	273	292.5	19.5	7%	8.93	10.52	1.59	18%	0			3.5				2.5			1	
27438	Arthroplasty, patella; with pro	090	332	360	28	8%	11.89	13.95	2.06	17%	0			4				4			1	

27440	Arthroplasty, knee, tibial plate	090	334	362	28	8%	11.09	13.15	2.06	19%	0			4				4			1	
27441	Arthroplasty, knee, tibial plate	090	360	390.5	30.5	8%	11.54	13.72	2.18	19%	0			4				4.5			1	
27442	Arthroplasty, femoral condyle	090	307	327.5	20.5	7%	12.37	14.07	1.70	14%	0			4				2.5			1	
27443	Arthroplasty, femoral condyle	090	323	343.5	20.5	6%	11.41	13.11	1.70	15%	0			4				2.5			1	
27445	Arthroplasty, knee, hinge pros	090	447	488.5	41.5	9%	18.66	21.43	2.77	15%	0			4.5				6.5			1	
27446	Arthroplasty, knee, condyle ar	090	310	333	23	7%	17.13	18.32	1.19	7%	-2				2	1					0.5	
27447	Arthroplasty, knee, condyle ar	090	374	387	13	3%	19.60	21.21	1.61	8%	0				3				2		1	
27448	Osteotomy, femur, shaft or su	090	324	347	23	7%	11.60	13.42	1.82	16%	0			4				3			1	
27450	Osteotomy, femur, shaft or su	090	392	418.5	26.5	7%	14.61	16.66	2.05	14%	0			4.5				3.5			1	
27454	Osteotomy, multiple, with rea	090	430	473	43	10%	19.17	21.43	2.26	12%	0				4			3			1	
27455	Osteotomy, proximal tibia, ind	090	344	367	23	7%	13.36	15.18	1.82	14%	0			4				3			1	
27457	Osteotomy, proximal tibia, ind	090	370	394.5	24.5	7%	14.03	15.86	1.83	13%	0			3.5				3.5			1	
27465	Osteoplasty, femur; shortenin	090	383.5	416.5	33	9%	18.60	20.64	2.04	11%	0			2	2			3			1	
27466	Osteoplasty, femur; lengtheni	090	467	507	40	9%	17.28	20.04	2.76	16%	0			5				6			1	
27468	Osteoplasty, femur; combined	090	515	557.5	42.5	8%	19.97	22.85	2.88	14%	0			5				6.5			1	
27470	Repair, nonunion or malunion	090	400	421	21	5%	17.14	19.25	2.11	12%	0			4	1			2	1		1	
27472	Repair, nonunion or malunion	090	502	544.5	42.5	8%	18.72	21.60	2.88	15%	0			5				6.5			1	
27475	Arrest, epiphyseal, any metho	090	252	264	12	5%	8.93	10.16	1.23	14%	0			3.5				1			1	
27477	Arrest, epiphyseal, any metho	090	262	274	12	5%	10.14	11.37	1.23	12%	0			3.5				1			1	
27479	Arrest, epiphyseal, any metho	090	326	341.5	15.5	5%	13.16	14.62	1.46	11%	0			4				1.5			1	
27485	Arrest, hemiepiphyseal, distal	090	241	253	12	5%	9.13	10.36	1.23	13%	0			3.5				1			1	
27486	Revision of total knee arthrop	090	470	523	53	11%	21.12	23.86	2.74	13%	0				4			5			1	
27487	Revision of total knee arthrop	090	520	573	53	10%	27.11	29.85	2.74	10%	0				4			5			1	
27488	Removal of prosthesis, includi	090	470	523	53	11%	17.60	20.34	2.74	16%	0				4			5			1	
27495	Prophylactic treatment (nailin	090	452	493.5	41.5	9%	16.54	19.31	2.77	17%	0			4.5				6.5			1	
27496	Decompression fasciotomy, th	090	287	315	28	10%	6.78	8.84	2.06	30%	0			4				4			1	
27497	Decompression fasciotomy, th	090	301	327	26	9%	7.79	9.63	1.84	24%	0			3				4			1	
27498	Decompression fasciotomy, th	090	327	355	28	9%	8.66	10.72	2.06	24%	0			4				4			1	
27499	Decompression fasciotomy, th	090	332	350	18	5%	9.43	11.01	1.58	17%	0			4				2			1	
27500	Closed treatment of femoral s	090	216	232	16	7%	6.30	7.66	1.36	22%	0			3				2			1	
27501	Closed treatment of supracon	090	169	185	16	9%	6.45	7.68	1.23	19%	0			2	1			1			1	
27502	Closed treatment of femoral s	090	328	361	33	10%	11.36	13.66	2.30	20%	0			4				5			1	
27503	Closed treatment of supracon	090	249	272	23	9%	11.27	12.96	1.69	15%	0			3	1			2			1	
27506	Open treatment of femoral sh	090	501.5	565.5	64	13%	19.65	22.92	3.27	17%	0				4.5			6.5			1	
27507	Open treatment of femoral sh	090	376	397	21	6%	14.48	16.08	1.60	11%	0			3				3			1	
27508	Closed treatment of femoral f	090	221	236.5	15.5	7%	6.20	7.66	1.46	24%	0			4				1.5			1	
27509	Percutaneous skeletal fixation	090	297	315	18	6%	8.14	9.72	1.58	19%	0			4				2			1	
27510	Closed treatment of femoral f	090	298	326	28	9%	9.80	11.86	2.06	21%	0			4				4			1	
27511	Open treatment of femoral su	090	439	449	10	2%	15.11	16.96	1.85	12%	0			3	1			1	2		1	
27513	Open treatment of femoral su	090	464	474	10	2%	19.25	21.10	1.85	10%	0			3	1			1	2		1	
27514	Open treatment of femoral fra	090	409	419	10	2%	14.60	16.45	1.85	13%	0			3	1			1	2		1	
27516	Closed treatment of distal fen	090	215	224	9	4%	5.59	6.80	1.21	22%	0			4.5							1	
27517	Closed treatment of distal fen	090	249	263	14	6%	9.12	10.57	1.45	16%	0			4.5				1			1	
27519	Open treatment of distal fema	090	359	373	14	4%	13.25	14.90	1.65	12%	0			3	1			1	1		1	
27520	Closed treatment of patellar f	090	124	131	7	6%	3.04	3.81	0.77	25%	0			3.5								
27524	Open treatment of patellar fra	090	274	289.5	15.5	6%	10.37	11.83	1.46	14%	0			4				1.5			1	
27530	Closed treatment of tibial frac	090	91	99	8	9%	2.65	3.53	0.88	33%	0			4								
27532	Closed treatment of tibial frac	090	218	228.5	10.5	5%	7.55	8.77	1.22	16%	0			4				0.5			1	
27535	Open treatment of tibial fract	090	389	394	5	1%	13.41	15.02	1.61	12%	0			3	1				2		1	
27536	Open treatment of tibial fract	090	475	523	48	10%	17.39	19.89	2.50	14%	0				4			4			1	
27538	Closed treatment of intercond	090	140	149	9	6%	5.09	6.08	0.99	19%	0			4.5								
27540	Open treatment of intercondy	090	334	343	9	3%	11.30	12.71	1.41	12%	0			3	1				1		1	
27550	Closed treatment of knee dislo	090	143	152	9	6%	5.98	6.97	0.99	17%	0			4.5								
27552	Closed treatment of knee dislo	090	228	239.5	11.5	5%	8.18	9.51	1.33	16%	0			4.5				0.5			1	
27556	Open treatment of knee dislo	090	369	383	14	4%	13.00	14.65	1.65	13%	0			3	1			1	1		1	
27557	Open treatment of knee dislo	090	399	413	14	4%	15.90	17.55	1.65	10%	0			3	1			1	1		1	
27558	Open treatment of knee dislo	090	429	443	14	3%	18.39	20.04	1.65	9%	0			3	1			1	1		1	
27560	Closed treatment of patellar d	090	105	112	7	7%	3.99	4.76	0.77	19%	0			3.5								
27562	Closed treatment of patellar d	090	168	176	8	5%	5.98	6.97	0.99	17%	0			4							0.5	
27566	Open treatment of patellar dis	090	303	323.5	20.5	7%	12.71	14.41	1.70	13%	0			4				2.5			1	
27570	Manipulation of knee joint un	010	71	73	2	3%	1.79	2.01	0.22	12%	0			1								
27580	Arthrodesis, knee, any techniq	090	450	498	48	11%	21.10	23.60	2.50	12%	0				4			4			1	
27590	Amputation, thigh, through fe	090	449	509.5	60.5	13%	13.47	17.09	3.62	27%	0			4				10.5			1	
27591	Amputation, thigh, through fe	090	462	515	53	11%	13.94	17.20	3.26	23%	0			4				9			1	
27592	Amputation, thigh, through fe	090	358	398.5	40.5	11%	10.98	13.64	2.66	24%	0			4				6.5			1	
27594	Amputation, thigh, through fe	090	268	283.5	15.5	6%	7.29	8.75	1.46	20%	0			4				1.5			1	
27596	Amputation, thigh, through fe	090	345	374	29	8%	11.29	13.46	2.17	19%	0			4.5				4			1	

27598	Disarticulation at knee	090	340	369	29	9%	11.22	13.39	2.17	19%	0			4.5				4			1	
27600	Decompression fasciotomy, le	090	211	227	16	8%	6.03	7.39	1.36	23%	0			3				2			1	
27601	Decompression fasciotomy, le	090	220	237	17	8%	6.05	7.52	1.47	24%	0			3.5				2			1	
27602	Decompression fasciotomy, le	090	253	272.5	19.5	8%	7.82	9.41	1.59	20%	0			3.5				2.5			1	
27603	Incision and drainage, leg or a	090	199	211	12	6%	5.23	6.46	1.23	24%	0			3.5				1			1	
27604	Incision and drainage, leg or a	090	130	135	5	4%	4.59	5.25	0.66	14%	0			2.5							0.5	
27605	Tenotomy, percutaneous, Ach	010	88	90	2	2%	2.92	3.14	0.22	8%	0			1								
27606	Tenotomy, percutaneous, Ach	010	131	133	2	2%	4.18	4.62	0.44	11%	0			1							1	
27607	Incision (eg, osteomyelitis or b	090	281	308	27	10%	8.62	10.57	1.95	23%	0			3.5				4			1	
27610	Arthrotomy, ankle, including e	090	311	344	33	11%	9.13	11.43	2.30	25%	0			4				5			1	
27612	Arthrotomy, posterior capsula	090	353	387	34	10%	8.15	10.56	2.41	30%	0			4.5				5			1	
27613	Biopsy, soft tissue of leg or an	010	77	79	2	3%	2.22	2.44	0.22	10%	0			1								
27614	Biopsy, soft tissue of leg or an	090	192	198	6	3%	5.80	6.68	0.88	15%	0			3							1	
27615	Radical resection of tumor (eg	090	416	440	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
27616	Radical resection of tumor (eg	090	463	489	26	6%	19.63	21.59	1.96	10%	-2			1	2	1		1	1		1	
27618	Excision, tumor, soft tissue of	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
27619	Excision, tumor, soft tissue of	090	225	236	11	5%	6.91	7.79	0.88	13%	0			2	1						0.5	
27620	Arthrotomy, ankle, with joint	090	180	187	7	4%	6.15	7.03	0.88	14%	0			3.5							0.5	
27625	Arthrotomy, with synovectom	090	249	257	8	3%	8.49	9.59	1.10	13%	0			4							1	
27626	Arthrotomy, with synovectom	090	268	276	8	3%	9.10	10.20	1.10	12%	0			4							1	
27630	Excision of lesion of tendon sh	090	146	152	6	4%	4.94	5.60	0.66	13%	0			3								
27632	Excision, tumor, soft tissue of	090	183	192	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
27634	Excision, tumor, soft tissue of	090	281	302	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1	
27635	Excision or curettage of bone	090	267	277.5	10.5	4%	8.03	9.25	1.22	15%	0			4				0.5			1	
27637	Excision or curettage of bone	090	336	355	19	6%	10.31	12.00	1.69	16%	0			4.5				2			1	
27638	Excision or curettage of bone	090	315	333	18	6%	10.99	12.57	1.58	14%	0			4				2			1	
27640	Partial excision (craterization,	090	382	418.5	36.5	10%	12.24	14.77	2.53	21%	0			4.5				5.5			1	
27641	Partial excision (craterization,	090	319	344.5	25.5	8%	9.84	11.78	1.94	20%	0			4				3.5			1	
27645	Radical resection of tumor; tib	090	553	580	27	5%	27.21	29.61	2.40	9%	-2			1	2	1		2	2		1	
27646	Radical resection of tumor; fib	090	540	562	22	4%	23.21	25.37	2.16	9%	-2			1	2	1		1	2		1	
27647	Radical resection of tumor; ta	090	469	484	15	3%	20.26	22.09	1.83	9%	-2			1	1	1		1	2		1	
27650	Repair, primary, open or perc	090	239	264	25	10%	9.21	10.75	1.54	17%	0			2	3						0.5	
27652	Repair, primary, open or perc	090	312	331	19	6%	10.78	12.47	1.69	16%	0			4.5				2			1	
27654	Repair, secondary, Achilles te	090	283	308	25	9%	10.53	12.07	1.54	15%	0			2	3						0.5	
27656	Repair, fascial defect of leg	090	171	177	6	4%	4.71	5.48	0.77	16%	0			3							0.5	
27658	Repair, flexor tendon, leg; pri	090	196	202	6	3%	5.12	6.00	0.88	17%	0			3							1	
27659	Repair, flexor tendon, leg; sec	090	246	258	12	5%	7.10	8.33	1.23	17%	0			3.5				1			1	
27664	Repair, extensor tendon, leg;	090	173	179	6	3%	4.73	5.50	0.77	16%	0			3							0.5	
27665	Repair, extensor tendon, leg;	090	201	208	7	3%	5.57	6.45	0.88	16%	0			3.5							0.5	
27675	Repair, dislocating peroneal te	090	228	235	7	3%	7.35	8.34	0.99	13%	0			3.5							1	
27676	Repair, dislocating peroneal te	090	274	287	13	5%	8.73	10.07	1.34	15%	0			4				1			1	
27680	Tenolysis, flexor or extensor t	090	197	203	6	3%	5.88	6.76	0.88	15%	0			3							1	
27681	Tenolysis, flexor or extensor t	090	232	241.5	9.5	4%	7.05	8.16	1.11	16%	0			3.5				0.5			1	
27685	Lengthening or shortening of	090	200	208	8	4%	6.69	7.68	0.99	15%	0			4							0.5	
27686	Lengthening or shortening of	090	252	264	12	5%	7.75	8.98	1.23	16%	0			3.5				1			1	
27687	Gastrocnemius recession (eg,	090	199	206	7	4%	6.41	7.29	0.88	14%	0			3.5							0.5	
27690	Transfer or transplant of singl	090	258	283	25	10%	9.17	10.71	1.54	17%	0			2	3						0.5	
27691	Transfer or transplant of singl	090	292	317	25	9%	10.49	12.14	1.65	16%	0			2	3						1	
27695	Repair, primary, disrupted liga	090	225	233	8	4%	6.70	7.80	1.10	16%	0			4							1	
27696	Repair, primary, disrupted liga	090	280	293	13	5%	8.58	9.92	1.34	16%	0			4				1			1	
27698	Repair, secondary, disrupted l	090	275	285.5	10.5	4%	9.61	10.83	1.22	13%	0			4				0.5			1	
27700	Arthroplasty, ankle;	090	310	325.5	15.5	5%	9.66	11.12	1.46	15%	0			4				1.5			1	
27702	Arthroplasty, ankle; with impl	090	416	447.5	31.5	8%	14.42	16.71	2.29	16%	0			4.5				4.5			1	
27703	Arthroplasty, ankle; revision,	090	488	533	45	9%	16.94	19.94	3.00	18%	0			5				7			1	
27704	Removal of ankle implant	090	251	259	8	3%	7.81	8.91	1.10	14%	0			4							1	
27705	Osteotomy; tibia	090	303	323.5	20.5	7%	10.86	12.56	1.70	16%	0			4				2.5			1	
27707	Osteotomy; fibula	090	243	260	17	7%	4.78	6.25	1.47	31%	0			3.5				2			1	
27709	Osteotomy; tibia and fibula	090	346	374	28	8%	17.48	19.28	1.80	10%	0			2	2			2			1	
27712	Osteotomy; multiple, with rea	090	400	443	43	11%	15.87	18.13	2.26	14%	0				4			3			1	
27715	Osteoplasty, tibia and fibula, l	090	457	503.5	46.5	10%	15.50	18.51	3.01	19%	0			4.5				7.5			1	
27720	Repair of nonunion or malunio	090	356	380	24	7%	12.36	14.29	1.93	16%	0			4.5				3			1	
27722	Repair of nonunion or malunio	090	389	415.5	26.5	7%	12.45	14.50	2.05	16%	0			4.5				3.5			1	
27724	Repair of nonunion or malunio	090	460	477	17	4%	19.31	20.85	1.54	8%	0			1	2			1	1		1	
27725	Repair of nonunion or malunio	090	464	511	47	10%	17.41	19.85	2.44	14%	-4				2	2		3			1	
27726	Repair of fibula nonunion and	090	319	337	18	6%	14.34	15.79	1.45	10%	0			3	1			1			1	
27727	Repair of congenital pseudart	090	445	480	35	8%	14.84	17.36	2.52	17%	0			5				5			1	
27730	Arrest, epiphyseal (epiphysiod	090	241	253	12	5%	7.70	8.93	1.23	16%	0			3.5				1			1	

27732	Arrest, epiphyseal (epiphysiod	090	183	189	6	3%	5.46	6.23	0.77	14%	0			3							0.5	
27734	Arrest, epiphyseal (epiphysiod	090	273	287.5	14.5	5%	8.83	10.18	1.35	15%	0			3.5				1.5			1	
27740	Arrest, epiphyseal (epiphysiod	090	315	328	13	4%	9.61	10.95	1.34	14%	0			4				1			1	
27742	Arrest, epiphyseal (epiphysiod	090	340	354	14	4%	10.63	12.08	1.45	14%	0			4.5				1			1	
27745	Prophylactic treatment (nailin	090	312	330	18	6%	10.49	12.07	1.58	15%	0			4				2			1	
27750	Closed treatment of tibial sha	090	143	150	7	5%	3.37	4.25	0.88	26%	0			3.5							0.5	
27752	Closed treatment of tibial sha	090	250	268	18	7%	6.27	7.85	1.58	25%	0			4				2			1	
27756	Percutaneous skeletal fixation	090	344	372	28	8%	7.45	9.51	2.06	28%	0			4				4			1	
27758	Open treatment of tibial shaft	090	435	471.5	36.5	8%	12.54	15.07	2.53	20%	0			4.5				5.5			1	
27759	Treatment of tibial shaft fract	090	324	347	23	7%	14.45	16.14	1.69	12%	0			3	1			2			1	
27760	Closed treatment of medial m	090	124	132	8	6%	3.21	4.09	0.88	27%	0			4								
27762	Closed treatment of medial m	090	212	221	9	4%	5.47	6.68	1.21	22%	0			4.5							1	
27766	Open treatment of medial ma	090	266	289	23	9%	7.89	9.45	1.56	20%	0			2	2			1			1	
27767	Closed treatment of posterior	090	96	109	13	14%	2.64	3.63	0.99	38%	0			3	1							
27768	Closed treatment of posterior	090	170	183	13	8%	5.14	6.24	1.10	21%	0			3	1						0.5	
27769	Open treatment of posterior m	090	279	297	18	6%	10.14	11.59	1.45	14%	0			3	1			1			1	
27780	Closed treatment of proximal	090	110	117	7	6%	2.83	3.60	0.77	27%	0			3.5								
27781	Closed treatment of proximal	090	146	154	8	5%	4.59	5.47	0.88	19%	0			4								
27784	Open treatment of proximal f	090	281	304	23	8%	9.67	11.23	1.56	16%	0			2	2			1			1	
27786	Closed treatment of distal fibu	090	114	121	7	6%	3.02	3.79	0.77	25%	0			3.5								
27788	Closed treatment of distal fibu	090	148	156	8	5%	4.64	5.52	0.88	19%	0			4								
27792	Open treatment of distal fibul	090	245	263	18	7%	8.75	9.96	1.21	14%	0			2	2						0.5	
27808	Closed treatment of bimalleol	090	127	135	8	6%	3.03	3.91	0.88	29%	0			4								
27810	Closed treatment of bimalleol	090	180	188	8	4%	5.32	6.31	0.99	19%	0			4							0.5	
27814	Open treatment of bimalleola	090	346	360	14	4%	10.62	12.14	1.52	14%	0			2	2				1		1	
27816	Closed treatment of trimalleo	090	119	126	7	6%	3.07	3.84	0.77	25%	0			3.5								
27818	Closed treatment of trimalleo	090	193	201	8	4%	5.69	6.68	0.99	17%	0			4							0.5	
27822	Open treatment of trimalleola	090	353	372	19	5%	11.21	12.84	1.63	15%	0			1	3				1		1	
27823	Open treatment of trimalleola	090	366	385	19	5%	13.16	14.79	1.63	12%	0			1	3				1		1	
27824	Closed treatment of fracture c	090	137	148	11	8%	3.31	4.08	0.77	23%	0			2	1							
27825	Closed treatment of fracture c	090	345	366	21	6%	6.69	8.29	1.60	24%	0			3				3			1	
27826	Open treatment of fracture of	090	328	347	19	6%	11.10	12.73	1.63	15%	0			1	3				1		1	
27827	Open treatment of fracture of	090	441	472	31	7%	14.79	16.99	2.20	15%	0			1	4			1	1		1	
27828	Open treatment of fracture of	090	471	502	31	7%	18.43	20.63	2.20	12%	0			1	4			1	1		1	
27829	Open treatment of distal tibio	090	271	294	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
27830	Closed treatment of proximal	090	152	159	7	5%	3.96	4.84	0.88	22%	0			3.5							0.5	
27831	Closed treatment of proximal	090	166	173	7	4%	4.73	5.61	0.88	19%	0			3.5							0.5	
27832	Open treatment of proximal t	090	301	324	23	8%	10.17	11.73	1.56	15%	0			2	2			1			1	
27840	Closed treatment of ankle dis	090	160	168	8	5%	4.77	5.76	0.99	21%	0			4							0.5	
27842	Closed treatment of ankle dis	090	225	235.5	10.5	5%	6.46	7.68	1.22	19%	0			4				0.5			1	
27846	Open treatment of ankle dislo	090	312	332.5	20.5	7%	10.28	11.98	1.70	17%	0			4				2.5			1	
27848	Open treatment of ankle dislo	090	334	354.5	20.5	6%	11.68	13.38	1.70	15%	0			4				2.5			1	
27860	Manipulation of ankle under g	010	105	107	2	2%	2.39	2.61	0.22	9%	0			1								
27870	Arthrodesis, ankle, open	090	400	438	38	10%	15.41	17.43	2.02	13%	0				4			2			1	
27871	Arthrodesis, tibiofibular joint,	090	301	316.5	15.5	5%	9.54	11.00	1.46	15%	0			4				1.5			1	
27880	Amputation, leg, through tibia	090	400	437	37	9%	15.37	17.87	2.50	16%	0			1	2			5	1		1	
27881	Amputation, leg, through tibia	090	468	515.5	47.5	10%	13.47	16.59	3.12	23%	0			5				7.5			1	
27882	Amputation, leg, through tibia	090	331	366.5	35.5	11%	9.79	12.21	2.42	25%	0			4				5.5			1	
27884	Amputation, leg, through tibia	090	292	315	23	8%	8.76	10.58	1.82	21%	0			4				3			1	
27886	Amputation, leg, through tibia	090	340	369	29	9%	10.02	12.19	2.17	22%	0			4.5				4			1	
27888	Amputation, ankle, through m	090	335	364	29	9%	10.37	12.54	2.17	21%	0			4.5				4			1	
27889	Ankle disarticulation	090	361	397.5	36.5	10%	10.86	13.39	2.53	23%	0			4.5				5.5			1	
27892	Decompression fasciotomy, le	090	307	330	23	7%	7.94	9.76	1.82	23%	0			4				3			1	
27893	Decompression fasciotomy, le	090	307	330	23	7%	7.90	9.72	1.82	23%	0			4				3			1	
27894	Decompression fasciotomy, le	090	433	493	60	14%	12.67	15.74	3.07	24%	0				5			5			1	
28005	Incision, bone cortex (eg, oste	090	320	351.5	31.5	10%	9.44	11.73	2.29	24%	0			4.5				4.5			1	
28008	Fasciotomy, foot and/or toe	090	159	165	6	4%	4.59	5.36	0.77	17%	0			3							0.5	
28010	Tenotomy, percutaneous, toe	090	90	95	5	6%	2.97	3.52	0.55	19%	0			2.5								
28011	Tenotomy, percutaneous, toe	090	123	129	6	5%	4.28	4.94	0.66	15%	0			3								
28020	Arthrotomy, including explora	090	161	167	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28022	Arthrotomy, including explora	090	157	163	6	4%	4.81	5.58	0.77	16%	0			3							0.5	
28024	Arthrotomy, including explora	090	151	157	6	4%	4.52	5.29	0.77	17%	0			3							0.5	
28035	Release, tarsal tunnel (poster	090	169	175	6	4%	5.23	6.00	0.77	15%	0			3							0.5	
28039	Excision, tumor, soft tissue of	090	153	162	9	6%	5.42	6.08	0.66	12%	0			1	1						0.5	
28041	Excision, tumor, soft tissue of	090	217	233	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
28043	Excision, tumor, soft tissue of	090	138	147	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
28045	Excision, tumor, soft tissue of	090	169	180	11	7%	5.45	6.33	0.88	16%	0			2	1						0.5	

28046	Radical resection of tumor (eg	090	334	367	33	10%	12.38	14.29	1.91	15%	0			1	3			2			1	
28047	Radical resection of tumor (eg	090	413	439	26	6%	17.45	19.41	1.96	11%	-2			1	2	1		1	1		1	
28050	Arthrotomy with biopsy; inter	090	163	169	6	4%	4.39	5.16	0.77	18%	0			3							0.5	
28052	Arthrotomy with biopsy; meta	090	149	154	5	3%	4.06	4.72	0.66	16%	0			2.5							0.5	
28054	Arthrotomy with biopsy; inter	090	133	138	5	4%	3.57	4.23	0.66	18%	0			2.5							0.5	
28055	Neurectomy, intrinsic muscula	090	197	203	6	3%	6.29	7.17	0.88	14%	0			3							1	
28060	Fasciectomy, plantar fascia; p	090	156	163	7	4%	5.40	6.17	0.77	14%	0			3.5								
28062	Fasciectomy, plantar fascia; ra	090	221	228	7	3%	6.69	7.57	0.88	13%	0			3.5							0.5	
28070	Synovectomy; intertarsal or ta	090	190	196	6	3%	5.24	6.12	0.88	17%	0			3							1	
28072	Synovectomy; metatarsophala	090	166	172	6	4%	4.72	5.49	0.77	16%	0			3							0.5	
28080	Excision, interdigital (Morton)	090	169	197	28	17%	4.86	6.18	1.32	27%	-2		1		4							
28086	Synovectomy, tendon sheath,	090	172	178	6	3%	4.92	5.69	0.77	16%	0			3							0.5	
28088	Synovectomy, tendon sheath,	090	142	147	5	4%	3.98	4.64	0.66	17%	0			2.5							0.5	
28090	Excision of lesion, tendon, ten	090	130	136	6	5%	4.55	5.21	0.66	15%	0			3								
28092	Excision of lesion, tendon, ten	090	115	121	6	5%	3.78	4.44	0.66	17%	0			3								
28100	Excision or curettage of bone	090	195	202	7	4%	5.83	6.71	0.88	15%	0			3.5							0.5	
28102	Excision or curettage of bone	090	273	281	8	3%	7.92	9.02	1.10	14%	0			4							1	
28103	Excision or curettage of bone	090	233	240	7	3%	6.67	7.66	0.99	15%	0			3.5							1	
28104	Excision or curettage of bone	090	173	179	6	3%	5.26	6.03	0.77	15%	0			3							0.5	
28106	Excision or curettage of bone	090	243	251	8	3%	7.35	8.45	1.10	15%	0			4							1	
28107	Excision or curettage of bone	090	232	239	7	3%	5.73	6.72	0.99	17%	0			3.5							1	
28108	Excision or curettage of bone	090	134	140	6	4%	4.30	4.96	0.66	15%	0			3								
28110	Ostectomy, partial excision, fi	090	151	157	6	4%	4.22	4.99	0.77	18%	0			3							0.5	
28111	Ostectomy, complete excision	090	171	177	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28112	Ostectomy, complete excision	090	163	169	6	4%	4.63	5.40	0.77	17%	0			3							0.5	
28113	Ostectomy, complete excision	090	178	208	30	17%	6.11	7.65	1.54	25%	0			1	4							
28114	Ostectomy, complete excision	090	339	387	48	14%	12.00	14.25	2.25	19%	-6				3	3						
28116	Ostectomy, excision of tarsal (	090	320	353	33	10%	9.14	10.92	1.78	19%	0				4			1			1	
28118	Ostectomy, calcaneus;	090	196	203	7	4%	6.13	7.01	0.88	14%	0			3.5							0.5	
28119	Ostectomy, calcaneus; for spu	090	183	190	7	4%	5.56	6.44	0.88	16%	0			3.5							0.5	
28120	Partial excision (craterization,	090	251	271	20	8%	7.31	8.74	1.43	20%	0			3	2						0.5	
28122	Partial excision (craterization,	090	230	248	18	8%	6.76	7.97	1.21	18%	0			2	2						0.5	
28124	Partial excision (craterization,	090	151	159	8	5%	5.00	5.88	0.88	18%	0			4								
28126	Resection, partial or complete	090	116	121	5	4%	3.64	4.19	0.55	15%	0			2.5								
28130	Talectomy (astragalectomy)	090	330	363	33	10%	9.50	11.28	1.78	19%	0				4			1			1	
28140	Metatarsectomy	090	228	237.5	9.5	4%	7.14	8.25	1.11	16%	0			3.5				0.5			1	
28150	Phalangectomy, toe, each toe	090	151	157	6	4%	4.23	5.00	0.77	18%	0			3							0.5	
28153	Resection, condyle(s), distal e	090	142	148	6	4%	3.80	4.57	0.77	20%	0			3							0.5	
28160	Hemiphalangectomy or interp	090	129	135	6	5%	3.88	4.54	0.66	17%	0			3								
28171	Radical resection of tumor; ta	090	365	388	23	6%	16.41	17.84	1.43	9%	-2			1	1	1		1			1	
28173	Radical resection of tumor; m	090	304	327	23	8%	14.16	15.59	1.43	10%	-2			1	1	1		1			1	
28175	Radical resection of tumor; ph	090	205	223	18	9%	8.29	9.37	1.08	13%	-2			1	1	1					0.5	
28190	Removal of foreign body, foot	010	64	66	2	3%	2.01	2.23	0.22	11%	0			1								
28192	Removal of foreign body, foot	090	141	147	6	4%	4.78	5.44	0.66	14%	0			3								
28193	Removal of foreign body, foot	090	189	196	7	4%	5.90	6.78	0.88	15%	0			3.5							0.5	
28200	Repair, tendon, flexor, foot; p	090	149	155	6	4%	4.74	5.40	0.66	14%	0			3								
28202	Repair, tendon, flexor, foot; s	090	240	249.5	9.5	4%	7.07	8.18	1.11	16%	0			3.5				0.5			1	
28208	Repair, tendon, extensor, foot	090	154	160	6	4%	4.51	5.28	0.77	17%	0			3							0.5	
28210	Repair, tendon, extensor, foot	090	209	216	7	3%	6.52	7.51	0.99	15%	0			3.5							1	
28220	Tenolysis, flexor, foot; single t	090	149	155	6	4%	4.67	5.44	0.77	16%	0			3							0.5	
28222	Tenolysis, flexor, foot; multipl	090	175	181	6	3%	5.76	6.53	0.77	13%	0			3							0.5	
28225	Tenolysis, extensor, foot; sing	090	133	138	5	4%	3.78	4.44	0.66	17%	0			2.5							0.5	
28226	Tenolysis, extensor, foot; mul	090	162	168	6	4%	4.67	5.44	0.77	16%	0			3							0.5	
28230	Tenotomy, open, tendon flexo	090	143	148	5	3%	4.36	5.02	0.66	15%	0			2.5							0.5	
28232	Tenotomy, open, tendon flexo	090	107	112	5	5%	3.51	4.06	0.55	16%	0			2.5								
28234	Tenotomy, open, extensor, fo	090	122	129	7	6%	3.54	4.31	0.77	22%	0			3.5								
28238	Reconstruction (advancement	090	248	257.5	9.5	4%	7.96	9.07	1.11	14%	0			3.5				0.5			1	
28240	Tenotomy, lengthening, or rel	090	139	144	5	4%	4.48	5.14	0.66	15%	0			2.5							0.5	
28250	Division of plantar fascia and (	090	164	170	6	4%	6.06	6.83	0.77	13%	0			3							0.5	
28260	Capsulotomy, midfoot; media	090	225	234.5	9.5	4%	8.19	9.30	1.11	14%	0			3.5				0.5			1	
28261	Capsulotomy, midfoot; with te	090	343	376	33	10%	13.11	14.89	1.78	14%	0				4			1			1	
28262	Capsulotomy, midfoot; extens	090	380	413	33	9%	17.21	18.99	1.78	10%	0				4			1			1	
28264	Capsulotomy, midtarsal (eg, H	090	269	282	13	5%	10.65	11.99	1.34	13%	0			4				1			1	
28270	Capsulotomy; metatarsophala	090	145	152	7	5%	4.93	5.70	0.77	16%	0			3.5								
28272	Capsulotomy; interphalangeal	090	113	118	5	4%	3.92	4.47	0.55	14%	0			2.5								
28280	Syndactylization, toes (eg, we	090	167	173	6	4%	5.33	6.10	0.77	14%	0			3							0.5	
28285	Correction, hammertoe (eg, in	090	190	208	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	

28286	Correction, cock-up fifth toe,	090	145	151	6	4%	4.70	5.36	0.66	14%	0			3								
28288	Ostectomy, partial, exostecto	090	169	197	28	17%	6.02	7.34	1.32	22%	-2		1		4							
28289	Hallux rigidus correction with	090	210	228	18	9%	6.90	8.11	1.21	18%	0			2	2						0.5	
28291	Hallux rigidus correction with	090	215	233	18	8%	8.01	9.22	1.21	15%	0			2	2						0.5	
28292	Correction, hallux valgus (bun	090	226	246	20	9%	7.44	8.87	1.43	19%	0			3	2						0.5	
28295	Correction, hallux valgus (bun	090	241	261	20	8%	8.57	10.00	1.43	17%	0			3	2						0.5	
28296	Correction, hallux valgus (bun	090	241	261	20	8%	8.25	9.68	1.43	17%	0			3	2						0.5	
28297	Correction, hallux valgus (bun	090	256	276	20	8%	9.29	10.72	1.43	15%	0			3	2						0.5	
28298	Correction, hallux valgus (bun	090	225	243	18	8%	7.75	8.96	1.21	16%	0			2	2						0.5	
28299	Correction, hallux valgus (bun	090	256	276	20	8%	9.29	10.72	1.43	15%	0			3	2						0.5	
28300	Osteotomy; calcaneus (eg, Dw	090	218	226	8	4%	9.73	10.72	0.99	10%	0			4							0.5	
28302	Osteotomy; talus	090	234	242	8	3%	9.74	10.84	1.10	11%	0			4							1	
28304	Osteotomy, tarsal bones, othe	090	239	249.5	10.5	4%	9.41	10.63	1.22	13%	0			4				0.5			1	
28305	Osteotomy, tarsal bones, othe	090	283	294.5	11.5	4%	10.77	12.10	1.33	12%	0			4.5				0.5			1	
28306	Osteotomy, with or without le	090	163	169	6	4%	6.00	6.66	0.66	11%	0			3								
28307	Osteotomy, with or without le	090	213	220	7	3%	6.50	7.38	0.88	14%	0			3.5							0.5	
28308	Osteotomy, with or without le	090	165	173	8	5%	5.48	6.36	0.88	16%	0			4								
28309	Osteotomy, with or without le	090	350	383	33	9%	14.16	15.94	1.78	13%	0				4			1			1	
28310	Osteotomy, shortening, angul	090	165	171	6	4%	5.57	6.34	0.77	14%	0			3							0.5	
28312	Osteotomy, shortening, angul	090	160	166	6	4%	4.69	5.46	0.77	16%	0			3							0.5	
28313	Reconstruction, angular defor	090	151	157	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28315	Sesamoidectomy, first toe (se	090	156	162	6	4%	5.00	5.77	0.77	15%	0			3							0.5	
28320	Repair, nonunion or malunion	090	254	262	8	3%	9.37	10.47	1.10	12%	0			4							1	
28322	Repair, nonunion or malunion	090	221	229	8	4%	8.53	9.52	0.99	12%	0			4							0.5	
28340	Reconstruction, toe, macroda	090	230	237	7	3%	7.15	8.14	0.99	14%	0			3.5							1	
28341	Reconstruction, toe, macroda	090	298	311	13	4%	8.72	10.06	1.34	15%	0			4				1			1	
28344	Reconstruction, toe(s); polyda	090	185	191	6	3%	4.40	5.28	0.88	20%	0			3							1	
28345	Reconstruction, toe(s); syndac	090	222	229	7	3%	6.09	7.08	0.99	16%	0			3.5							1	
28360	Reconstruction, cleft foot	090	395	430	35	9%	14.92	16.57	1.65	11%	0				5							
28400	Closed treatment of calcaneal	090	97	103	6	6%	2.31	2.97	0.66	29%	0			3								
28405	Closed treatment of calcaneal	090	164	171	7	4%	4.74	5.62	0.88	19%	0			3.5							0.5	
28406	Percutaneous skeletal fixation	090	229	239.5	10.5	5%	6.56	7.78	1.22	19%	0			4				0.5			1	
28415	Open treatment of calcaneal f	090	441	472	31	7%	16.19	18.39	2.20	14%	0			1	4			1	1		1	
28420	Open treatment of calcaneal f	090	481	512	31	6%	17.52	19.72	2.20	13%	0			1	4			1	1		1	
28430	Closed treatment of talus frac	090	89	94	5	6%	2.22	2.77	0.55	25%	0			2.5								
28435	Closed treatment of talus frac	090	116	122	6	5%	3.54	4.20	0.66	19%	0			3								
28436	Percutaneous skeletal fixation	090	190	198	8	4%	4.90	5.89	0.99	20%	0			4							0.5	
28445	Open treatment of talus fract	090	444	475	31	7%	15.76	17.96	2.20	14%	0			1	4			1	1		1	
28446	Open osteochondral autograf	090	339	364	25	7%	17.71	19.36	1.65	9%	0			2	3						1	
28450	Treatment of tarsal bone fract	090	87	92	5	6%	2.03	2.58	0.55	27%	0			2.5								
28455	Treatment of tarsal bone fract	090	113	119	6	5%	3.24	3.90	0.66	20%	0			3								
28456	Percutaneous skeletal fixation	090	182	189	7	4%	2.86	3.74	0.88	31%	0			3.5							0.5	
28465	Open treatment of tarsal bon	090	257	275	18	7%	8.80	10.01	1.21	14%	0			2	2						0.5	
28470	Closed treatment of metatars	090	77	83	6	8%	2.03	2.69	0.66	33%	0			3								
28475	Closed treatment of metatars	090	80.5	80.5	0	0%	3.01	3.01	-	0%	-7		3.5									
28476	Percutaneous skeletal fixation	090	168	177	9	5%	3.60	4.59	0.99	28%	0			4.5								
28485	Open treatment of metatarsa	090	242	260	18	7%	7.44	8.65	1.21	16%	0			2	2						0.5	
28490	Closed treatment of fracture g	090	64	67	3	5%	1.17	1.50	0.33	28%	0			1.5								
28495	Closed treatment of fracture g	090	89	93	4	4%	1.68	2.12	0.44	26%	0			2								
28496	Percutaneous skeletal fixation	090	142	148	6	4%	2.48	3.14	0.66	27%	0			3								
28505	Open treatment of fracture, g	090	227	245	18	8%	7.44	8.65	1.21	16%	0			2	2						0.5	
28510	Closed treatment of fracture,	090	53	56	3	6%	1.17	1.50	0.33	28%	0			1.5								
28515	Closed treatment of fracture,	090	71	75	4	6%	1.56	2.00	0.44	28%	0			2								
28525	Open treatment of fracture, p	090	207	225	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	
28530	Closed treatment of sesamoid	090	56	58	2	4%	1.11	1.33	0.22	20%	0			1								
28531	Open treatment of sesamoid f	090	225	234	9	4%	2.57	3.47	0.90	35%	0			2				1			1	
28540	Closed treatment of tarsal bo	090	106	112	6	6%	2.19	2.85	0.66	30%	0			3								
28545	Closed treatment of tarsal bo	090	142	148	6	4%	2.60	3.37	0.77	30%	0			3							0.5	
28546	Percutaneous skeletal fixation	090	184	192	8	4%	3.40	4.39	0.99	29%	0			4							0.5	
28555	Open treatment of tarsal bon	090	281	304	23	8%	9.65	11.21	1.56	16%	0			2	2			1			1	
28570	Closed treatment of talotarsa	090	92	96	4	4%	1.76	2.20	0.44	25%	0			2								
28575	Closed treatment of talotarsa	090	178	185	7	4%	3.49	4.48	0.99	28%	0			3.5							1	
28576	Percutaneous skeletal fixation	090	277	295	18	6%	4.60	6.18	1.58	34%	0			4				2			1	
28585	Open treatment of talotarsal j	090	324	354	30	9%	11.13	13.02	1.89	17%	0			2	3			1			1	
28600	Closed treatment of tarsomet	090	105	110	5	5%	2.02	2.57	0.55	27%	0			2.5								
28605	Closed treatment of tarsomet	090	156	163	7	4%	2.89	3.77	0.88	30%	0			3.5							0.5	
28606	Percutaneous skeletal fixation	090	224	232	8	4%	5.09	6.19	1.10	22%	0			4							1	

28615	Open treatment of tarsometa	090	323	355	32	10%	10.70	12.81	2.11	20%	0			3	3			1			1	
28630	Closed treatment of metatars	010	55	57	2	4%	1.75	1.97	0.22	13%	0			1								
28635	Closed treatment of metatars	010	61	63	2	3%	1.96	2.18	0.22	11%	0			1								
28645	Open treatment of metatarso	090	217	235	18	8%	7.44	8.65	1.21	16%	0			2	2						0.5	
28660	Closed treatment of interphal	010	49	51	2	4%	1.28	1.50	0.22	17%	0			1								
28665	Closed treatment of interphal	010	53	55	2	4%	1.97	2.19	0.22	11%	0			1								
28675	Open treatment of interphala	090	197	215	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	
28705	Arthrodesis; pantalar	090	490	516	26	5%	20.33	22.29	1.96	10%	-2			1	2	1		1	1		1	
28715	Arthrodesis; triple	090	366	398	32	9%	13.42	15.29	1.87	14%	0			2	4						0.5	
28725	Arthrodesis; subtalar	090	298	323	25	8%	11.22	12.76	1.54	14%	0			2	3						0.5	
28730	Arthrodesis, midtarsal or tars	090	308	333	25	8%	10.70	12.24	1.54	14%	0			2	3						0.5	
28735	Arthrodesis, midtarsal or tars	090	360	393	33	9%	12.23	14.01	1.78	15%	0				4			1			1	
28737	Arthrodesis, with tendon leng	090	340	373	33	10%	11.03	12.81	1.78	16%	0				4			1			1	
28740	Arthrodesis, midtarsal or tars	090	266	294	28	11%	9.29	10.72	1.43	15%	0				4						0.5	
28750	Arthrodesis, great toe; metata	090	237	265	28	12%	8.57	9.89	1.32	15%	0				4							
28755	Arthrodesis, great toe; interpl	090	172	178	6	3%	4.88	5.65	0.77	16%	0			3							0.5	
28760	Arthrodesis, with extensor ha	090	330	363	33	10%	9.14	10.92	1.78	19%	0				4			1			1	
28800	Amputation, foot; midtarsal (e	090	306	330	24	8%	8.79	10.72	1.93	22%	0			4.5				3			1	
28805	Amputation, foot; transmetat	090	376	424	48	13%	12.71	15.47	2.76	22%	0			2	2			6			1	
28810	Amputation, metatarsal, with	090	251	269	18	7%	6.64	8.22	1.58	24%	0			4				2			1	
28890	Extracorporeal shock wave, hi	090	140	146	6	4%	3.45	4.22	0.77	22%	0			3							0.5	
29800	Arthroscopy, temporomandib	090	161	172	11	7%	6.84	7.72	0.88	13%	0			2	1						0.5	
29804	Arthroscopy, temporomandib	090	206	224	18	9%	8.87	10.08	1.21	14%	0			2	2						0.5	
29805	Arthroscopy, shoulder, diagno	090	154	160	6	4%	6.03	6.69	0.66	11%	0			3								
29806	Arthroscopy, shoulder, surgica	090	298	318	20	7%	15.14	16.57	1.43	9%	0			3	2						0.5	
29807	Arthroscopy, shoulder, surgica	090	288	308	20	7%	14.67	16.10	1.43	10%	0			3	2						0.5	
29819	Arthroscopy, shoulder, surgica	090	196	203	7	4%	7.79	8.67	0.88	11%	0			3.5							0.5	
29820	Arthroscopy, shoulder, surgica	090	189	195	6	3%	7.21	7.98	0.77	11%	0			3							0.5	
29821	Arthroscopy, shoulder, surgica	090	223	230	7	3%	7.89	8.77	0.88	11%	0			3.5							0.5	
29822	Arthroscopy, shoulder, surgica	090	191	207	16	8%	7.03	8.02	0.99	14%	0			1	2						0.5	
29823	Arthroscopy, shoulder, surgica	090	211	227	16	8%	7.98	8.97	0.99	12%	0			1	2						0.5	
29824	Arthroscopy, shoulder, surgica	090	225	243	18	8%	8.98	10.19	1.21	13%	0			2	2						0.5	
29825	Arthroscopy, shoulder, surgica	090	212	219	7	3%	7.79	8.67	0.88	11%	0			3.5							0.5	
29827	Arthroscopy, shoulder, surgica	090	334	344	10	3%	15.59	16.80	1.21	8%	0			5							0.5	
29828	Arthroscopy, shoulder, surgica	090	252	270	18	7%	13.16	14.37	1.21	9%	0			2	2						0.5	
29830	Arthroscopy, elbow, diagnosti	090	132	137	5	4%	5.88	6.43	0.55	9%	0			2.5								
29834	Arthroscopy, elbow, surgical;	090	153	159	6	4%	6.42	7.08	0.66	10%	0			3								
29835	Arthroscopy, elbow, surgical;	090	160	166	6	4%	6.62	7.28	0.66	10%	0			3								
29836	Arthroscopy, elbow, surgical;	090	196	203	7	4%	7.72	8.49	0.77	10%	0			3.5								
29837	Arthroscopy, elbow, surgical;	090	165	171	6	4%	7.01	7.67	0.66	9%	0			3								
29838	Arthroscopy, elbow, surgical;	090	220	227	7	3%	7.88	8.76	0.88	11%	0			3.5							0.5	
29840	Arthroscopy, wrist, diagnostic	090	146	152	6	4%	5.68	6.34	0.66	12%	0			3								
29843	Arthroscopy, wrist, surgical; fo	090	157	163	6	4%	6.15	6.81	0.66	11%	0			3								
29844	Arthroscopy, wrist, surgical; s	090	160	166	6	4%	6.51	7.17	0.66	10%	0			3								
29845	Arthroscopy, wrist, surgical; s	090	199	206	7	4%	7.69	8.46	0.77	10%	0			3.5								
29846	Arthroscopy, wrist, surgical; e	090	179	185	6	3%	6.89	7.55	0.66	10%	0			3								
29847	Arthroscopy, wrist, surgical; in	090	190	196	6	3%	7.22	7.88	0.66	9%	0			3								
29848	Endoscopy, wrist, surgical, wit	090	179	200	21	12%	6.39	7.38	0.99	15%	0				3							
29850	Arthroscopically aided treatm	090	192	198	6	3%	8.27	9.04	0.77	9%	0			3							0.5	
29851	Arthroscopically aided treatm	090	274	297	23	8%	13.26	14.58	1.32	10%	0			1	3						0.5	
29855	Arthroscopically aided treatm	090	255	273	18	7%	10.76	11.97	1.21	11%	0			2	2						0.5	
29856	Arthroscopically aided treatm	090	314	332	18	6%	14.28	15.60	1.32	9%	0			2	2						1	
29860	Arthroscopy, hip, diagnostic w	090	244	265	21	9%	9.00	9.99	0.99	11%	0				3							
29861	Arthroscopy, hip, surgical; wit	090	254	275	21	8%	10.10	11.09	0.99	10%	0				3							
29862	Arthroscopy, hip, surgical; wit	090	297	325	28	9%	11.17	12.49	1.32	12%	0				4							
29863	Arthroscopy, hip, surgical; wit	090	297	325	28	9%	11.17	12.49	1.32	12%	0				4							
29866	Arthroscopy, knee, surgical; o	090	308	328	20	6%	14.67	16.10	1.43	10%	0			3	2						0.5	
29867	Arthroscopy, knee, surgical; o	090	404	425	21	5%	18.39	20.24	1.85	10%	0			2	3				1		1	
29868	Arthroscopy, knee, surgical; m	090	484	510	26	5%	25.10	27.19	2.09	8%	0			2	3			1	1		1	
29870	Arthroscopy, knee, diagnostic	090	129	134	5	4%	5.19	5.74	0.55	11%	0			2.5								
29871	Arthroscopy, knee, surgical; fo	090	184	190	6	3%	6.69	7.46	0.77	12%	0			3							0.5	
29873	Arthroscopy, knee, surgical; w	090	249	259	10	4%	6.24	7.45	1.21	19%	0			5							0.5	
29874	Arthroscopy, knee, surgical; fo	090	181	187	6	3%	7.19	7.96	0.77	11%	0			3							0.5	
29875	Arthroscopy, knee, surgical; s	090	168	174	6	4%	6.45	7.11	0.66	10%	0			3								
29876	Arthroscopy, knee, surgical; s	090	233	254	21	9%	8.87	9.97	1.10	12%	0				3						0.5	
29877	Arthroscopy, knee, surgical; d	090	197	218	21	11%	8.30	9.29	0.99	12%	0				3							
29879	Arthroscopy, knee, surgical; a	090	217	238	21	10%	8.99	10.09	1.10	12%	0				3						0.5	

29880	Arthroscopy, knee, surgical; w	090	199	215	16	8%	7.39	8.38	0.99	13%	0			1	2						0.5	
29881	Arthroscopy, knee, surgical; w	090	194	210	16	8%	7.03	8.02	0.99	14%	0			1	2						0.5	
29882	Arthroscopy, knee, surgical; w	090	244	265	21	9%	9.60	10.70	1.10	11%	0				3						0.5	
29883	Arthroscopy, knee, surgical; w	090	311	329	18	6%	11.77	13.09	1.32	11%	0			2	2						1	
29884	Arthroscopy, knee, surgical; w	090	208	229	21	10%	8.28	9.38	1.10	13%	0				3						0.5	
29885	Arthroscopy, knee, surgical; d	090	250.5	275	24.5	10%	10.21	11.48	1.27	12%	0				3.5						0.5	
29886	Arthroscopy, knee, surgical; d	090	221	242	21	10%	8.49	9.59	1.10	13%	0				3						0.5	
29887	Arthroscopy, knee, surgical; d	090	261.5	286	24.5	9%	10.16	11.43	1.27	12%	0				3.5						0.5	
29888	Arthroscopically aided anterio	090	295	313	18	6%	14.30	15.51	1.21	8%	0			2	2						0.5	
29889	Arthroscopically aided poster	090	433	465	32	7%	17.41	19.26	1.85	11%	-2			1	3	1					1	
29891	Arthroscopy, ankle, surgical, e	090	227	255	28	12%	9.67	10.99	1.32	14%	0				4							
29892	Arthroscopically aided repair	090	272	300	28	10%	10.27	11.59	1.32	13%	0				4							
29893	Endoscopic plantar fasciotom	090	247	274	27	11%	6.32	7.97	1.65	26%	0			3	3							
29894	Arthroscopy, ankle (tibiotalar	090	179	185	6	3%	7.35	8.12	0.77	10%	0			3							0.5	
29895	Arthroscopy, ankle (tibiotalar	090	178	184	6	3%	7.13	7.90	0.77	11%	0			3							0.5	
29897	Arthroscopy, ankle (tibiotalar	090	186	192	6	3%	7.32	8.09	0.77	11%	0			3							0.5	
29898	Arthroscopy, ankle (tibiotalar	090	222	229	7	3%	8.49	9.37	0.88	10%	0			3.5							0.5	
29899	Arthroscopy, ankle (tibiotalar	090	395	433	38	10%	15.41	17.43	2.02	13%	0				4			2			1	
29900	Arthroscopy, metacarpophala	090	220	233	13	6%	5.88	6.98	1.10	19%	0			3	1						0.5	
29901	Arthroscopy, metacarpophala	090	235	248	13	6%	6.59	7.69	1.10	17%	0			3	1						0.5	
29902	Arthroscopy, metacarpophala	090	250	263	13	5%	7.16	8.26	1.10	15%	0			3	1						0.5	
29904	Arthroscopy, subtalar joint, su	090	228	249	21	9%	8.65	9.75	1.10	13%	0				3						0.5	
29905	Arthroscopy, subtalar joint, su	090	244	267	23	9%	9.18	10.50	1.32	14%	0			1	3						0.5	
29906	Arthroscopy, subtalar joint, su	090	244	267	23	9%	9.65	10.97	1.32	14%	0			1	3						0.5	
29907	Arthroscopy, subtalar joint, su	090	293	316	23	8%	12.18	13.61	1.43	12%	0			1	3						1	
29914	Arthroscopy, hip, surgical; wit	090	280	298	18	6%	14.67	15.88	1.21	8%	0			2	2						0.5	
29915	Arthroscopy, hip, surgical; wit	090	270	288	18	7%	15.00	16.21	1.21	8%	0			2	2						0.5	
29916	Arthroscopy, hip, surgical; wit	090	270	288	18	7%	15.00	16.21	1.21	8%	0			2	2						0.5	
30000	Drainage abscess or hematom	010	56	58	2	4%	1.48	1.70	0.22	15%	0			1								
30020	Drainage abscess or hematom	010	57	59	2	4%	1.48	1.70	0.22	15%	0			1								
30110	Excision, nasal polyp(s), simpl	010	62	64	2	3%	1.68	1.90	0.22	13%	0			1								
30115	Excision, nasal polyp(s), exten	090	120	124	4	3%	4.44	4.88	0.44	10%	0			2								
30117	Excision or destruction (eg, las	090	110	114	4	4%	3.26	3.70	0.44	13%	0			2								
30118	Excision or destruction (eg, las	090	288	297.5	9.5	3%	9.92	11.03	1.11	11%	0			3.5				0.5			1	
30120	Excision or surgical planing of	090	160	165	5	3%	5.39	5.94	0.55	10%	0			2.5								
30124	Excision dermoid cyst, nose; s	090	101	105	4	4%	3.20	3.64	0.44	14%	0			2								
30125	Excision dermoid cyst, nose; c	090	252	258	6	2%	7.30	8.18	0.88	12%	0			3							1	
30130	Excision inferior turbinate, pa	090	122	126	4	3%	3.47	4.02	0.55	16%	0			2							0.5	
30150	Rhinectomy; partial	090	267	284	17	6%	9.55	11.02	1.47	15%	0			3.5				2			1	
30160	Rhinectomy; total	090	302	319	17	6%	9.99	11.46	1.47	15%	0			3.5				2			1	
30210	Displacement therapy (Proetz	010	39	41	2	5%	1.13	1.35	0.22	19%	0			1								
30220	Insertion, nasal septal prosthe	010	51	53	2	4%	1.59	1.81	0.22	14%	0			1								
30300	Removal foreign body, intrana	010	46	48	2	4%	1.09	1.31	0.22	20%	0			1								
30310	Removal foreign body, intrana	010	68	70	2	3%	2.01	2.23	0.22	11%	0			1								
30320	Removal foreign body, intrana	090	151	156	5	3%	4.64	5.19	0.55	12%	0			2.5								
30400	Rhinoplasty, primary; lateral a	090	312	338	26	8%	10.86	12.58	1.72	16%	-4			4		2						
30410	Rhinoplasty, primary; complet	090	362	388	26	7%	14.00	15.72	1.72	12%	-4			4		2						
30420	Rhinoplasty, primary; includin	090	399	425	26	7%	16.90	18.62	1.72	10%	-4			4		2						
30430	Rhinoplasty, secondary; mino	090	274	300	26	9%	8.24	9.96	1.72	21%	-4			4		2						
30435	Rhinoplasty, secondary; intern	090	354	380	26	7%	12.73	14.45	1.72	14%	-4			4		2						
30450	Rhinoplasty, secondary; major	090	414	440	26	6%	19.66	21.38	1.72	9%	-4			4		2						
30460	Rhinoplasty for nasal deformi	090	232	241	9	4%	10.32	10.87	0.55	5%	0			1	1							
30462	Rhinoplasty for nasal deformi	090	388	406	18	5%	20.28	21.38	1.10	5%	0			2	2							
30465	Repair of nasal vestibular sten	090	277	295	18	6%	12.36	13.57	1.21	10%	0			2	2						0.5	
30520	Septoplasty or submucous res	090	210.5	228.5	18	9%	7.01	8.22	1.21	17%	0			2	2						0.5	
30540	Repair choanal atresia; intran	090	196	203	7	4%	7.92	8.80	0.88	11%	0			3.5							0.5	
30545	Repair choanal atresia; transp	090	305	315.5	10.5	3%	11.62	12.84	1.22	10%	0			4				0.5			1	
30560	Lysis intranasal synechia	010	46	48	2	4%	1.31	1.53	0.22	17%	0			1								
30580	Repair fistula; oromaxillary (c	090	204	212	8	4%	6.88	7.76	0.88	13%	0			4								
30600	Repair fistula; oronasal	090	167	173	6	4%	6.16	6.82	0.66	11%	0			3								
30620	Septal or other intranasal der	090	234	242	8	3%	6.16	7.26	1.10	18%	0			4							1	
30630	Repair nasal septal perforatio	090	260	267	7	3%	7.29	8.17	0.88	12%	0			3.5							0.5	
30801	Ablation, soft tissue of inferio	010	46	48	2	4%	1.14	1.36	0.22	19%	0			1								
30802	Ablation, soft tissue of inferio	010	56	58	2	4%	2.08	2.30	0.22	11%	0			1								
30915	Ligation arteries; ethmoidal	090	242	252	10	4%	7.44	8.45	1.01	14%	0			2.5				1			1	
30920	Ligation arteries; internal max	090	428	441	13	3%	11.14	13.01	1.87	17%	0			2	1			2	2		1	
30930	Fracture nasal inferior turbina	010	56	58	2	4%	1.31	1.53	0.22	17%	0			1								

31000	Lavage by cannulation; maxilla	010	52	54	2	4%	1.20	1.42	0.22	18%	0			1								
31002	Lavage by cannulation; sphen	010	62	64	2	3%	1.96	2.18	0.22	11%	0			1								
31020	Sinusotomy, maxillary (antrot	090	105	110	5	5%	3.07	3.62	0.55	18%	0			2.5								
31030	Sinusotomy, maxillary (antrot	090	167	171	4	2%	6.01	6.67	0.66	11%	0			2								1
31032	Sinusotomy, maxillary (antrot	090	211	216	5	2%	6.69	7.46	0.77	12%	0			2.5								1
31040	Pterygomaxillary fossa surger	090	300	314.5	14.5	5%	9.77	11.12	1.35	14%	0			3.5				1.5				1
31050	Sinusotomy, sphenoid, with o	090	147	151	4	3%	5.37	5.92	0.55	10%	0			2								0.5
31051	Sinusotomy, sphenoid, with o	090	179	185	6	3%	7.25	8.02	0.77	11%	0			3								0.5
31070	Sinusotomy frontal; external,	090	144	149	5	3%	4.40	5.06	0.66	15%	0			2.5								0.5
31075	Sinusotomy frontal; transorbit	090	263	277.5	14.5	6%	9.51	10.86	1.35	14%	0			3.5				1.5				1
31080	Sinusotomy frontal; obliterati	090	343	373.5	30.5	9%	12.74	14.40	1.66	13%	0				4			0.5				1
31081	Sinusotomy frontal; obliterati	090	365	400.5	35.5	10%	14.19	16.09	1.90	13%	0				4			1.5				1
31084	Sinusotomy frontal; obliterati	090	387	422.5	35.5	9%	14.95	16.85	1.90	13%	0				4			1.5				1
31085	Sinusotomy frontal; obliterati	090	400	435.5	35.5	9%	15.64	17.54	1.90	12%	0				4			1.5				1
31086	Sinusotomy frontal; nonoblite	090	370	408	38	10%	14.36	16.38	2.02	14%	0				4			2				1
31087	Sinusotomy frontal; nonoblite	090	423.5	463	39.5	9%	14.57	16.67	2.10	14%	0				3.5			3				1
31090	Sinusotomy, unilateral, 3 or m	090	425	464	39	9%	11.17	13.35	2.18	20%	-4			1	2	2		1				1
31200	Ethmoidectomy; intranasal, a	090	186	193	7	4%	5.14	6.02	0.88	17%	0			3.5								0.5
31201	Ethmoidectomy; intranasal, to	090	237	246.5	9.5	4%	8.60	9.71	1.11	13%	0			3.5				0.5				1
31205	Ethmoidectomy; extranasal, t	090	258	272.5	14.5	6%	10.58	11.93	1.35	13%	0			3.5				1.5				1
31225	Maxillectomy; without orbital	090	608	634	26	4%	26.70	29.59	2.89	11%	-2			1	3	1		1	2	1		1
31230	Maxillectomy; with orbital exe	090	688	719	31	5%	30.82	33.95	3.13	10%	-2			1	3	1		2	2	1		1
31239	Nasal/sinus endoscopy, surgic	010	168	175	7	4%	9.04	9.48	0.44	5%	0				1							0.5
31241	Nasal/sinus endoscopy, surgic	000	142	142	0	0%	8.00	8.11	0.11	1%	0											0.5
31290	Nasal/sinus endoscopy, surgic	010	578	600	22	4%	18.61	20.64	2.03	11%	-1						1	3	2			1
31291	Nasal/sinus endoscopy, surgic	010	581	603	22	4%	19.56	21.59	2.03	10%	-1						1	3	2			1
31292	Nasal/sinus endoscopy, surgic	010	453	465	12	3%	15.90	17.45	1.55	10%	-1						1	1	2			1
31293	Nasal/sinus endoscopy, surgic	010	528	545	17	3%	17.47	19.26	1.79	10%	-1						1	2	2			1
31294	Nasal/sinus endoscopy, surgic	010	563	580	17	3%	20.31	22.10	1.79	9%	-1						1	2	2			1
31300	Laryngotomy (thyrotomy, lary	090	414	457	43	10%	15.91	18.17	2.26	14%	0				4			3				1
31360	Laryngectomy; total, without	090	768	809	41	5%	29.91	33.90	3.99	13%	-4			1	3	2		3	3	1		1
31365	Laryngectomy; total, with rad	090	893	939	46	5%	38.81	43.04	4.23	11%	-4			1	3	2		4	3	1		1
31367	Laryngectomy; subtotal supra	090	728	764	36	5%	30.57	34.32	3.75	12%	-4			1	3	2		2	3	1		1
31368	Laryngectomy; subtotal supra	090	858	899	41	5%	34.19	38.18	3.99	12%	-4			1	3	2		3	3	1		1
31370	Partial laryngectomy (hemilar	090	728	764	36	5%	27.57	31.32	3.75	14%	-4			1	3	2		2	3	1		1
31375	Partial laryngectomy (hemilar	090	698	734	36	5%	26.07	29.82	3.75	14%	-4			1	3	2		2	3	1		1
31380	Partial laryngectomy (hemilar	090	708	744	36	5%	25.57	29.32	3.75	15%	-4			1	3	2		2	3	1		1
31382	Partial laryngectomy (hemilar	090	728	764	36	5%	28.57	32.32	3.75	13%	-4			1	3	2		2	3	1		1
31390	Pharyngolaryngectomy, with r	090	988	1026	38	4%	42.51	46.90	4.39	10%	-4			1	3	2		3	3	2		1
31395	Pharyngolaryngectomy, with r	090	1048	1091	43	4%	43.80	48.43	4.63	11%	-4			1	3	2		4	3	2		1
31400	Arytenoidectomy or arytenoid	090	481	514	33	7%	11.60	13.90	2.30	20%	0			4				5				1
31420	Epiglottidectomy	090	436	465.5	29.5	7%	11.43	13.50	2.07	18%	0			3.5				4.5				1
31545	Laryngoscopy, direct, operati	000	154	154	0	0%	6.30	6.41	0.11	2%	0											0.5
31546	Laryngoscopy, direct, operati	000	189	189	0	0%	9.73	9.84	0.11	1%	0											0.5
31551	Laryngoplasty; for laryngeal st	090	658	684	26	4%	21.50	24.43	2.93	14%	0				3			3	1	2		1
31552	Laryngoplasty; for laryngeal st	090	505	527	22	4%	20.50	22.15	1.65	8%	0				3			1	1			1
31553	Laryngoplasty; for laryngeal st	090	718	717	-1	0%	22.00	24.81	2.81	13%	0				3				4	2		1
31554	Laryngoplasty; for laryngeal st	090	540	567	27	5%	22.00	23.89	1.89	9%	0				3			2	1			1
31561	Laryngoscopy, direct, operati	000	218	218	0	0%	5.99	6.21	0.22	4%	0											1
31571	Laryngoscopy, direct, with inje	000	129	129	0	0%	4.26	4.37	0.11	3%	0											0.5
31580	Laryngoplasty; for laryngeal w	090	405	431	26	6%	14.60	16.05	1.45	10%	0				3			1				1
31584	Laryngoplasty; with open redu	090	445	467	22	5%	17.58	19.23	1.65	9%	0				3			1	1			1
31587	Laryngoplasty, cricoid split, w	090	445	474	29	7%	15.27	17.80	2.53	17%	0				3			3	1	1		1
31590	Laryngeal reinnervation by ne	090	291	313	22	8%	7.85	9.26	1.41	18%	-2			3	1	1						
31591	Laryngoplasty, medialization,	090	275	296	21	8%	13.56	14.66	1.10	8%	0				3							0.5
31592	Cricotracheal resection	090	738	741	3	0%	25.00	27.61	2.61	10%	0				3				3	2		1
31610	Tracheostomy, fenestration p	090	367	391	24	7%	12.00	14.29	2.29	19%	0				3			2	1	1		1
31611	Construction of tracheoesoph	090	164	169	5	3%	6.00	6.66	0.66	11%	0			2.5								0.5
31613	Tracheostoma revision; simple	090	155	160	5	3%	4.71	5.48	0.77	16%	0			2.5								1
31614	Tracheostoma revision; comp	090	346	361	15	4%	8.63	10.59	1.96	23%	0			2	2			1	2			1
31750	Tracheoplasty; cervical	090	540	561	21	4%	15.39	17.77	2.38	15%	0				4			1	3			1
31755	Tracheoplasty; tracheopharyn	090	414	452	38	9%	17.54	19.70	2.16	12%	-4			3	2	2						
31760	Tracheoplasty; intrathoracic	090	623	671	48	8%	23.48	26.50	3.02	13%	0			4				8				1
31766	Carinal reconstruction	090	788	841.5	53.5	7%	31.67	34.83	3.16	10%	0			3				9.5				1
31770	Bronchoplasty; graft repair	090	544	588	44	8%	23.54	26.12	2.58	11%	0			2				8				1
31775	Bronchoplasty; excision steno	090	557	602	45	8%	24.59	27.28	2.69	11%	0			2.5				8				1
31780	Excision tracheal stenosis and	090	619	631	12	2%	19.84	22.57	2.73	14%	0			3	1			3	4			1

31781	Excision tracheal stenosis and	090	602	637	35	6%	24.85	27.06	2.21	9%	0			2.5				6			1	
31785	Excision of tracheal tumor or c	090	524	550.5	26.5	5%	18.35	20.09	1.74	9%	0			2				4.5			1	
31786	Excision of tracheal tumor or c	090	722	762	40	6%	25.42	27.87	2.45	10%	0			2.5				7			1	
31800	Suture of tracheal wound or in	090	301	311	10	3%	8.18	9.19	1.01	12%	0			2.5				1			1	
31805	Suture of tracheal wound or in	090	382	394.5	12.5	3%	13.42	14.55	1.13	8%	0			2.5				1.5			1	
31820	Surgical closure tracheostomy	090	168	174.5	6.5	4%	4.64	5.42	0.78	17%	0			2				0.5			1	
31825	Surgical closure tracheostomy	090	230	241	11	5%	7.07	8.19	1.12	16%	0			3				1			1	
31830	Revision of tracheostomy scar	090	153	158	5	3%	4.62	5.28	0.66	14%	0			2.5							0.5	
32035	Thoracostomy; with rib resect	090	667	723	56	8%	11.29	14.57	3.28	29%	0			3				10			1	
32036	Thoracostomy; with open flap	090	674	730	56	8%	12.30	15.58	3.28	27%	0			3				10			1	
32096	Thoracotomy, with diagnostic	090	436	434	-2	0%	13.75	15.74	1.99	14%	0				1			1	2	2	1	
32097	Thoracotomy, with diagnostic	090	401	402	1	0%	13.75	15.34	1.59	12%	0				1			1	2	1	1	
32098	Thoracotomy, with biopsy(ies	090	341	346	5	1%	12.91	14.30	1.39	11%	0				1			1	1	1	1	
32100	Thoracotomy; with exploratio	090	411	412	1	0%	13.75	15.34	1.59	12%	0				1			1	2	1	1	
32110	Thoracotomy; with control of	090	561	580	19	3%	25.28	27.33	2.05	8%	-2				1	1		2	1	1	1	
32120	Thoracotomy; for postoperati	090	647	700.5	53.5	8%	14.39	17.16	2.77	19%	-3					1.5		8			1	
32124	Thoracotomy; with open intra	090	696	744.5	48.5	7%	15.45	17.98	2.53	16%	-3					1.5		7			1	
32140	Thoracotomy; with cyst(s) ren	090	664	712.5	48.5	7%	16.66	19.19	2.53	15%	-3					1.5		7			1	
32141	Thoracotomy; with resection-	090	673	662	-11	-2%	27.18	30.19	3.01	11%	0			1	1			1	4	3	1	
32150	Thoracotomy; with removal o	090	626	672	46	7%	16.82	19.23	2.41	14%	-3					1.5		6.5			1	
32151	Thoracotomy; with removal o	090	656	704.5	48.5	7%	16.94	19.47	2.53	15%	-3					1.5		7			1	
32160	Thoracotomy; with cardiac ma	090	788	832	44	6%	13.10	15.42	2.32	18%	-2					1		7			1	
32200	Pneumonostomy, with open d	090	691	758.5	67.5	10%	18.68	22.11	3.43	18%	-5					2.5		9			1	
32215	Pleural scarification for repea	090	471	509.5	38.5	8%	13.05	15.10	2.05	16%	-3					1.5		5			1	
32220	Decortication, pulmonary (sep	090	722	756	34	5%	26.65	29.51	2.86	11%	-2			2	2	1		3	2		1	
32225	Decortication, pulmonary (sep	090	716	767	51	7%	16.75	19.40	2.65	16%	-3					1.5		7.5			1	
32310	Pleurectomy, parietal (separa	090	516	559.5	43.5	8%	15.28	17.57	2.29	15%	-3					1.5		6			1	
32320	Decortication and parietal ple	090	735	765	30	4%	27.25	30.49	3.24	12%	-2			1	2	1		3	1	2	1	
32440	Removal of lung, pneumonect	090	628	638	10	2%	27.28	29.55	2.27	8%	0			2	1			2	2	1	1	
32442	Removal of lung, pneumonect	090	1035	1020	-15	-1%	56.47	60.79	4.32	8%	0				2			1	4	6	1	
32445	Removal of lung, pneumonect	090	1182	1180	-2	0%	63.84	68.89	5.05	8%	-4			1	1	2		1	4	6	1	
32480	Removal of lung, other than p	090	593	612	19	3%	25.82	28.13	2.31	9%	0			2	1			3	1	1	1	
32482	Removal of lung, other than p	090	680	706	26	4%	27.44	29.95	2.51	9%	-2			1	1	1		3	1	1	1	
32484	Removal of lung, other than p	090	561	561	0	0%	25.38	27.59	2.21	9%	0			1	1			1	2	2	1	
32486	Removal of lung, other than p	090	812	802	-10	-1%	42.88	46.09	3.21	7%	0			1	1			1	3	4	1	
32488	Removal of lung, other than p	090	836	839	3	0%	42.99	46.42	3.43	8%	-2			1	1	1		1	2	4	1	
32491	Removal of lung, other than p	090	887	1000	113	13%	25.24	31.65	6.41	25%	0				3			20	2		1	
32503	Resection of apical lung tumo	090	645	687	42	7%	31.74	34.48	2.74	9%	0			1	2			6	1		1	
32504	Resection of apical lung tumo	090	705	747	42	6%	36.54	39.28	2.74	7%	0			1	2			6	1		1	
32505	Thoracotomy; with therapeut	090	427	430	3	1%	15.75	17.56	1.81	11%	0			1	1			1	2	1	1	
32540	Extrapleural enucleation of en	090	740	732	-8	-1%	30.35	33.89	3.54	12%	0			1	2			1	5	3	1	
32552	Removal of indwelling tunnele	010	82	84	2	2%	2.53	2.86	0.33	13%	0			1							0.5	
32601	Thoracoscopy, diagnostic (sep	000	193	189	-4	-2%	5.50	5.70	0.20	4%	0								1			
32607	Thoracoscopy; with diagnostic	000	178	174	-4	-2%	5.50	5.70	0.20	4%	0								1			
32608	Thoracoscopy; with diagnostic	000	195	191	-4	-2%	6.84	7.04	0.20	3%	0								1			
32609	Thoracoscopy; with biopsy(ies	000	178	174	-4	-2%	4.58	4.78	0.20	4%	0								1			
32650	Thoracoscopy, surgical; with p	090	290	304	14	5%	10.83	11.97	1.14	11%	0			2				2			1	
32651	Thoracoscopy, surgical; with p	090	502	496	-6	-1%	18.78	20.79	2.01	11%	0			1	1			1	5		1	
32652	Thoracoscopy, surgical; with t	090	645	648	3	0%	29.13	31.87	2.74	9%	0			1	2			1	3	2	1	
32653	Thoracoscopy, surgical; with r	090	509	503	-6	-1%	18.17	20.18	2.01	11%	0			1	1			1	5		1	
32654	Thoracoscopy, surgical; with d	090	515	507	-8	-2%	20.52	23.13	2.61	13%	0			1	1			1	4	2	1	
32655	Thoracoscopy, surgical; with r	090	425	427	2	0%	16.17	17.78	1.61	10%	0			1	1			1	3		1	
32656	Thoracoscopy, surgical; with p	090	377	401	24	6%	13.26	14.75	1.49	11%	0			1	1			3			1	
32658	Thoracoscopy, surgical; with r	090	330	339	9	3%	11.71	12.61	0.90	8%	0			2				1			1	
32659	Thoracoscopy, surgical; with d	090	357	376	19	5%	11.94	13.19	1.25	10%	0			1	1			2			1	
32661	Thoracoscopy, surgical; with e	090	300	309	9	3%	13.33	14.23	0.90	7%	0			2				1			1	
32662	Thoracoscopy, surgical; with e	090	350	355	5	1%	14.99	15.96	0.97	6%	0			1	1				1		1	
32663	Thoracoscopy, surgical; with l	090	507	511	4	1%	24.64	26.65	2.01	8%	0			1	1			1	1	2	1	
32664	Thoracoscopy, surgical; with t	090	330	339	9	3%	14.28	15.18	0.90	6%	0			2				1			1	
32665	Thoracoscopy, surgical; with e	090	512	511	-1	0%	21.53	23.54	2.01	9%	0			1	1			1	3	1	1	
32666	Thoracoscopy, surgical; with t	090	332	343	11	3%	14.50	15.91	1.41	10%	0			1	1			1		1	1	
32669	Thoracoscopy, surgical; with r	090	502	506	4	1%	23.53	25.54	2.01	9%	0			1	1			1	1	2	1	
32670	Thoracoscopy, surgical; with r	090	532	536	4	1%	28.52	30.53	2.01	7%	0			1	1			1	1	2	1	
32671	Thoracoscopy, surgical; with r	090	602	606	4	1%	31.92	33.93	2.01	6%	0			1	1			1	1	2	1	
32672	Thoracoscopy, surgical; with r	090	567	564	-3	-1%	27.00	29.61	2.61	10%	0			1	1			1	2	3	1	
32673	Thoracoscopy, surgical; with r	090	447	454	7	2%	21.13	22.74	1.61	8%	0			1	1			1	1	1	1	
32800	Repair lung hernia through ch	090	578	629	51	9%	15.71	18.36	2.65	17%	-3					1.5		7.5			1	

32810	Closure of chest wall following	090	523	569	46	9%	14.95	17.36	2.41	16%	-3					1.5		6.5			1	
32815	Open closure of major bronch	090	1147	1133	-14	-1%	50.03	55.68	5.65	11%	-4			1	1	2		1	7	6	1	
32820	Major reconstruction, chest w	090	854	894.5	40.5	5%	22.51	24.65	2.14	10%	-2				2	1		3.5			1	
32851	Lung transplant, single; witho	090	1165	1182	17	1%	59.64	63.04	3.40	6%	-3					1	1	1	3	3		1
32852	Lung transplant, single; with c	090	1320	1330	10	1%	65.50	69.50	4.00	6%	-3					1	1	1	4	4		1
32853	Lung transplant, double (bilat	090	1440	1447	7	0%	84.48	88.88	4.40	5%	-3					1	1	1	4	5		1
32854	Lung transplant, double (bilat	090	1600	1596	-4	0%	90.00	95.20	5.20	6%	-3					1	1	1	6	6		1
32900	Resection of ribs, extrapleural	090	821	872	51	6%	23.81	26.46	2.65	11%	-3					1.5		7.5			1	
32905	Thoracoplasty, Schede type or	090	721	762	41	6%	23.29	25.46	2.17	9%	-3					1.5		5.5			1	
32906	Thoracoplasty, Schede type or	090	751	792	41	5%	29.30	31.47	2.17	7%	-3					1.5		5.5			1	
32940	Pneumonolysis, extraperioste	090	546	582	36	7%	21.34	23.27	1.93	9%	-3					1.5		4.5			1	
32997	Total lung lavage (unilateral)	000	424	435	11	3%	7.31	8.83	1.52	21%	0				2			1	2		1	
33020	Pericardiotomy for removal o	090	321	326	5	2%	14.31	15.70	1.39	10%	0				1			1	1	1	1	
33025	Creation of pericardial windov	090	301	310	9	3%	13.20	14.39	1.19	9%	0				1			1		1	1	
33030	Pericardiectomy, subtotal or c	090	739	746	7	1%	36.00	38.41	2.41	7%	-2				1	1		1	2	2	1	
33031	Pericardiectomy, subtotal or c	090	839	852	13	2%	45.00	47.84	2.84	6%	-2				1	1		1	2	3		1
33050	Resection of pericardial cyst o	090	623	666.5	43.5	7%	16.97	19.26	2.29	13%	-3					1.5		6			1	
33120	Excision of intracardiac tumor	090	686	686	0	0%	38.45	40.53	2.08	5%	-2					1		1	2	2	1	
33130	Resection of external cardiac	090	719	770	51	7%	24.17	26.82	2.65	11%	-3					1.5		7.5			1	
33140	Transmyocardial laser revascu	090	621	622	1	0%	28.34	30.62	2.28	8%	-2					1		1	1	3	1	
33141	Transmyocardial laser revascu	ZZZ	32.2	31.9	-0.3	-1%	2.54	2.58	0.04	2%	0									0.1		
33202	Insertion of epicardial electro	090	301	309	8	3%	13.20	14.19	0.99	8%	0				1			1	1		1	
33203	Insertion of epicardial electro	090	326	334	8	2%	13.97	14.96	0.99	7%	0				1			1	1		1	
33206	Insertion of new or replaceme	090	248.5	269	20.5	8%	7.14	8.34	1.20	17%	0				1.5			2			1	
33207	Insertion of new or replaceme	090	233.5	236.5	3	1%	7.80	8.55	0.75	10%	0				1				1		1	
33208	Insertion of new or replaceme	090	231	234	3	1%	8.52	9.27	0.75	9%	0				1				1		1	
33212	Insertion of pacemaker pulse	090	124	131	7	6%	5.01	5.45	0.44	9%	0				1						0.5	
33213	Insertion of pacemaker pulse	090	125	132	7	6%	5.28	5.72	0.44	8%	0				1						0.5	
33214	Upgrade of implanted pacema	090	262	266	4	2%	7.59	8.03	0.44	6%	0			2								
33215	Repositioning of previously im	090	179	186	7	4%	4.92	5.60	0.68	14%	0			1				1			1	
33216	Insertion of a single transvend	090	262	266	4	2%	5.62	6.06	0.44	8%	0			2								
33217	Insertion of 2 transvenous ele	090	262	266	4	2%	5.59	6.03	0.44	8%	0			2								
33218	Repair of single transvenous e	090	246	260	14	6%	5.82	6.48	0.66	11%	0				2							
33220	Repair of 2 transvenous electr	090	276	290	14	5%	5.90	6.56	0.66	11%	0				2							
33221	Insertion of pacemaker pulse	090	129	136	7	5%	5.55	5.99	0.44	8%	0				1						0.5	
33222	Relocation of skin pocket for p	090	275	281	6	2%	4.85	5.51	0.66	14%	0			3								
33223	Relocation of skin pocket for i	090	230	234	4	2%	6.30	6.74	0.44	7%	0			2								
33224	Insertion of pacing electrode,	000	204	204	0	0%	9.04	9.15	0.11	1%	0										0.5	
33226	Repositioning of previously im	000	189	189	0	0%	8.68	8.79	0.11	1%	0										0.5	
33227	Removal of permanent pacem	090	124	131	7	6%	5.25	5.69	0.44	8%	0				1						0.5	
33228	Removal of permanent pacem	090	129	136	7	5%	5.52	5.96	0.44	8%	0				1						0.5	
33229	Removal of permanent pacem	090	139	146	7	5%	5.79	6.23	0.44	8%	0				1						0.5	
33230	Insertion of implantable defib	090	150	157	7	5%	6.07	6.51	0.44	7%	0				1						0.5	
33231	Insertion of implantable defib	090	150	157	7	5%	6.34	6.78	0.44	7%	0				1						0.5	
33233	Removal of permanent pacem	090	150	154	4	3%	3.14	3.58	0.44	14%	0			2								
33234	Removal of transvenous pace	090	292	296	4	1%	7.66	8.10	0.44	6%	0			2								
33235	Removal of transvenous pace	090	390	420	30	8%	9.90	11.28	1.38	14%	-2						2					
33236	Removal of permanent epicar	090	346	372	26	8%	12.73	14.57	1.84	14%	0			3				4			1	
33237	Removal of permanent epicar	090	456	487	31	7%	13.84	15.92	2.08	15%	0			3				5			1	
33238	Removal of permanent transv	090	472	505	33	7%	15.40	17.70	2.30	15%	0			4				5			1	
33240	Insertion of implantable defib	090	135	142	7	5%	5.80	6.24	0.44	8%	0				1						0.5	
33241	Removal of implantable defib	090	171	173	2	1%	3.04	3.26	0.22	7%	0			1								
33243	Removal of single or dual char	090	537	583	46	9%	23.57	25.98	2.41	10%	0				3			5			1	
33244	Removal of single or dual char	090	310	320	10	3%	13.74	14.84	1.10	8%	0			5								
33249	Insertion or replacement of pa	090	239	260	21	9%	14.92	15.91	0.99	7%	0				3							
33250	Operative ablation of suprave	090	983	1034	51	5%	25.90	28.55	2.65	10%	-3					1.5		7.5			1	
33251	Operative ablation of suprave	090	1001	1052	51	5%	28.92	31.57	2.65	9%	-3					1.5		7.5			1	
33254	Operative tissue ablation and	090	416	433	17	4%	23.71	25.12	1.41	6%	-2				1	1		1	1		1	
33255	Operative tissue ablation and	090	516	529	13	3%	29.04	30.65	1.61	6%	-2				1	1		1	2		1	
33256	Operative tissue ablation and	090	646	655	9	1%	34.90	36.71	1.81	5%	-2				1	1		1	3		1	
33257	Operative tissue ablation and	ZZZ	180.35	185.52	5.17	3%	9.63	10.31	0.68	7%	0				1					0.61	0.5	
33258	Operative tissue ablation and	ZZZ	190.3	196.28	5.98	3%	11.00	11.58	0.58	5%	0				1					0.34	0.5	
33259	Operative tissue ablation and	ZZZ	222.75	234.92	12.17	5%	14.14	15.15	1.01	7%	0				2					0.61	0.5	
33261	Operative ablation of ventricu	090	1004	1055	51	5%	28.92	31.57	2.65	9%	-3					1.5		7.5			1	
33262	Removal of implantable defib	090	150	157	7	5%	5.81	6.25	0.44	8%	0				1						0.5	
33263	Removal of implantable defib	090	150	157	7	5%	6.08	6.52	0.44	7%	0				1						0.5	
33264	Removal of implantable defib	090	150	157	7	5%	6.35	6.79	0.44	7%	0				1						0.5	

33265	Endoscopy, surgical; operative	090	446	463	17	4%	23.71	25.12	1.41	6%	-2				1	1		1	1		1	
33266	Endoscopy, surgical; operative	090	536	549	13	2%	33.04	34.65	1.61	5%	-2				1	1		1	2		1	
33267	Exclusion of left atrial append	090	401	400	-1	0%	18.50	19.45	0.95	5%	0				1				2		1	
33269	Exclusion of left atrial append	090	323	323	0	0%	14.31	15.46	1.15	8%	0				1				1	1	1	
33270	Insertion or replacement of pa	090	232	241	9	4%	9.10	9.74	0.64	7%	-2					1					1	
33271	Insertion of subcutaneous imp	090	202	211	9	4%	7.50	8.14	0.64	9%	-2					1					1	
33272	Removal of subcutaneous imp	090	151	158	7	5%	5.42	5.86	0.44	8%	0				1						0.5	
33273	Repositioning of previously im	090	202	211	9	4%	6.50	7.14	0.64	10%	-2					1					1	
33274	Transcatheter insertion or rep	090	173	180	7	4%	7.80	8.24	0.44	6%	0				1						0.5	
33275	Transcatheter removal of per	090	188	195	7	4%	8.59	9.03	0.44	5%	0				1						0.5	
33300	Repair of cardiac wound; with	090	859	853	-6	-1%	44.97	47.85	2.88	6%	-2					1		1	2	4	1	
33305	Repair of cardiac wound; with	090	1251	1245	-6	0%	76.93	79.81	2.88	4%	-2					1		1	2	4	1	
33310	Cardiotomy, exploratory (inclu	090	532	575.5	43.5	8%	20.34	22.63	2.29	11%	-3					1.5		6			1	
33315	Cardiotomy, exploratory (inclu	090	621	625	4	1%	35.00	36.88	1.88	5%	-2					1		1	1	2	1	
33320	Suture repair of aorta or great	090	516.5	559.5	43	8%	18.54	20.82	2.28	12%	0				1.5			6.5			1	
33321	Suture repair of aorta or great	090	754	808	54	7%	20.81	23.61	2.80	13%	0				2			8			1	
33322	Suture repair of aorta or great	090	884	935	51	6%	24.42	27.07	2.65	11%	-3					1.5		7.5			1	
33330	Insertion of graft, aorta or gre	090	916	969.5	53.5	6%	25.29	28.06	2.77	11%	-3					1.5		8			1	
33335	Insertion of graft, aorta or gre	090	963	1019	56	6%	33.91	36.80	2.89	9%	-3					1.5		8.5			1	
33361	Transcatheter aortic valve rep	000	275	275	0	0%	22.47	22.47	-	0%	0											
33362	Transcatheter aortic valve rep	000	303	303	0	0%	24.54	24.54	-	0%	0											
33363	Transcatheter aortic valve rep	000	300	300	0	0%	25.47	25.47	-	0%	0											
33364	Transcatheter aortic valve rep	000	294	294	0	0%	25.97	25.97	-	0%	0											
33365	Transcatheter aortic valve rep	000	320	320	0	0%	26.59	26.59	-	0%	0											
33366	Transcatheter aortic valve rep	000	320	320	0	0%	29.35	29.35	-	0%	0											
33390	Valvuloplasty, aortic valve, op	090	622	625	3	0%	35.00	36.81	1.81	5%	0			1	1			1	2	1	1	
33391	Valvuloplasty, aortic valve, op	090	676	686	10	1%	41.50	43.51	2.01	5%	-2				1	1		1	2	1	1	
33404	Construction of apical-aortic c	090	846	899.5	53.5	6%	31.37	34.14	2.77	9%	-3					1.5		8			1	
33405	Replacement, aortic valve, op	090	768	772	4	1%	41.32	44.13	2.81	7%	-2				1	1		1	2	3	1	
33406	Replacement, aortic valve, op	090	853	857	4	0%	52.68	55.49	2.81	5%	-2				1	1		1	2	3	1	
33410	Replacement, aortic valve, op	090	800	804	4	0%	46.41	49.22	2.81	6%	-2				1	1		1	2	3	1	
33411	Replacement, aortic valve; wit	090	1059	1052	-7	-1%	62.07	65.68	3.61	6%	-2				1	1		1	4	4	1	
33412	Replacement, aortic valve; wit	090	866	867	1	0%	59.00	61.28	2.28	4%	-2					1		1	1	3	1	
33413	Replacement, aortic valve; by	090	898	906	8	1%	59.87	62.48	2.61	4%	-2				1	1		1	1	3	1	
33414	Repair of left ventricular outfl	090	763	764	1	0%	39.37	41.65	2.28	6%	-2					1		1	1	3	1	
33415	Resection or incision of subva	090	679	679	0	0%	37.27	39.35	2.08	6%	-2					1		1	2	2	1	
33416	Ventriculomyotomy (-myector	090	664	683	19	3%	36.56	38.61	2.05	6%	-2				1	1		2	1	1	1	
33417	Aortoplasty (gusset) for supra	090	750	780.5	30.5	4%	29.33	30.99	1.66	6%	-4					2		2.5			1	
33418	Transcatheter mitral valve rep	090	561	580	19	3%	32.25	33.74	1.49	5%	-4					2			2			1
33420	Valvotomy, mitral valve; close	090	761	814.5	53.5	7%	25.79	28.56	2.77	11%	-3					1.5		8			1	
33422	Valvotomy, mitral valve; open	090	892	943	51	6%	29.73	32.38	2.65	9%	-3					1.5		7.5			1	
33425	Valvuloplasty, mitral valve, wi	090	880	881	1	0%	49.96	53.17	3.21	6%	-2				1	1		1	2	4	1	
33426	Valvuloplasty, mitral valve, wi	090	776	780	4	1%	43.28	46.09	2.81	6%	-2				1	1		1	2	3	1	
33427	Valvuloplasty, mitral valve, wi	090	737	744	7	1%	44.83	47.24	2.41	5%	-2				1	1		1	2	2	1	
33430	Replacement, mitral valve, wi	090	913	933	20	2%	50.93	54.10	3.17	6%	-2				2	1		1	2	3		1
33440	Replacement, aortic valve; by	090	998	996	-2	0%	64.00	66.92	2.92	5%	-2					1		2	3	3	1	
33460	Valvectomy, tricuspid valve, w	090	877	867	-10	-1%	44.70	47.78	3.08	7%	-2					1		1	3	4	1	
33463	Valvuloplasty, tricuspid valve;	090	1127	1108	-19	-2%	57.08	61.29	4.21	7%	-2				1	1		1	7	4	1	
33464	Valvuloplasty, tricuspid valve;	090	871	868	-3	0%	44.62	48.03	3.41	8%	-2				1	1		1	3	4	1	
33465	Replacement, tricuspid valve,	090	972	964	-8	-1%	50.72	54.13	3.41	7%	-2				1	1		1	5	3	1	
33468	Tricuspid valve repositioning a	090	806	807	1	0%	45.13	47.41	2.28	5%	-2					1		1	1	3	1	
33471	Valvotomy, pulmonary valve,	090	572	608	36	6%	22.96	24.89	1.93	8%	-2				1	1		4			1	
33474	Valvotomy, pulmonary valve,	090	738	745	7	1%	39.40	41.81	2.41	6%	-2				1	1		1	2	2	1	
33475	Replacement, pulmonary valv	090	750	757	7	1%	42.40	44.81	2.41	6%	-2				1	1		1	2	2	1	
33476	Right ventricular resection for	090	859	877	18	2%	26.57	27.63	1.06	4%	-4					2					1	
33478	Outflow tract augmentation (a	090	882	900	18	2%	27.54	28.60	1.06	4%	-4					2					1	
33496	Repair of non-structural prost	090	881	887	6	1%	29.84	32.29	2.45	8%	-2				1	1		2	5		1	
33500	Repair of coronary arterioven	090	690	736	46	7%	27.94	30.35	2.41	9%	-3					1.5		6.5			1	
33501	Repair of coronary arterioven	090	411	419	8	2%	19.51	21.56	2.05	11%	0			1	1			2	2	1	1	
33502	Repair of anomalous coronary	090	688	718.5	30.5	4%	21.85	23.51	1.66	8%	-4					2		2.5			1	
33503	Repair of anomalous coronary	090	838	895.5	57.5	7%	22.51	25.43	2.92	13%	-2						2	5.5			1	
33504	Repair of anomalous coronary	090	789	829.5	40.5	5%	25.46	27.60	2.14	8%	-4					2		4.5			1	
33505	Repair of anomalous coronary	090	678	727	49	7%	38.40	41.51	3.11	8%	0				1			9		1	1	
33506	Repair of anomalous coronary	090	678	727	49	7%	37.85	40.96	3.11	8%	0				1			9		1	1	
33507	Repair of anomalous (eg, intra	090	563.5	576.5	13	2%	31.40	32.63	1.23	4%	0				1			2	1		1	
33510	Coronary artery bypass, vein c	090	718	717	-1	0%	34.98	37.68	2.70	8%	-2			1		1		1	2	3	1	
33511	Coronary artery bypass, vein c	090	750	749	-1	0%	38.45	41.15	2.70	7%	-2			1		1		1	2	3	1	

33512	Coronary artery bypass, vein	090	832	828	-4	0%	43.98	47.08	3.10	7%	-2			1		1		1	2	4	1	
33513	Coronary artery bypass, vein	090	850	846	-4	0%	45.37	48.47	3.10	7%	-2			1		1		1	2	4	1	
33514	Coronary artery bypass, vein	090	867	863	-4	0%	48.08	51.18	3.10	6%	-2			1		1		1	2	4	1	
33516	Coronary artery bypass, vein	090	883	879	-4	0%	49.76	52.86	3.10	6%	-2			1		1		1	2	4	1	
33517	Coronary artery bypass, using	ZZZ	53.5	52.6	-0.9	-2%	3.61	3.73	0.12	3%	0									0.3		
33518	Coronary artery bypass, using	ZZZ	112.6	110.56	-2.04	-2%	7.93	8.20	0.27	3%	0									0.68		
33519	Coronary artery bypass, using	ZZZ	139.8	137.52	-2.28	-2%	10.49	10.79	0.30	3%	0									0.76		
33521	Coronary artery bypass, using	ZZZ	158.05	155.68	-2.37	-1%	12.59	12.91	0.32	3%	0									0.79		
33522	Coronary artery bypass, using	ZZZ	174.45	171.72	-2.73	-2%	14.14	14.50	0.36	3%	0									0.91		
33523	Coronary artery bypass, using	ZZZ	193	190	-3	-2%	16.08	16.48	0.40	2%	0									1		
33530	Reoperation, coronary artery	ZZZ	112.4	111.08	-1.32	-1%	10.13	10.31	0.18	2%	0									0.44		
33533	Coronary artery bypass, using	090	682	685	3	0%	33.75	36.25	2.50	7%	-2			1		1		1	1	3	1	
33534	Coronary artery bypass, using	090	717	720	3	0%	39.88	42.38	2.50	6%	-2			1		1		1	1	3	1	
33535	Coronary artery bypass, using	090	755	758	3	0%	44.75	47.25	2.50	6%	-2			1		1		1	1	3	1	
33536	Coronary artery bypass, using	090	783	786	3	0%	48.43	50.93	2.50	5%	-2			1		1		1	1	3	1	
33542	Myocardial resection (eg, ven	090	848	852	4	0%	48.21	51.02	2.81	6%	-2				1	1		1	2	3	1	
33545	Repair of postinfarction ventr	090	939	953	14	1%	57.06	60.10	3.04	5%	-2				1	1		1	1	4		1
33548	Surgical ventricular restoratio	090	928	948	20	2%	54.14	57.31	3.17	6%	-2				2	1		1	2	3		1
33600	Closure of atrioventricular val	090	628	676	48	8%	30.31	32.81	2.50	8%	-4					2		6			1	
33602	Closure of semilunar valve (ac	090	628	676	48	8%	29.34	31.84	2.50	9%	-4					2		6			1	
33606	Anastomosis of pulmonary art	090	728	786	58	8%	31.53	34.51	2.98	9%	-4					2		8			1	
33608	Repair of complex cardiac and	090	668	711	43	6%	31.88	34.14	2.26	7%	-4					2		5			1	
33610	Repair of complex cardiac and	090	648	701	53	8%	31.40	34.14	2.74	9%	-4					2		7			1	
33611	Repair of double outlet right v	090	673	732	59	9%	35.57	38.61	3.04	9%	-2					1		10			1	
33612	Repair of double outlet right v	090	673	732	59	9%	36.57	39.61	3.04	8%	-2					1		10			1	
33615	Repair of complex cardiac and	090	696	762	66	9%	35.89	39.26	3.37	9%	-2				1	1		10			1	
33617	Repair of complex cardiac and	090	811	868	57	7%	39.09	42.42	3.33	9%	-2				1	1		9	1		1	
33619	Repair of single ventricle with	090	1039	1058	19	2%	48.76	52.90	4.14	8%	-12		5	1		1		7	6	1	1	
33620	Application of right and left pu	090	609	630	21	3%	30.00	32.55	2.55	9%	0				1			5	2	1	1	
33621	Transthoracic insertion of cati	090	363.5	385.5	22	6%	16.18	17.23	1.05	6%	0				1			3				
33622	Reconstruction of complex ca	090	986	1017	31	3%	64.00	67.72	3.72	6%	-2					1		7	1	3	1	
33641	Repair atrial septal defect, sec	090	562	569	7	1%	29.58	31.06	1.48	5%	-2					1		1	1	1	1	
33645	Direct or patch closure, sinus	090	546	553	7	1%	31.30	32.78	1.48	5%	-2					1		1	1	1	1	
33647	Repair of atrial septal defect a	090	614	618	4	1%	33.00	34.88	1.88	6%	-2					1		1	1	2	1	
33660	Repair of incomplete or partia	090	613	620	7	1%	31.83	33.31	1.48	5%	-2					1		1	1	1	1	
33665	Repair of intermediate or tran	090	613	620	7	1%	34.85	36.33	1.48	4%	-2					1		1	1	1	1	
33670	Repair of complete atrioventr	090	626	645	19	3%	36.63	38.30	1.67	5%	0				1			3		1	1	
33675	Closure of multiple ventricula	090	628	644	16	3%	35.95	37.71	1.76	5%	-2					1		3	2		1	
33676	Closure of multiple ventricula	090	658	674	16	2%	36.95	38.71	1.76	5%	-2					1		3	2		1	
33677	Closure of multiple ventricula	090	688	704	16	2%	38.45	40.21	1.76	5%	-2					1		3	2		1	
33681	Closure of single ventricular s	090	506.5	559.5	53	10%	32.34	35.08	2.74	8%	-2				2	1		6			1	
33684	Closure of single ventricular s	090	616	623	7	1%	34.37	35.85	1.48	4%	-2					1		1	1	1	1	
33688	Closure of single ventricular s	090	628	635	7	1%	34.75	36.23	1.48	4%	-2					1		1	1	1	1	
33690	Banding of pulmonary artery	090	636	666.5	30.5	5%	20.36	22.02	1.66	8%	-4					2		2.5			1	
33692	Complete repair tetralogy of F	090	684	697	13	2%	36.15	38.31	2.16	6%	-2					1		3	2	1	1	
33694	Complete repair tetralogy of F	090	718	777	59	8%	35.57	38.61	3.04	9%	-2					1		10			1	
33697	Complete repair tetralogy of F	090	693	752	59	9%	37.57	40.61	3.04	8%	-2					1		10			1	
33702	Repair sinus of Valsalva fistula	090	751	769.5	18.5	2%	27.24	28.33	1.09	4%	-2				1	1		0.5			1	
33710	Repair sinus of Valsalva fistula	090	656	663	7	1%	37.50	38.98	1.48	4%	-2					1		1	1	1	1	
33720	Repair sinus of Valsalva aneur	090	770	786	16	2%	27.26	28.23	0.97	4%	-2				1	1					1	
33724	Repair of isolated partial anor	090	559	574	15	3%	27.63	28.95	1.32	5%	-2					1		2	1		1	
33726	Repair of pulmonary venous s	090	643	663	20	3%	37.12	38.68	1.56	4%	-2					1		3	1		1	
33730	Complete repair of anomalous	090	671	737	66	10%	36.14	39.51	3.37	9%	-2				1	1		10			1	
33732	Repair of cor triatriatum or su	090	578	621	43	7%	28.96	31.22	2.26	8%	-4					2		5			1	
33735	Atrial septectomy or septosto	090	770	800.5	30.5	4%	22.20	23.86	1.66	7%	-4					2		2.5			1	
33736	Atrial septectomy or septosto	090	548	591	43	8%	24.32	26.58	2.26	9%	-4					2		5			1	
33737	Atrial septectomy or septosto	090	706	732	26	4%	22.47	23.92	1.45	6%	-2				1	1		2			1	
33750	Shunt; subclavian to pulmona	090	722	750	28	4%	22.22	23.76	1.54	7%	-4					2		2			1	
33755	Shunt; ascending aorta to pul	090	750	775.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33762	Shunt; descending aorta to pu	090	755	780.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33764	Shunt; central, with prosthetic	090	750	775.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33766	Shunt; superior vena cava to p	090	756	781.5	25.5	3%	23.57	24.99	1.42	6%	-4					2		1.5			1	
33767	Shunt; superior vena cava to p	090	608	651	43	7%	25.30	27.56	2.26	9%	-4					2		5			1	
33770	Repair of transposition of the	090	696	716	20	3%	39.07	41.18	2.11	5%	0				1			4	1	1	1	
33771	Repair of transposition of the	090	716	736	20	3%	40.63	42.74	2.11	5%	0				1			4	1	1	1	
33774	Repair of transposition of the	090	998	1024.5	26.5	3%	31.73	33.18	1.45	5%	-3					1	1	0.5			1	
33775	Repair of transposition of the	090	1043	1063.5	20.5	2%	32.99	34.17	1.18	4%	-4					2		0.5			1	

33776	Repair of transposition of the	090	1096	1133.5	37.5	3%	34.75	36.71	1.96	6%	-2						2	1.5			1	
33777	Repair of transposition of the	090	993	1040.5	47.5	5%	34.17	36.61	2.44	7%	-2						2	3.5			1	
33778	Repair of transposition of the	090	838.5	887.5	49	6%	42.75	46.48	3.73	9%	-2				1	1		9	3		1	
33779	Repair of transposition of the	090	733	755	22	3%	43.23	45.43	2.20	5%	-2					1		4	1	1	1	
33780	Repair of transposition of the	090	731	760	29	4%	43.90	46.29	2.39	5%	0				1			6	2		1	
33781	Repair of transposition of the	090	738	767	29	4%	43.21	45.60	2.39	6%	0				1			6	2		1	
33782	Aortic root translocation with	090	866	867	1	0%	60.08	62.36	2.28	4%	-2					1		1	1	3	1	
33783	Aortic root translocation with	090	926	927	1	0%	65.08	67.36	2.28	4%	-2					1		1	1	3	1	
33786	Total repair, truncus arteriosu	090	838.5	892.5	54	6%	41.87	45.84	3.97	9%	-2				1	1		10	3		1	
33788	Reimplantation of an anomalo	090	736	766.5	30.5	4%	27.42	29.08	1.66	6%	-4					2		2.5			1	
33800	Aortic suspension (aortopexy)	090	375	386	11	3%	17.28	18.61	1.33	8%	0				1			2	1.5		1	
33802	Division of aberrant vessel (va	090	556	584.5	28.5	5%	18.37	19.94	1.57	9%	-2				1	1		2.5			1	
33803	Division of aberrant vessel (va	090	586	614.5	28.5	5%	20.31	21.88	1.57	8%	-2				1	1		2.5			1	
33813	Obliteration of aortopulmona	090	664	685	21	3%	21.36	22.57	1.21	6%	-2				1	1		1			1	
33814	Obliteration of aortopulmona	090	838	856	18	2%	26.57	27.63	1.06	4%	-4					2					1	
33820	Repair of patent ductus arteri	090	414	428	14	3%	16.69	17.57	0.88	5%	-2					1		1			1	
33822	Repair of patent ductus arteri	090	463	472	9	2%	17.71	18.35	0.64	4%	-2					1					1	
33824	Repair of patent ductus arteri	090	615	633.5	18.5	3%	20.23	21.32	1.09	5%	-2				1	1		0.5			1	
33840	Excision of coarctation of aort	090	639	662.5	23.5	4%	21.34	22.67	1.33	6%	-2				1	1		1.5			1	
33845	Excision of coarctation of aort	090	726	749	23	3%	22.93	24.23	1.30	6%	-4					2		1			1	
33851	Excision of coarctation of aort	090	700	726	26	4%	21.98	23.43	1.45	7%	-2				1	1		2			1	
33852	Repair of hypoplastic or interr	090	719	745	26	4%	24.41	25.86	1.45	6%	-2				1	1		2			1	
33853	Repair of hypoplastic or interr	090	668	726	58	9%	32.51	35.49	2.98	9%	-4					2		8			1	
33858	Ascending aorta graft, with ca	090	911	922	11	1%	63.40	65.61	2.21	3%	-2				1	1		1	1	2	1	
33859	Ascending aorta graft, with ca	090	778	782	4	1%	45.13	47.01	1.88	4%	-2					1		1	1	2	1	
33863	Ascending aorta graft, with ca	090	838	842	4	0%	58.79	60.67	1.88	3%	-2					1		1	1	2	1	
33864	Ascending aorta graft, with ca	090	838	842	4	0%	60.08	61.96	1.88	3%	-2					1		1	1	2	1	
33871	Transverse aortic arch graft, v	090	901	905	4	0%	60.88	62.76	1.88	3%	-2					1		1	1	2	1	
33875	Descending thoracic aorta gra	090	993	1006	13	1%	50.72	53.56	2.84	6%	-2				1	1		1	2	3		1
33877	Repair of thoracoabdominal a	090	1110	1130	20	2%	69.03	72.20	3.17	5%	-2				2	1		1	2	3		1
33880	Endovascular repair of descen	090	599	611	12	2%	34.58	36.30	1.72	5%	0				2			1	1	1	1	
33881	Endovascular repair of descen	090	554	566	12	2%	29.58	31.30	1.72	6%	0				2			1	1	1	1	
33883	Placement of proximal extens	090	404	419	15	4%	21.09	22.41	1.32	6%	0				2			1	1		1	
33886	Placement of distal extension	090	379	394	15	4%	18.09	19.41	1.32	7%	0				2			1	1		1	
33910	Pulmonary artery embolecton	090	889	893	4	0%	48.21	51.02	2.81	6%	-2				1	1		1	2	3	1	
33915	Pulmonary artery embolecton	090	858	904	46	5%	24.95	27.36	2.41	10%	-3					1.5		6.5			1	
33916	Pulmonary endarterectomy, v	090	1259	1258	-1	0%	78.00	82.05	4.05	5%	-2				1	1		2	3	5	1	
33917	Repair of pulmonary artery st	090	608	651	43	7%	25.30	27.56	2.26	9%	-4					2		5			1	
33920	Repair of pulmonary atresia w	090	658	706	48	7%	32.74	35.24	2.50	8%	-4					2		6			1	
33922	Transection of pulmonary arte	090	546	587	41	8%	24.22	26.39	2.17	9%	-2				1	1		5			1	
33925	Repair of pulmonary artery ar	090	641	665	24	4%	31.30	33.21	1.91	6%	0				1			4		1	1	
33926	Repair of pulmonary artery ar	090	846	891	45	5%	44.73	48.04	3.31	7%	0				1			9	1	1	1	
33935	Heart-lung transplant with rec	090	1713	1708	-5	0%	91.78	97.71	5.93	6%	-3				1	1	1	1	8	6		1
33945	Heart transplant, with or with	090	1716	1745	29	2%	89.50	95.71	6.21	7%	-5				3	2	1	1	6	5		1
33951	Extracorporeal membrane oxy	000	170	175	5	3%	8.15	8.39	0.24	3%	0							1				
33952	Extracorporeal membrane oxy	000	158	163	5	3%	8.15	8.39	0.24	3%	0							1				
33953	Extracorporeal membrane oxy	000	190	186	-4	-2%	9.11	9.31	0.20	2%	0								1			
33954	Extracorporeal membrane oxy	000	178	174	-4	-2%	9.11	9.31	0.20	2%	0								1			
33955	Extracorporeal membrane oxy	000	250	250	0	0%	16.00	16.00	-	0%	0											
33956	Extracorporeal membrane oxy	000	250	250	0	0%	16.00	16.00	-	0%	0											
33957	Extracorporeal membrane oxy	000	130	135	5	4%	3.51	3.75	0.24	7%	0							1				
33958	Extracorporeal membrane oxy	000	118	123	5	4%	3.51	3.75	0.24	7%	0							1				
33959	Extracorporeal membrane oxy	000	130	135	5	4%	4.47	4.71	0.24	5%	0							1				
33962	Extracorporeal membrane oxy	000	118	123	5	4%	4.47	4.71	0.24	5%	0							1				
33963	Extracorporeal membrane oxy	000	183	180	-3	-2%	9.00	9.40	0.40	4%	0									1		
33964	Extracorporeal membrane oxy	000	195	192	-3	-2%	9.50	9.90	0.40	4%	0									1		
33965	Extracorporeal membrane oxy	000	130	135	5	4%	3.51	3.75	0.24	7%	0							1				
33966	Extracorporeal membrane oxy	000	133	138	5	4%	4.50	4.74	0.24	5%	0							1				
33969	Extracorporeal membrane oxy	000	163	159	-4	-2%	5.22	5.42	0.20	4%	0								1			
33971	Removal of intra-aortic balloo	090	494	518	24	5%	11.99	13.35	1.36	11%	-2					1		3			1	
33974	Removal of intra-aortic balloo	090	314	333	19	6%	15.03	16.15	1.12	7%	0				2			1			1	
33984	Extracorporeal membrane oxy	000	153	149	-4	-3%	5.46	5.66	0.20	4%	0								1			
33985	Extracorporeal membrane oxy	000	200	197	-3	-2%	9.89	10.29	0.40	4%	0									1		
33986	Extracorporeal membrane oxy	000	205	202	-3	-1%	10.00	10.40	0.40	4%	0									1		
33988	Insertion of left heart vent by	000	250	250	0	0%	15.00	15.00	-	0%	0											
33989	Removal of left heart vent by	000	205	202	-3	-1%	9.50	9.90	0.40	4%	0									1		
34001	Embolectomy or thrombecton	090	384	386	2	1%	17.88	19.36	1.48	8%	0				2				3		1	

34051	Embolectomy or thrombector	090	594	636.5	42.5	7%	16.99	19.56	2.57	15%	0			2.5				7.5			1	
34101	Embolectomy or thrombector	090	322	337	15	5%	10.93	12.38	1.45	13%	0			1	1			2	1		1	
34111	Embolectomy or thrombector	090	307	322	15	5%	10.93	12.38	1.45	13%	0			1	1			2	1		1	
34151	Embolectomy or thrombector	090	508	531	23	5%	26.52	28.87	2.35	9%	0			2	1			4	2		1	
34201	Embolectomy or thrombector	090	422	438	16	4%	19.48	21.24	1.76	9%	0				2			2	2		1	
34203	Embolectomy or thrombector	090	413	440	27	7%	17.86	19.88	2.02	11%	0			1	2			3	1		1	
34401	Thrombectomy, direct or with	090	503	526	23	5%	26.52	28.87	2.35	9%	0			2	1			4	2		1	
34421	Thrombectomy, direct or with	090	412	428	16	4%	13.37	15.26	1.89	14%	0			1	1			3	2		1	
34451	Thrombectomy, direct or with	090	533	556	23	4%	28.52	30.87	2.35	8%	0			2	1			4	2		1	
34471	Thrombectomy, direct or with	090	453	475	22	5%	21.11	23.02	1.91	9%	0			2	1			3	1		1	
34490	Thrombectomy, direct or with	090	367	387	20	5%	10.91	12.60	1.69	15%	0			1	1			3	1		1	
34501	Valvuloplasty, femoral vein	090	393	405	12	3%	16.85	18.28	1.43	8%	0			2	1			1	1		1	
34502	Reconstruction of vena cava,	090	741	796	55	7%	28.07	30.90	2.83	10%	-4				1	2		6			1	
34510	Venous valve transposition, a	090	448	465	17	4%	19.91	21.58	1.67	8%	0			2	1			2	1		1	
34520	Cross-over vein graft to venou	090	443	465	22	5%	19.18	20.96	1.78	9%	0			1	2			2	1		1	
34530	Saphenopopliteal vein anasto	090	436	460	24	6%	17.93	19.93	2.00	11%	0			2	2			2	1		1	
34701	Endovascular repair of infrare	090	482	484	2	0%	23.71	25.08	1.37	6%	0			1	1				1	1	1	
34702	Endovascular repair of infrare	090	677	686	9	1%	36.00	38.63	2.63	7%	-2			1	1	1		1	2	2	1	
34703	Endovascular repair of infrare	090	507	509	2	0%	26.52	27.89	1.37	5%	0			1	1				1	1	1	
34704	Endovascular repair of infrare	090	737	746	9	1%	45.00	47.63	2.63	6%	-2			1	1	1		1	2	2	1	
34705	Endovascular repair of infrare	090	512	514	2	0%	29.58	30.95	1.37	5%	0			1	1				1	1	1	
34706	Endovascular repair of infrare	090	735	744	9	1%	45.00	47.63	2.63	6%	-2			1	1	1		1	2	2	1	
34707	Endovascular repair of iliac ar	090	482	484	2	0%	22.28	23.65	1.37	6%	0			1	1				1	1	1	
34708	Endovascular repair of iliac ar	090	677	686	9	1%	36.50	39.13	2.63	7%	-2			1	1	1		1	2	2	1	
34710	Delayed placement of distal o	090	397	407	10	3%	15.00	16.21	1.21	8%	0			1	1			1	1		1	
34712	Transcatheter delivery of enh	090	307	317	10	3%	12.00	13.21	1.21	10%	0			1	1			1	1		1	
34718	Endovascular repair of iliac ar	090	477	479	2	0%	24.00	25.37	1.37	6%	0			1	1				1	1	1	
34830	Open repair of infrarenal aort	090	665	682	17	3%	35.23	38.25	3.02	9%	0			1	2			3	2	2	1	
34831	Open repair of infrarenal aort	090	690	707	17	2%	37.98	41.00	3.02	8%	0			1	2			3	2	2	1	
34832	Open repair of infrarenal aort	090	710	727	17	2%	37.98	41.00	3.02	8%	0			1	2			3	2	2	1	
35001	Direct repair of aneurysm, pse	090	568	617.5	49.5	9%	20.81	23.84	3.03	15%	0			3.5				8.5			1	
35002	Direct repair of aneurysm, pse	090	592	644	52	9%	22.23	25.38	3.15	14%	0			3.5				9			1	
35005	Direct repair of aneurysm, pse	090	551	600.5	49.5	9%	19.29	22.32	3.03	16%	0			3.5				8.5			1	
35011	Direct repair of aneurysm, pse	090	357	376	19	5%	18.58	19.83	1.25	7%	0			1	1			2			1	
35013	Direct repair of aneurysm, pse	090	433	455	22	5%	23.23	25.01	1.78	8%	0			1	2			2	1		1	
35021	Direct repair of aneurysm, pse	090	745	797.5	52.5	7%	22.17	25.22	3.05	14%	0			2.5				9.5			1	
35022	Direct repair of aneurysm, pse	090	764	816.5	52.5	7%	25.70	28.75	3.05	12%	0			2.5				9.5			1	
35045	Direct repair of aneurysm, pse	090	329	342	13	4%	18.01	18.91	0.90	5%	0			0.5	1			1			1	
35081	Direct repair of aneurysm, pse	090	677	693	16	2%	33.53	35.80	2.27	7%	-2			1	1	1		2	3		1	
35082	Direct repair of aneurysm, pse	090	792	810	18	2%	42.09	45.00	2.91	7%	-2			1	1	1		3	3	1	1	
35091	Direct repair of aneurysm, pse	090	790	845	55	7%	35.35	38.21	2.86	8%	0							11			1	
35092	Direct repair of aneurysm, pse	090	1172	1179	7	1%	50.97	54.44	3.47	7%	-2			1	1	1		2	3	3	1	
35102	Direct repair of aneurysm, pse	090	732	748	16	2%	36.53	38.80	2.27	6%	-2			1	1	1		2	3		1	
35103	Direct repair of aneurysm, pse	090	740	764	24	3%	43.62	46.28	2.66	6%	0			1	2			4	3		1	
35111	Direct repair of aneurysm, pse	090	483	496	13	3%	26.28	28.15	1.87	7%	0			2	1			2	2		1	
35112	Direct repair of aneurysm, pse	090	690	708	18	3%	32.57	34.55	1.98	6%	0			1	2			2	2		1	
35121	Direct repair of aneurysm, pse	090	563	586	23	4%	31.52	33.87	2.35	7%	0			2	1			4	2		1	
35122	Direct repair of aneurysm, pse	090	770	784	14	2%	37.89	40.07	2.18	6%	0			1	2			2	3		1	
35131	Direct repair of aneurysm, pse	090	528	546	18	3%	26.40	28.51	2.11	8%	0			2	1			3	2		1	
35132	Direct repair of aneurysm, pse	090	655	673	18	3%	32.57	34.55	1.98	6%	0			1	2			2	2		1	
35141	Direct repair of aneurysm, pse	090	427	442	15	4%	20.91	22.36	1.45	7%	0			1	1			2	1		1	
35142	Direct repair of aneurysm, pse	090	555	582	27	5%	25.16	27.18	2.02	8%	0			1	2			3	1		1	
35151	Direct repair of aneurysm, pse	090	473	495	22	5%	23.72	25.63	1.91	8%	0			2	1			3	1		1	
35152	Direct repair of aneurysm, pse	090	590	605	15	3%	27.66	30.04	2.38	9%	0			1	2			2	2	1	1	
35180	Repair, congenital arteriovend	090	500	541	41	8%	15.10	17.66	2.56	17%	0			3				7			1	
35182	Repair, congenital arteriovend	090	553	572	19	3%	31.71	33.89	2.18	7%	0			1	2			2	1	1	1	
35184	Repair, congenital arteriovend	090	413	424	11	3%	18.82	20.14	1.32	7%	0			1.5	1			1	1		1	
35188	Repair, acquired or traumatic	090	380	390	10	3%	18.00	19.21	1.21	7%	0			1	1			1	1		1	
35189	Repair, acquired or traumatic	090	548	560.5	12.5	2%	29.98	32.24	2.26	8%	0			1	2			1.5	2	1	1	
35190	Repair, acquired or traumatic	090	416	444.5	28.5	7%	13.42	15.38	1.96	15%	0			3				4.5			1	
35201	Repair blood vessel, direct; ne	090	382	415.5	33.5	9%	16.93	19.13	2.20	13%	0			3				5.5			1	
35206	Repair blood vessel, direct; up	090	282	301	19	7%	13.84	15.09	1.25	9%	0			1	1			2			1	
35207	Repair blood vessel, direct; ha	090	376	409.5	33.5	9%	10.94	13.14	2.20	20%	0			3				5.5			1	
35211	Repair blood vessel, direct; int	090	806	856	50	6%	24.58	27.51	2.93	12%	0			2.5				9			1	
35216	Repair blood vessel, direct; int	090	658	677	19	3%	36.61	38.90	2.29	6%	-4	1			1	1		3	3		1	
35221	Repair blood vessel, direct; int	090	545	553	8	1%	26.62	28.67	2.05	8%	0			1	1			2	2	1	1	
35226	Repair blood vessel, direct; lo	090	327	337	10	3%	15.30	16.51	1.21	8%	0			1	1			1	1		1	

35231	Repair blood vessel with vein	090	382	384	2	1%	21.16	22.53	1.37	6%	0			1	1				1	1	1	
35236	Repair blood vessel with vein	090	367	382	15	4%	18.02	19.47	1.45	8%	0			1	1			2	1		1	
35241	Repair blood vessel with vein	090	797	847	50	6%	25.58	28.51	2.93	11%	0			2.5				9			1	
35246	Repair blood vessel with vein	090	577	584	7	1%	28.23	29.84	1.61	6%	0			1	1			1	1	1	1	
35251	Repair blood vessel with vein	090	532	540	8	2%	31.91	33.96	2.05	6%	0			1	1			2	2	1	1	
35256	Repair blood vessel with vein	090	347	371	24	7%	19.06	20.55	1.49	8%	0			1	1			3			1	
35261	Repair blood vessel with graft	090	382	384	2	1%	18.96	20.33	1.37	7%	0			1	1				1	1	1	
35266	Repair blood vessel with graft	090	337	352	15	4%	15.83	17.28	1.45	9%	0			1	1			2	1		1	
35271	Repair blood vessel with graft	090	778	828	50	6%	24.58	27.51	2.93	12%	0			2.5				9			1	
35276	Repair blood vessel with graft	090	553.5	572	18.5	3%	25.83	27.45	1.62	6%	0			1	1.5			2	1		1	
35281	Repair blood vessel with graft	090	595	613	18	3%	30.06	32.04	1.98	7%	0			1	2			2	2		1	
35286	Repair blood vessel with graft	090	350	381	31	9%	17.19	19.01	1.82	11%	0			1	2			3			1	
35301	Thromboendarterectomy, inc	090	404	411	7	2%	21.16	22.64	1.48	7%	0				2				1	1	1	
35302	Thromboendarterectomy, inc	090	392	402	10	3%	21.35	22.56	1.21	6%	0			1	1			1	1		1	
35303	Thromboendarterectomy, inc	090	392	402	10	3%	23.60	24.81	1.21	5%	0			1	1			1	1		1	
35304	Thromboendarterectomy, inc	090	422	432	10	2%	24.60	25.81	1.21	5%	0			1	1			1	1		1	
35305	Thromboendarterectomy, inc	090	402	412	10	2%	23.60	24.81	1.21	5%	0			1	1			1	1		1	
35311	Thromboendarterectomy, inc	090	532	535	3	1%	28.60	30.41	1.81	6%	0			1	1			1	2	1	1	
35321	Thromboendarterectomy, inc	090	337	356	19	6%	16.59	17.84	1.25	8%	0			1	1			2			1	
35331	Thromboendarterectomy, inc	090	558	581	23	4%	27.72	30.07	2.35	8%	0			2	1			4	2		1	
35341	Thromboendarterectomy, inc	090	549	596	47	9%	26.21	29.12	2.91	11%	0			3.5				8			1	
35351	Thromboendarterectomy, inc	090	502	505	3	1%	24.61	26.42	1.81	7%	0			1	1			1	2	1	1	
35355	Thromboendarterectomy, inc	090	457	473	16	4%	19.86	21.75	1.89	10%	0			1	1			3	2		1	
35361	Thromboendarterectomy, inc	090	605	620	15	2%	30.24	32.62	2.38	8%	0			1	2			2	2	1	1	
35363	Thromboendarterectomy, inc	090	655	675	20	3%	32.35	34.97	2.62	8%	0			1	2			3	2	1	1	
35371	Thromboendarterectomy, inc	090	325	344	19	6%	15.31	16.56	1.25	8%	0			1	1			2			1	
35372	Thromboendarterectomy, inc	090	347	366	19	5%	18.58	19.83	1.25	7%	0			1	1			2			1	
35501	Bypass graft, with vein; comm	090	449	464	15	3%	29.09	30.41	1.32	5%	0				2			1	1		1	
35506	Bypass graft, with vein; caroti	090	452	464	12	3%	25.33	27.05	1.72	7%	0				2			1	1	1	1	
35508	Bypass graft, with vein; caroti	090	404	419	15	4%	26.09	27.41	1.32	5%	0				2			1	1		1	
35509	Bypass graft, with vein; caroti	090	439	454	15	3%	28.09	29.41	1.32	5%	0				2			1	1		1	
35510	Bypass graft, with vein; caroti	090	497	508	11	2%	24.39	25.91	1.52	6%	0				2			1	2		1	
35511	Bypass graft, with vein; subcla	090	407	408	1	0%	22.20	23.37	1.17	5%	0			1	1				2		1	
35512	Bypass graft, with vein; subcla	090	462	473	11	2%	23.89	25.41	1.52	6%	0				2			1	2		1	
35515	Bypass graft, with vein; subcla	090	414	429	15	4%	26.09	27.41	1.32	5%	0				2			1	1		1	
35516	Bypass graft, with vein; subcla	090	424	444	20	5%	24.21	25.77	1.56	6%	0				2			2	1		1	
35518	Bypass graft, with vein; axillar	090	457	459	2	0%	22.65	24.26	1.61	7%	0			1	1			1	3		1	
35521	Bypass graft, with vein; axillar	090	530	540	10	2%	24.13	26.27	2.14	9%	0			1	2			1	2	1	1	
35522	Bypass graft, with vein; axillar	090	497	508	11	2%	23.15	24.67	1.52	7%	0				2			1	2		1	
35523	Bypass graft, with vein; brach	090	485	498	13	3%	24.13	25.87	1.74	7%	0			1	2			1	2		1	
35525	Bypass graft, with vein; brach	090	415	430	15	4%	21.69	23.01	1.32	6%	0				2			1	1		1	
35526	Bypass graft, with vein; aortos	090	562	565	3	1%	31.55	33.36	1.81	6%	0			1	1			1	2	1	1	
35531	Bypass graft, with vein; aorto	090	740	747	7	1%	39.11	41.65	2.54	6%	0			1	2			1	2	2	1	
35533	Bypass graft, with vein; axillar	090	615	625	10	2%	29.92	32.06	2.14	7%	0			1	2			1	2	1	1	
35535	Bypass graft, with vein; hepat	090	690	705	15	2%	38.13	40.51	2.38	6%	0			1	2			2	2	1	1	
35536	Bypass graft, with vein; splen	090	550	565	15	3%	33.73	36.11	2.38	7%	0			1	2			2	2	1	1	
35537	Bypass graft, with vein; aortoi	090	683	696	13	2%	41.88	43.62	1.74	4%	0			1	2			1	2		1	
35538	Bypass graft, with vein; aortol	090	798	820	22	3%	47.03	49.19	2.16	5%	-2			1	2	1		1	2		1	
35539	Bypass graft, with vein; aortof	090	720	738	18	2%	44.11	46.09	1.98	4%	0			1	2			2	2		1	
35540	Bypass graft, with vein; aortof	090	780	798	18	2%	49.33	51.31	1.98	4%	0			1	2			2	2		1	
35556	Bypass graft, with vein; femor	090	586	605	19	3%	26.75	28.93	2.18	8%	0			1	2			2	1	1	1	
35558	Bypass graft, with vein; femor	090	530	540	10	2%	23.13	25.27	2.14	9%	0			1	2			1	2	1	1	
35560	Bypass graft, with vein; aortor	090	590	605	15	3%	34.03	36.41	2.38	7%	0			1	2			2	2	1	1	
35563	Bypass graft, with vein; ilioilia	090	535	545	10	2%	26.12	28.26	2.14	8%	0			1	2			1	2	1	1	
35565	Bypass graft, with vein; iliofer	090	535	545	10	2%	25.13	27.27	2.14	9%	0			1	2			1	2	1	1	
35566	Bypass graft, with vein; femor	090	718	747	29	4%	32.35	35.00	2.65	8%	0			1	2			3	2	1		1
35570	Bypass graft, with vein; tibial-	090	667	683	16	2%	29.15	31.84	2.69	9%	0				3			2	3	1	1	
35571	Bypass graft, with vein; poplit	090	510	542	32	6%	25.52	27.78	2.26	9%	0			1	2			4	1		1	
35583	In-situ vein bypass; femoral-p	090	588	607	19	3%	27.75	29.93	2.18	8%	0			1	2			2	1	1	1	
35585	In-situ vein bypass; femoral-a	090	717	746	29	4%	32.35	35.00	2.65	8%	0			1	2			3	2	1		1
35587	In-situ vein bypass; popliteal-t	090	523	555	32	6%	26.21	28.47	2.26	9%	0			1	2			4	1		1	
35601	Bypass graft, with other than	090	484	496	12	2%	27.09	28.81	1.72	6%	0				2			1	1	1	1	
35606	Bypass graft, with other than	090	414	421	7	2%	22.46	23.94	1.48	7%	0				2				1	1	1	
35612	Bypass graft, with other than	090	485	498	13	3%	20.35	22.09	1.74	9%	0			1	2			1	2		1	
35616	Bypass graft, with other than	090	367	377	10	3%	21.82	23.03	1.21	6%	0			1	1			1	1		1	
35621	Bypass graft, with other than	090	412	432	20	5%	21.03	22.72	1.69	8%	0			1	1			3	1		1	
35623	Bypass graft, with other than	090	475	485	10	2%	25.92	28.06	2.14	8%	0			1	2			1	2	1	1	

35626	Bypass graft, with other than	090	520	532	12	2%	29.14	30.99	1.85	6%	0			1	1			2	1	1	1	
35631	Bypass graft, with other than	090	648	663	15	2%	36.03	38.41	2.38	7%	0			1	2			2	2	1	1	
35632	Bypass graft, with other than	090	690	705	15	2%	36.13	38.51	2.38	7%	0			1	2			2	2	1	1	
35633	Bypass graft, with other than	090	705	723	18	3%	39.11	41.09	1.98	5%	0			1	2			2	2		1	
35634	Bypass graft, with other than	090	680	695	15	2%	35.33	37.71	2.38	7%	0			1	2			2	2	1	1	
35636	Bypass graft, with other than	090	603	609	6	1%	31.75	34.09	2.34	7%	0			1	2			1	3	1	1	
35637	Bypass graft, with other than	090	605	623	18	3%	33.05	35.03	1.98	6%	0			1	2			2	2		1	
35638	Bypass graft, with other than	090	635	653	18	3%	33.60	35.58	1.98	6%	0			1	2			2	2		1	
35642	Bypass graft, with other than	090	463	504	41	9%	18.94	21.50	2.56	14%	0			3				7			1	
35645	Bypass graft, with other than	090	463	504	41	9%	18.43	20.99	2.56	14%	0			3				7			1	
35646	Bypass graft, with other than	090	645	662	17	3%	32.98	35.58	2.60	8%	-2			2		1		3	2	1	1	
35647	Bypass graft, with other than	090	573	587	14	2%	29.73	32.04	2.31	8%	0			2	1			3	3		1	
35650	Bypass graft, with other than	090	382	384	2	1%	20.16	21.53	1.37	7%	0			1	1				1	1	1	
35654	Bypass graft, with other than	090	513	526	13	3%	26.28	28.15	1.87	7%	0			2	1			2	2		1	
35656	Bypass graft, with other than	090	447	481	34	8%	20.47	22.44	1.97	10%	0			1	1			5			1	
35661	Bypass graft, with other than	090	440	467	27	6%	20.35	22.37	2.02	10%	0			1	2			3	1		1	
35663	Bypass graft, with other than	090	503	513	10	2%	23.93	26.07	2.14	9%	0			1	2			1	2	1	1	
35665	Bypass graft, with other than	090	480	507	27	6%	22.35	24.37	2.02	9%	0			1	2			3	1		1	
35666	Bypass graft, with other than	090	490	522	32	7%	23.66	25.92	2.26	10%	0			1	2			4	1		1	
35671	Bypass graft, with other than	090	435	448	13	3%	20.77	22.51	1.74	8%	0			1	2			1	2		1	
35691	Transposition and/or reimplar	090	417	433	16	4%	18.41	19.77	1.36	7%	0			3				2			1	
35693	Transposition and/or reimplar	090	372	388	16	4%	15.73	17.09	1.36	9%	0			3				2			1	
35694	Transposition and/or reimplar	090	456	472	16	4%	19.28	20.64	1.36	7%	0			3				2			1	
35695	Transposition and/or reimplar	090	532	535	3	1%	20.06	21.58	1.52	8%	0			3				1	2		1	
35701	Exploration not followed by su	090	229	236	7	3%	7.50	8.18	0.68	9%	0			1				1			1	
35702	Exploration not followed by su	090	219	226	7	3%	7.12	7.80	0.68	10%	0			1				1			1	
35703	Exploration not followed by su	090	229	236	7	3%	7.50	8.18	0.68	9%	0			1				1			1	
35800	Exploration for postoperative	090	336	345	9	3%	12.00	13.83	1.83	15%	0			2	1			1	1	1	1	
35820	Exploration for postoperative	090	799	787	-12	-2%	36.89	40.57	3.68	10%	-2					1		1	2	6	1	
35840	Exploration for postoperative	090	431	433	2	0%	20.75	23.18	2.43	12%	0			2	1			1	2	2	1	
35860	Exploration for postoperative	090	406	411	5	1%	15.25	17.28	2.03	13%	0			2	1			1	2	1	1	
35870	Repair of graft-enteric fistula	090	715	759.5	44.5	6%	24.50	27.29	2.79	11%	0			3.5				7.5			1	
35875	Thrombectomy of arterial or v	090	297	316	19	6%	10.72	11.97	1.25	12%	0			1	1			2			1	
35876	Thrombectomy of arterial or v	090	402	431	29	7%	17.82	19.55	1.73	10%	0			1	1			4			1	
35879	Revision, lower extremity arte	090	421	448	27	6%	17.41	19.30	1.89	11%	-2				1	1		3	1		1	
35881	Revision, lower extremity arte	090	450	477	27	6%	19.35	21.37	2.02	10%	0			1	2			3	1		1	
35883	Revision, femoral anastomosi	090	462	468	6	1%	23.15	24.56	1.41	6%	0			1	1			1	2		1	
35884	Revision, femoral anastomosi	090	482	488	6	1%	24.65	26.06	1.41	6%	0			1	1			1	2		1	
35901	Excision of infected graft; nec	090	482	510	28	6%	8.38	10.44	2.06	25%	0			4				4			1	
35903	Excision of infected graft; extr	090	416	437	21	5%	9.53	11.13	1.60	17%	0			3				3			1	
35905	Excision of infected graft; thor	090	720	745	25	3%	33.52	36.38	2.86	9%	0			1	2			4	2	1	1	
35907	Excision of infected graft; abd	090	720	745	25	3%	37.27	40.13	2.86	8%	0			1	2			4	2	1	1	
36260	Insertion of implantable intra-	090	287	295.5	8.5	3%	9.91	10.91	1.00	10%	0			3				0.5			1	
36261	Revision of implanted intra-ar	090	233	240.5	7.5	3%	5.63	6.52	0.89	16%	0			2.5				0.5			1	
36262	Removal of implanted intra-ar	090	181	185	4	2%	4.11	4.77	0.66	16%	0			2							1	
36557	Insertion of tunneled centrally	010	117	119	2	2%	4.89	5.22	0.33	7%	0			1							0.5	
36558	Insertion of tunneled centrally	010	111	113	2	2%	4.59	4.92	0.33	7%	0			1							0.5	
36560	Insertion of tunneled centrally	010	134	136	2	1%	6.04	6.37	0.33	5%	0			1							0.5	
36561	Insertion of tunneled centrally	010	120	122	2	2%	5.79	6.12	0.33	6%	0			1							0.5	
36563	Insertion of tunneled centrally	010	140	142	2	1%	5.99	6.32	0.33	6%	0			1							0.5	
36565	Insertion of tunneled centrally	010	120	122	2	2%	5.79	6.12	0.33	6%	0			1							0.5	
36566	Insertion of tunneled centrally	010	135	137	2	1%	6.29	6.62	0.33	5%	0			1							0.5	
36570	Insertion of peripherally inser	010	135	137	2	1%	5.11	5.44	0.33	6%	0			1							0.5	
36571	Insertion of peripherally inser	010	130	132	2	2%	5.09	5.42	0.33	6%	0			1							0.5	
36576	Repair of central venous acce	010	114	116	2	2%	2.99	3.32	0.33	11%	0			1							0.5	
36578	Replacement, catheter only, c	010	106	108	2	2%	3.29	3.62	0.33	10%	0			1							0.5	
36581	Replacement, complete, of a t	010	110	112	2	2%	3.23	3.56	0.33	10%	0			1							0.5	
36582	Replacement, complete, of a t	010	146	148	2	1%	4.99	5.32	0.33	7%	0			1							0.5	
36583	Replacement, complete, of a t	010	147	149	2	1%	5.04	5.37	0.33	7%	0			1							0.5	
36585	Replacement, complete, of a p	010	131	133	2	2%	4.59	4.92	0.33	7%	0			1							0.5	
36589	Removal of tunneled central v	010	79	79	0	0%	2.28	2.39	0.11	5%	-2		1								0.5	
36590	Removal of tunneled central v	010	105	107	2	2%	3.10	3.43	0.33	11%	0			1							0.5	
36818	Arteriovenous anastomosis, o	090	248	257	9	4%	12.39	13.05	0.66	5%	0			1	1						0.5	
36819	Arteriovenous anastomosis, o	090	283	292	9	3%	13.29	13.95	0.66	5%	0			1	1						0.5	
36820	Arteriovenous anastomosis, o	090	258	267	9	3%	13.07	13.73	0.66	5%	0			1	1						0.5	
36821	Arteriovenous anastomosis, o	090	233	242	9	4%	11.90	12.56	0.66	6%	0			1	1						0.5	
36823	Insertion of arterial and venou	090	606	618	12	2%	22.98	25.34	2.36	10%	0			2	2			1	2	1	1	

36825	Creation of arteriovenous fist	090	306	322	16	5%	14.17	15.16	0.99	7%	0			1	2						0.5	
36830	Creation of arteriovenous fist	090	248	257	9	4%	12.03	12.69	0.66	5%	0			1	1						0.5	
36831	Thrombectomy, open, arterio	090	248	257	9	4%	11.00	11.66	0.66	6%	0			1	1						0.5	
36832	Revision, open, arteriovenous	090	276	292	16	6%	13.50	14.49	0.99	7%	0			1	2						0.5	
36833	Revision, open, arteriovenous	090	306	322	16	5%	14.50	15.49	0.99	7%	0			1	2						0.5	
36835	Insertion of Thomas shunt (se	090	242	257	15	6%	7.51	8.76	1.25	17%	0			2.5				2			1	
36838	Distal revascularization and in	090	424	439	15	4%	21.69	23.01	1.32	6%	0				2			1	1		1	
37140	Venous anastomosis, open; pe	090	845	866	21	2%	40.00	42.93	2.93	7%	0				3			3	3	1	1	
37145	Venous anastomosis, open; re	090	798	823	25	3%	37.00	39.73	2.73	7%	0				3			3	2	1	1	
37160	Venous anastomosis, open; ca	090	785	810	25	3%	38.00	40.73	2.73	7%	0				3			3	2	1	1	
37180	Venous anastomosis, open; sp	090	805	830	25	3%	36.50	39.23	2.73	7%	0				3			3	2	1	1	
37181	Venous anastomosis, open; sp	090	785	801	16	2%	40.00	42.69	2.69	7%	0				3			2	3	1	1	
37215	Transcatheter placement of in	090	337	347	10	3%	17.75	18.83	1.08	6%	0				2				1		1	
37216	Transcatheter placement of in	090	341	351	10	3%	17.98	19.06	1.08	6%	0				2				1		1	
37217	Transcatheter placement of in	090	403	410	7	2%	20.38	21.86	1.48	7%	0				2				1	1	1	
37218	Transcatheter placement of in	090	255	274	19	7%	14.75	15.87	1.12	8%	0				2			1			1	
37500	Vascular endoscopy, surgical,	090	261	277	16	6%	11.67	12.66	0.99	8%	0			1	2						0.5	
37565	Ligation, internal jugular vein	090	312	314	2	1%	12.05	13.42	1.37	11%	0			1	1				1	1	1	
37600	Ligation; external carotid arte	090	322	324	2	1%	12.42	13.79	1.37	11%	0			1	1				1	1	1	
37605	Ligation; internal or common	090	342	344	2	1%	14.28	15.65	1.37	10%	0			1	1				1	1	1	
37606	Ligation; internal or common	090	606	637	31	5%	8.81	10.89	2.08	24%	0			3				5			1	
37607	Ligation or banding of angioac	090	242	246	4	2%	6.25	6.69	0.44	7%	0			2								
37609	Ligation or biopsy, temporal a	010	130	132	2	2%	3.05	3.38	0.33	11%	0			1							0.5	
37615	Ligation, major artery (eg, pos	090	489	511.5	22.5	5%	7.80	9.41	1.61	21%	0			2.5				3.5			1	
37616	Ligation, major artery (eg, pos	090	656	696	40	6%	18.97	21.42	2.45	13%	0			2.5				7			1	
37617	Ligation, major artery (eg, pos	090	475	483	8	2%	23.79	25.84	2.05	9%	0			1	1			2	2	1	1	
37618	Ligation, major artery (eg, pos	090	359	376.5	17.5	5%	6.03	7.40	1.37	23%	0			2.5				2.5			1	
37619	Ligation of inferior vena cava	090	683	698	15	2%	30.00	32.38	2.38	8%	0			1	2			2	2	1	1	
37650	Ligation of femoral vein	090	262	267	5	2%	8.49	9.46	0.97	11%	0			1	1				1		1	
37660	Ligation of common iliac vein	090	397	404	7	2%	22.28	23.89	1.61	7%	0			1	1			1	1	1	1	
37700	Ligation and division of long s	090	152	156	4	3%	3.82	4.37	0.55	14%	0			2							0.5	
37718	Ligation, division, and strippin	090	178	187	9	5%	7.13	7.79	0.66	9%	0			1	1						0.5	
37722	Ligation, division, and strippin	090	198	207	9	5%	8.16	8.82	0.66	8%	0			1	1						0.5	
37735	Ligation and division and com	090	365	381	16	4%	10.90	12.26	1.36	12%	0			3				2			1	
37760	Ligation of perforator veins, s	090	335	348.5	13.5	4%	10.78	12.02	1.24	12%	0			3				1.5			1	
37761	Ligation of perforator vein(s),	090	224	240	16	7%	9.13	10.12	0.99	11%	0			1	2						0.5	
37765	Stab phlebectomy of varicose	010	117	124	7	6%	4.80	5.13	0.33	7%	0				1							
37766	Stab phlebectomy of varicose	010	133	140	7	5%	6.00	6.33	0.33	5%	0				1							
37780	Ligation and division of short s	090	179	183	4	2%	3.93	4.59	0.66	17%	0			2							1	
37785	Ligation, division, and/or excis	090	177	181	4	2%	3.93	4.48	0.55	14%	0			2							0.5	
37788	Penile revascularization, arter	090	627	624	-3	0%	23.33	25.23	1.90	8%	0			4					2	1	1	
37790	Penile venous occlusive proce	090	257	261	4	2%	8.43	8.87	0.44	5%	0			2								
38100	Splenectomy; total (separate	090	442	459	17	4%	19.55	21.64	2.09	11%	0			1	1			3	1	1	1	
38101	Splenectomy; partial (separat	090	442	459	17	4%	19.55	21.64	2.09	11%	0			1	1			3	1	1	1	
38115	Repair of ruptured spleen (spl	090	492	505	13	3%	21.88	24.17	2.29	10%	0			1	1			3	2	1	1	
38120	Laparoscopy, surgical, splened	090	434	468	34	8%	17.07	18.91	1.84	11%	0				2			4			1	
38300	Drainage of lymph node absce	010	134	143	9	7%	2.36	2.91	0.55	23%	0			1	1							
38305	Drainage of lymph node absce	090	186	202	16	9%	6.68	7.67	0.99	15%	0			1	2						0.5	
38308	Lymphangiotomy or other ope	090	178	187	9	5%	6.81	7.47	0.66	10%	0			1	1						0.5	
38380	Suture and/or ligation of thor	090	350	370.5	20.5	6%	8.46	10.16	1.70	20%	0			4				2.5			1	
38381	Suture and/or ligation of thor	090	348	369.5	21.5	6%	13.38	14.88	1.50	11%	0			2				3.5			1	
38382	Suture and/or ligation of thor	090	335	359	24	7%	10.65	12.58	1.93	18%	0			4.5				3			1	
38500	Biopsy or excision of lymph no	010	115	117	2	2%	3.79	4.12	0.33	9%	0			1							0.5	
38510	Biopsy or excision of lymph no	010	152	159	7	5%	6.74	7.18	0.44	7%	0				1						0.5	
38520	Biopsy or excision of lymph no	090	193	202	9	5%	7.03	7.69	0.66	9%	0			1	1						0.5	
38525	Biopsy or excision of lymph no	090	178	187	9	5%	6.43	7.09	0.66	10%	0			1	1						0.5	
38530	Biopsy or excision of lymph no	090	205.5	214.5	9	4%	8.34	9.00	0.66	8%	0			1	1						0.5	
38531	Biopsy or excision of lymph no	090	223	237	14	6%	6.74	7.51	0.77	11%	0				2						0.5	
38542	Dissection, deep jugular node	090	198	212	14	7%	7.95	8.72	0.77	10%	0				2						0.5	
38550	Excision of cystic hygroma, ax	090	211	219	8	4%	7.11	8.10	0.99	14%	0			4							0.5	
38555	Excision of cystic hygroma, ax	090	536	564.5	28.5	5%	15.59	17.86	2.27	15%	0			5.5				3.5			1	
38562	Limited lymphadenectomy for	090	326	350	24	7%	11.06	12.99	1.93	17%	0			4.5				3			1	
38564	Limited lymphadenectomy for	090	349	372.5	23.5	7%	11.38	13.10	1.72	15%	0			3				3.5			1	
38570	Laparoscopy, surgical; with re	010	220	229	9	4%	8.49	9.26	0.77	9%	0			1	1						1	
38571	Laparoscopy, surgical; with bil	010	250	259	9	4%	12.00	12.77	0.77	6%	0			1	1						1	
38572	Laparoscopy, surgical; with bil	010	321	337	16	5%	15.60	16.57	0.97	6%	-2				1	1					1	
38573	Laparoscopy, surgical; with bil	010	360	376	16	4%	20.00	20.86	0.86	4%	-2				1	1					0.5	

38700	Suprahyoid lymphadenectom	090	300	321	21	7%	12.81	14.15	1.34	10%	0			1	2			1			1	
38720	Cervical lymphadenectomy (c	090	482	518	36	7%	21.95	24.26	2.31	11%	-2				3	1		2	1		1	
38724	Cervical lymphadenectomy (r	090	512	548	36	7%	23.95	26.26	2.31	10%	-2				3	1		2	1		1	
38740	Axillary lymphadenectomy; su	090	231	247	16	7%	10.70	11.69	0.99	9%	0			1	2						0.5	
38745	Axillary lymphadenectomy; co	090	270.5	288.5	18	7%	13.87	14.95	1.08	8%	-2			1	1	1					0.5	
38760	Inguinofemoral lymphadenect	090	241	257	16	7%	13.62	14.61	0.99	7%	0			1	2						0.5	
38765	Inguinofemoral lymphadenect	090	465	475	10	2%	21.91	24.05	2.14	10%	0			1	2			1	2	1	1	
38770	Pelvic lymphadenectomy, incl	090	403	438	35	9%	14.06	16.27	2.21	16%	0			2.5				6			1	
38780	Retroperitoneal transabdomir	090	551	597.5	46.5	8%	17.70	20.71	3.01	17%	0			4.5				7.5			1	
38794	Cannulation, thoracic duct	090	207	214	7	3%	4.62	5.61	0.99	21%	0			3.5							1	
39000	Mediastinotomy with explora	090	381.5	412	30.5	8%	7.57	9.25	1.68	22%	0				1.5			4			1	
39010	Mediastinotomy with explora	090	423.5	451.5	28	7%	13.19	14.75	1.56	12%	0				1.5			3.5			1	
39200	Resection of mediastinal cyst	090	459	493.5	34.5	8%	15.09	16.96	1.87	12%	0				1			5.5			1	
39220	Resection of mediastinal tum	090	436	442	6	1%	19.55	20.96	1.41	7%	0			1	1			1	2		1	
39401	Mediastinoscopy; includes bio	000	142	142	0	0%	5.44	5.55	0.11	2%	0										0.5	
39402	Mediastinoscopy; with lymph	000	157	157	0	0%	7.25	7.36	0.11	2%	0										0.5	
39501	Repair, laceration of diaphrag	090	378	411.5	33.5	9%	13.98	16.18	2.20	16%	0			3				5.5			1	
39503	Repair, neonatal diaphragmat	090	2138	2139	1	0%	108.91	113.68	4.77	4%	-2			2	2	1			5	5		1
39540	Repair, diaphragmatic hernia	090	490	521.5	31.5	6%	14.57	16.55	1.98	14%	0			2				5.5			1	
39541	Repair, diaphragmatic hernia	090	522	557	35	7%	15.75	17.96	2.21	14%	0			2.5				6			1	
39545	Imbrication of diaphragm for	090	466	499.5	33.5	7%	14.67	16.87	2.20	15%	0			3				5.5			1	
39560	Resection, diaphragm; with si	090	323	350	27	8%	13.06	15.12	2.06	16%	0			3				5	1			
39561	Resection, diaphragm; with co	090	505	549	44	9%	19.99	22.85	2.86	14%	-6					3		5	2			
40500	Vermilionectomy (lip shave), v	090	206	214	8	4%	4.47	5.35	0.88	20%	0			4								
40510	Excision of lip; transverse wed	090	153	158	5	3%	4.82	5.37	0.55	11%	0			2.5								
40520	Excision of lip; V-excision with	090	151	156	5	3%	4.79	5.34	0.55	11%	0			2.5								
40525	Excision of lip; full thickness, r	090	270	277	7	3%	7.72	8.60	0.88	11%	0			3.5							0.5	
40527	Excision of lip; full thickness, r	090	316	324	8	3%	9.32	10.42	1.10	12%	0			4							1	
40530	Resection of lip, more than or	090	191	197	6	3%	5.54	6.31	0.77	14%	0			3							0.5	
40650	Repair lip, full thickness; verm	090	126	132	6	5%	3.78	4.44	0.66	17%	0			3								
40652	Repair lip, full thickness; up to	090	154	161	7	5%	4.43	5.20	0.77	17%	0			3.5								
40654	Repair lip, full thickness; over	090	183	190	7	4%	5.48	6.25	0.77	14%	0			3.5								
40700	Plastic repair of cleft lip/nasal	090	337	370	33	10%	14.17	15.95	1.78	13%	0				4			1			1	
40701	Plastic repair of cleft lip/nasal	090	380	413	33	9%	17.23	19.01	1.78	10%	0				4			1			1	
40702	Plastic repair of cleft lip/nasal	090	348.5	378	29.5	8%	14.27	15.89	1.62	11%	0				3.5			1			1	
40720	Plastic repair of cleft lip/nasal	090	357.5	384.5	27	8%	14.72	16.22	1.50	10%	0				3.5			0.5			1	
40761	Plastic repair of cleft lip/nasal	090	387	415.5	28.5	7%	15.84	17.41	1.57	10%	0				3			1.5			1	
40800	Drainage of abscess, cyst, her	010	63	65	2	3%	1.23	1.45	0.22	18%	-2		1	1								
40801	Drainage of abscess, cyst, her	010	87	91	4	5%	2.63	3.07	0.44	17%	0			2								
40804	Removal of embedded foreign	010	78	80	2	3%	1.30	1.52	0.22	17%	-2		1	1								
40805	Removal of embedded foreign	010	97	101	4	4%	2.79	3.23	0.44	16%	0			2								
40808	Biopsy, vestibule of mouth	010	46	48	2	4%	1.05	1.27	0.22	21%	0			1								
40810	Excision of lesion of mucosa a	010	56	58	2	4%	1.36	1.58	0.22	16%	0			1								
40812	Excision of lesion of mucosa a	010	68	70	2	3%	2.37	2.59	0.22	9%	-2		1	1								
40814	Excision of lesion of mucosa a	090	96	100	4	4%	3.52	3.96	0.44	13%	-2		1	2								
40816	Excision of lesion of mucosa a	090	114	118	4	4%	3.77	4.21	0.44	12%	-2		1	2								
40818	Excision of mucosa of vestibul	090	123	134	11	9%	2.83	3.60	0.77	27%	0			2	1							
40819	Excision of frenum, labial or b	090	77	81	4	5%	2.51	2.95	0.44	18%	0			2								
40820	Destruction of lesion or scar o	010	68	70	2	3%	1.34	1.56	0.22	16%	-2		1	1								
40830	Closure of laceration, vestibul	010	68	70	2	3%	1.82	2.04	0.22	12%	-2		1	1								
40831	Closure of laceration, vestibul	010	99	103	4	4%	2.57	3.01	0.44	17%	-2		1	2								
40840	Vestibuloplasty; anterior	090	272	283	11	4%	9.15	9.92	0.77	8%	-2		1	2	1							
40842	Vestibuloplasty; posterior, un	090	250	261	11	4%	9.15	9.92	0.77	8%	-2		1	2	1							
40843	Vestibuloplasty; posterior, bil	090	370	392	22	6%	12.79	13.81	1.02	8%	-3		1		1		1					
40844	Vestibuloplasty; entire arch	090	417	443	26	6%	16.80	18.26	1.46	9%	-3		1	2	1		1					
40845	Vestibuloplasty; complex (incl	090	397	423	26	7%	19.36	20.82	1.46	8%	-3		1	2	1		1					
41000	Intraoral incision and drainage	010	51	53	2	4%	1.35	1.57	0.22	16%	0			1								
41005	Intraoral incision and drainage	010	53	55	2	4%	1.31	1.53	0.22	17%	0			1								
41006	Intraoral incision and drainage	090	104	108	4	4%	3.34	3.89	0.55	16%	0			2							0.5	
41007	Intraoral incision and drainage	090	106	110	4	4%	3.20	3.75	0.55	17%	0			2							0.5	
41008	Intraoral incision and drainage	090	109	113	4	4%	3.46	4.01	0.55	16%	0			2							0.5	
41009	Intraoral incision and drainage	090	119	124	5	4%	3.71	4.37	0.66	18%	0			2.5							0.5	
41010	Incision of lingual frenum (fre	010	40	42	2	5%	1.11	1.33	0.22	20%	0			1								
41015	Extraoral incision and drainag	090	131	136	5	4%	4.08	4.74	0.66	16%	0			2.5							0.5	
41016	Extraoral incision and drainag	090	169	174	5	3%	4.19	4.96	0.77	18%	0			2.5							1	
41017	Extraoral incision and drainag	090	176	181	5	3%	4.19	4.96	0.77	18%	0			2.5							1	
41018	Extraoral incision and drainag	090	179	184	5	3%	5.22	5.99	0.77	15%	0			2.5							1	

41100	Biopsy of tongue; anterior tw	010	66	68	2	3%	1.42	1.64	0.22	15%	0			1								
41105	Biopsy of tongue; posterior or	010	51	53	2	4%	1.47	1.69	0.22	15%	0			1								
41108	Biopsy of floor of mouth	010	42	44	2	5%	1.10	1.32	0.22	20%	0			1								
41110	Excision of lesion of tongue w	010	56	58	2	4%	1.56	1.78	0.22	14%	0			1								
41112	Excision of lesion of tongue w	090	93	97	4	4%	2.83	3.27	0.44	16%	0			2								
41113	Excision of lesion of tongue w	090	104	108	4	4%	3.29	3.73	0.44	13%	0			2								
41114	Excision of lesion of tongue w	090	275	289.5	14.5	5%	8.82	10.17	1.35	15%	0			3.5				1.5			1	
41115	Excision of lingual frenum (fre	010	48	50	2	4%	1.79	2.01	0.22	12%	0			1								
41116	Excision, lesion of floor of mo	090	74	77	3	4%	2.52	2.85	0.33	13%	0			1.5								
41120	Glossectomy; less than one-ha	090	278	308	30	11%	11.14	12.66	1.52	14%	-2				3	1					0.5	
41130	Glossectomy; hemiglossectom	090	407	452	45	11%	15.74	18.09	2.35	15%	-2				3	1		3			1	
41135	Glossectomy; partial, with uni	090	696	734	38	5%	30.14	33.60	3.46	11%	-2			1	4	1		2	2	1	1	
41140	Glossectomy; complete or tot	090	728	769	41	6%	29.15	33.14	3.99	14%	-4			1	3	2		3	3	1	1	
41145	Glossectomy; complete or tot	090	913	964	51	6%	37.93	42.40	4.47	12%	-4			1	3	2		5	3	1	1	
41150	Glossectomy; composite proc	090	713	758	45	6%	29.86	33.65	3.79	13%	-4			1	3	2		3	2	1	1	
41153	Glossectomy; composite proc	090	826	865	39	5%	33.59	37.49	3.90	12%	-2			1	4	1		3	3	1	1	
41155	Glossectomy; composite proc	090	968	1011	43	4%	44.30	48.93	4.63	10%	-4			1	3	2		4	3	2	1	
41250	Repair of laceration 2.5 cm or	010	69	71	2	3%	1.96	2.18	0.22	11%	0			1								
41251	Repair of laceration 2.5 cm or	010	80	82	2	2%	2.32	2.54	0.22	9%	0			1								
41252	Repair of laceration of tongue	010	91	93	2	2%	3.02	3.24	0.22	7%	0			1								
41510	Suture of tongue to lip for mic	090	97	101	4	4%	3.51	3.95	0.44	13%	0			2								
41512	Tongue base suspension, perr	090	209	220	11	5%	6.86	7.74	0.88	13%	0			2	1						0.5	
41520	Frenoplasty (surgical revision	090	90	94	4	4%	2.83	3.27	0.44	16%	0			2								
41800	Drainage of abscess, cyst, her	010	59	63	4	7%	1.27	1.71	0.44	35%	0			2								
41805	Removal of embedded foreign	010	55	59	4	7%	1.34	1.78	0.44	33%	0			2								
41806	Removal of embedded foreign	010	80	84	4	5%	2.79	3.23	0.44	16%	0			2								
41822	Excision of fibrous tuberositie	010	107	111	4	4%	2.41	2.85	0.44	18%	0			2								
41823	Excision of osseous tuberositi	090	138	151	13	9%	3.77	4.76	0.99	26%	0			3	1							
41825	Excision of lesion or tumor (ex	010	57	61	4	7%	1.41	1.85	0.44	31%	0			2								
41826	Excision of lesion or tumor (ex	010	73	77	4	5%	2.41	2.85	0.44	18%	0			2								
41827	Excision of lesion or tumor (ex	090	141	152	11	8%	3.83	4.60	0.77	20%	0			2	1							
41828	Excision of hyperplastic alveol	010	129	131	2	2%	3.14	3.36	0.22	7%	0			1								
41830	Alveolectomy, including curet	010	154	158	4	3%	3.45	3.89	0.44	13%	-2		1	2								
41872	Gingivoplasty, each quadrant	090	122	133	11	9%	3.01	3.78	0.77	26%	0			2	1							
41874	Alveoloplasty, each quadrant	090	152	156	4	3%	3.19	3.63	0.44	14%	0			2								
42000	Drainage of abscess of palate,	010	49	51	2	4%	1.28	1.50	0.22	17%	0			1								
42100	Biopsy of palate, uvula	010	42	44	2	5%	1.36	1.58	0.22	16%	0			1								
42104	Excision, lesion of palate, uvul	010	52	54	2	4%	1.69	1.91	0.22	13%	0			1								
42106	Excision, lesion of palate, uvul	010	68	70	2	3%	2.15	2.37	0.22	10%	0			1								
42107	Excision, lesion of palate, uvul	090	160	165	5	3%	4.56	5.22	0.66	14%	0			2.5							0.5	
42120	Resection of palate or extensi	090	306	329	23	8%	11.86	13.42	1.56	13%	0			2	2			1			1	
42140	Uvulectomy, excision of uvula	090	84	87	3	4%	1.70	2.03	0.33	19%	0			1.5								
42145	Palatopharyngoplasty (eg, uvu	090	262	283	21	8%	9.78	10.99	1.21	12%	0				3						1	
42160	Destruction of lesion, palate c	010	54	56	2	4%	1.85	2.07	0.22	12%	0			1								
42180	Repair, laceration of palate; u	010	65	67	2	3%	2.55	2.77	0.22	9%	0			1								
42182	Repair, laceration of palate; o	010	90	92	2	2%	3.87	4.09	0.22	6%	0			1								
42200	Palatoplasty for cleft palate, s	090	330	346	16	5%	12.53	13.76	1.23	10%	-2		1	2	1			1			1	
42205	Palatoplasty for cleft palate, v	090	288	304	16	6%	13.66	15.02	1.36	10%	0			3				2			1	
42210	Palatoplasty for cleft palate, v	090	390	406	16	4%	15.03	16.26	1.23	8%	-2		1	2	1			1			1	
42215	Palatoplasty for cleft palate; r	090	265	272	7	3%	8.99	9.98	0.99	11%	0			3.5							1	
42220	Palatoplasty for cleft palate; s	090	260	266	6	2%	7.16	8.04	0.88	12%	0			3							1	
42225	Palatoplasty for cleft palate; a	090	287	296.5	9.5	3%	9.77	10.88	1.11	11%	0			3.5				0.5			1	
42226	Lengthening of palate, and ph	090	316	330.5	14.5	5%	10.35	11.70	1.35	13%	0			3.5				1.5			1	
42227	Lengthening of palate, with is	090	291	307	16	5%	9.90	11.26	1.36	14%	0			3				2			1	
42235	Repair of anterior palate, inclu	090	248	254	6	2%	8.01	8.89	0.88	11%	0			3							1	
42260	Repair of nasolabial fistula	090	280	291	11	4%	10.22	11.21	0.99	10%	-2		1	2	1						1	
42280	Maxillary impression for palat	010	53	55	2	4%	1.59	1.81	0.22	14%	0			1								
42281	Insertion of pin-retained palat	010	83	85	2	2%	1.98	2.31	0.33	17%	0			1							0.5	
42300	Drainage of abscess; parotid,	010	66	68	2	3%	1.98	2.20	0.22	11%	0			1								
42305	Drainage of abscess; parotid,	090	203	213	10	5%	6.31	7.32	1.01	16%	0			2.5				1			1	
42310	Drainage of abscess; submaxil	010	57	59	2	4%	1.61	1.83	0.22	14%	0			1								
42320	Drainage of abscess; submaxil	010	77	79	2	3%	2.40	2.62	0.22	9%	0			1								
42330	Sialolithotomy; submandibula	010	63	65	2	3%	2.26	2.48	0.22	10%	0			1								
42335	Sialolithotomy; submandibula	090	98	102	4	4%	3.41	3.85	0.44	13%	0			2								
42340	Sialolithotomy; parotid, extrac	090	136	141	5	4%	4.72	5.27	0.55	12%	0			2.5								
42405	Biopsy of salivary gland; incisi	010	95	97	2	2%	3.34	3.56	0.22	7%	0			1								
42408	Excision of sublingual salivary	090	134	139	5	4%	4.66	5.21	0.55	12%	0			2.5								

42409	Marsupialization of sublingual	090	87	91	4	5%	2.91	3.35	0.44	15%	0			2								
42410	Excision of parotid tumor or p	090	285	294.5	9.5	3%	9.57	10.68	1.11	12%	0			3.5				0.5			1	
42415	Excision of parotid tumor or p	090	333	349	16	5%	17.16	18.15	0.99	6%	0			1	2						0.5	
42420	Excision of parotid tumor or p	090	383	399	16	4%	19.53	20.52	0.99	5%	0			1	2						0.5	
42425	Excision of parotid tumor or p	090	348	365	17	5%	13.42	14.89	1.47	11%	0			3.5				2			1	
42426	Excision of parotid tumor or p	090	654	692	38	6%	22.66	25.20	2.54	11%	0			4				6			1	
42440	Excision of submandibular (su	090	198	207	9	5%	6.14	6.80	0.66	11%	0			1	1						0.5	
42450	Excision of sublingual gland	090	155	160	5	3%	4.74	5.40	0.66	14%	0			2.5							0.5	
42500	Plastic repair of salivary duct,	090	148	153	5	3%	4.42	5.08	0.66	15%	0			2.5							0.5	
42505	Plastic repair of salivary duct,	090	207	213	6	3%	6.32	7.09	0.77	12%	0			3							0.5	
42507	Parotid duct diversion, bilater	090	191	197	6	3%	6.25	6.91	0.66	11%	0			3								
42509	Parotid duct diversion, bilater	090	349	358.5	9.5	3%	11.76	12.87	1.11	9%	0			3.5				0.5			1	
42510	Parotid duct diversion, bilater	090	270	278.5	8.5	3%	8.35	9.35	1.00	12%	0			3				0.5			1	
42600	Closure salivary fistula	090	163	168	5	3%	4.94	5.60	0.66	13%	0			2.5							0.5	
42665	Ligation salivary duct, intraora	090	92	96	4	4%	2.63	3.07	0.44	17%	0			2								
42700	Incision and drainage abscess	010	53	55	2	4%	1.67	1.89	0.22	13%	0			1								
42720	Incision and drainage abscess	010	278	280	2	1%	6.31	7.41	1.10	17%	0							2	2		1	
42725	Incision and drainage abscess	090	390	413	23	6%	12.41	14.63	2.22	18%	0			1	2			3	2		1	
42800	Biopsy; oropharynx	010	45	47	2	4%	1.44	1.66	0.22	15%	0			1								
42804	Biopsy; nasopharynx, visible le	010	49	51	2	4%	1.29	1.51	0.22	17%	0			1								
42806	Biopsy; nasopharynx, survey fl	010	74	76	2	3%	1.63	1.85	0.22	13%	0			1								
42808	Excision or destruction of lesio	010	87	89	2	2%	2.35	2.57	0.22	9%	0			1								
42809	Removal of foreign body from	010	72	74	2	3%	1.86	2.08	0.22	12%	0			1								
42810	Excision branchial cleft cyst or	090	126	131	5	4%	3.38	3.93	0.55	16%	0			2.5								
42815	Excision branchial cleft cyst, v	090	240	250	10	4%	7.31	8.32	1.01	14%	0			2.5				1			1	
42820	Tonsillectomy and adenoidect	090	151	158	7	5%	4.22	4.77	0.55	13%	0				1						1	
42821	Tonsillectomy and adenoidect	090	141	144	3	2%	4.36	4.80	0.44	10%	0			1.5							0.5	
42825	Tonsillectomy, primary or sec	090	130	134	4	3%	3.51	4.06	0.55	16%	0			2							0.5	
42826	Tonsillectomy, primary or sec	090	124	127	3	2%	3.45	3.89	0.44	13%	0			1.5							0.5	
42830	Adenoidectomy, primary; you	090	103	106	3	3%	2.65	2.98	0.33	12%	0			1.5								
42831	Adenoidectomy, primary; age	090	93	97	4	4%	2.81	3.25	0.44	16%	0			2								
42835	Adenoidectomy, secondary; y	090	81	84	3	4%	2.38	2.71	0.33	14%	0			1.5								
42836	Adenoidectomy, secondary; a	090	84	87	3	4%	3.26	3.59	0.33	10%	0			1.5								
42842	Radical resection of tonsil, ton	090	330	360	30	9%	12.23	13.99	1.76	14%	-2			1	2	1		1			1	
42844	Radical resection of tonsil, ton	090	445	476	31	7%	17.78	19.98	2.20	12%	-2			1	2	1		2	1		1	
42845	Radical resection of tonsil, ton	090	825	852	27	3%	32.56	36.44	3.88	12%	-2			1	2	1		4	3	2	1	
42860	Excision of tonsil tags	090	76	79	3	4%	2.30	2.63	0.33	14%	0			1.5								
42870	Excision or destruction lingual	090	167	172	5	3%	5.52	6.18	0.66	12%	0			2.5							0.5	
42890	Limited pharyngectomy	090	510	542	32	6%	19.13	21.77	2.64	14%	-2			1	2	1		3	2		1	
42892	Resection of lateral pharynge	090	643	679	36	6%	26.03	29.40	3.37	13%	-2			1	3	1		3	2	1	1	
42894	Resection of pharyngeal wall	090	836	871	35	4%	33.92	38.02	4.10	12%	-2			1	4	1		3	4	1	1	
42900	Suture pharynx for wound or	010	163	165	2	1%	5.29	5.73	0.44	8%	0			1							1	
42950	Pharyngoplasty (plastic or rec	090	293	300	7	2%	8.27	9.26	0.99	12%	0			3.5							1	
42953	Pharyngoesophageal repair	090	409	429.5	20.5	5%	9.45	11.15	1.70	18%	0			4				2.5			1	
42955	Pharyngostomy (fistulization o	090	282	308	26	9%	8.01	9.85	1.84	23%	0			3				4			1	
42960	Control oropharyngeal hemor	010	70	72	2	3%	2.38	2.60	0.22	9%	0			1								
42961	Control oropharyngeal hemor	090	193	200.5	7.5	4%	5.77	6.66	0.89	15%	0			2.5				0.5			1	
42962	Control oropharyngeal hemor	090	234	245	11	5%	7.40	8.52	1.12	15%	0			3				1			1	
42970	Control of nasopharyngeal he	090	193	209.5	16.5	9%	5.82	7.08	1.26	22%	0			2				2.5			1	
42971	Control of nasopharyngeal he	090	227	243.5	16.5	7%	6.60	7.86	1.26	19%	0			2				2.5			1	
42972	Control of nasopharyngeal he	090	243	259.5	16.5	7%	7.59	8.85	1.26	17%	0			2				2.5			1	
43020	Esophagotomy, cervical appro	090	221	227	6	3%	8.23	9.11	0.88	11%	0			3							1	
43030	Cricopharyngeal myotomy	090	244	256.5	12.5	5%	7.99	9.12	1.13	14%	0			2.5				1.5			1	
43045	Esophagotomy, thoracic appro	090	536.5	588.5	52	10%	21.88	24.58	2.70	12%	0				3.5			5.5			1	
43100	Excision of lesion, esophagus,	090	334	353.5	19.5	6%	9.66	11.25	1.59	16%	0			3.5				2.5			1	
43101	Excision of lesion, esophagus,	090	459	494	35	8%	17.07	19.28	2.21	13%	0			2.5				6			1	
43107	Total or near total esophagect	090	977	1003	26	3%	52.05	55.48	3.43	7%	-2			1	2	1		2	3	2		1
43108	Total or near total esophagect	090	1358	1358	0	0%	82.87	87.86	4.99	6%	-2			1	2	1		1	6	5		1
43112	Total or near total esophagect	090	1097	1128	31	3%	62.00	65.67	3.67	6%	-2			1	2	1		3	3	2		1
43113	Total or near total esophagect	090	1358	1358	0	0%	80.06	85.05	4.99	6%	-2			1	2	1		1	6	5		1
43116	Partial esophagectomy, cervic	090	1403	1406	3	0%	92.99	97.58	4.59	5%	-2			1	2	1		1	6	4		1
43117	Partial esophagectomy, distal	090	1067	1098	31	3%	57.50	61.17	3.67	6%	-2			1	2	1		3	3	2		1
43118	Partial esophagectomy, distal	090	1184	1188	4	0%	67.07	71.86	4.79	7%	-2			1	2	1		1	5	5		1
43121	Partial esophagectomy, distal	090	962	977	15	2%	51.43	55.42	3.99	8%	-2			1	2	1		1	3	4		1
43122	Partial esophagectomy, thora	090	1015	1054	39	4%	44.18	47.69	3.51	8%	-2			1	2	1		4	3	1		1
43123	Partial esophagectomy, thora	090	1419	1411	-8	-1%	83.12	88.51	5.39	6%	-2			1	2	1		1	8	5		1
43124	Total or partial esophagectom	090	1398	1398	0	0%	69.09	75.01	5.92	9%	-2			1	3	1		1	7	6		1

43130	Diverticulectomy of hypophar	090	362	395	33	9%	12.53	14.83	2.30	18%	0			4				5			1	
43135	Diverticulectomy of hypophar	090	571	570	-1	0%	26.17	28.18	2.01	8%	0			1	1			1	3	1	1	
43180	Esophagoscopy, rigid, transor	090	201	208	7	3%	9.03	9.58	0.55	6%	0				1						1	
43279	Laparoscopy, surgical, esopha	090	404	419	15	4%	22.10	23.42	1.32	6%	0				2			1	1		1	
43280	Laparoscopy, surgical, esopha	090	404	428	24	6%	18.10	19.46	1.36	8%	0				2			2			1	
43281	Laparoscopy, surgical, repair d	090	424	439	15	4%	26.60	27.92	1.32	5%	0				2			1	1		1	
43282	Laparoscopy, surgical, repair d	090	454	469	15	3%	30.10	31.42	1.32	4%	0				2			1	1		1	
43284	Laparoscopy, surgical, esopha	090	218	232	14	6%	10.13	10.90	0.77	8%	0				2						0.5	
43285	Removal of esophageal sphinc	090	233	247	14	6%	10.47	11.24	0.77	7%	0				2						0.5	
43286	Esophagectomy, total or near	090	957	983	26	3%	55.00	58.43	3.43	6%	-2			1	2	1		2	3	2		1
43287	Esophagectomy, distal two-th	090	1097	1123	26	2%	63.00	66.43	3.43	5%	-2			1	2	1		2	3	2		1
43288	Esophagectomy, total or near	090	1157	1183	26	2%	66.42	69.85	3.43	5%	-2			1	2	1		2	3	2		1
43300	Esophagoplasty (plastic repair	090	312	320	8	3%	9.33	10.43	1.10	12%	0			4							1	
43305	Esophagoplasty (plastic repair	090	403	433.5	30.5	8%	18.10	20.28	2.18	12%	0			4				4.5			1	
43310	Esophagoplasty (plastic repair	090	528	565.5	37.5	7%	26.26	28.59	2.33	9%	0			2.5				6.5			1	
43312	Esophagoplasty (plastic repair	090	563	599	36	6%	29.25	31.26	2.01	7%	0			0.5				7			1	
43313	Esophagoplasty for congenita	090	713	758	45	6%	48.45	51.72	3.27	7%	-2				4	1		2	2	1		1
43314	Esophagoplasty for congenita	090	713	758	45	6%	53.43	56.70	3.27	6%	-2				4	1		2	2	1		1
43320	Esophagogastrostomy (cardio	090	740	748	8	1%	23.31	26.29	2.98	13%	0			1	2			2	3	2	1	
43325	Esophagogastric fundoplasty,	090	600	612	12	2%	22.60	25.38	2.78	12%	0			1	2			2	2	2	1	
43327	Esophagogastric fundoplasty p	090	412	424	12	3%	13.35	15.07	1.72	13%	0				2			1	1	1	1	
43328	Esophagogastric fundoplasty p	090	514	523	9	2%	19.91	22.03	2.12	11%	0				2			1	1	2	1	
43330	Esophagomyotomy (Heller typ	090	550	557	7	1%	22.19	24.73	2.54	11%	0			1	2			1	2	2	1	
43331	Esophagomyotomy (Heller typ	090	620	627	7	1%	23.06	25.60	2.54	11%	0			1	2			1	2	2	1	
43332	Repair, paraesophageal hiatal	090	482	490	8	2%	19.62	21.54	1.92	10%	0				2			1	2	1	1	
43333	Repair, paraesophageal hiatal	090	512	520	8	2%	21.46	23.38	1.92	9%	0				2			1	2	1	1	
43334	Repair, paraesophageal hiatal	090	549	562	13	2%	22.12	24.28	2.16	10%	0				2			2	2	1	1	
43335	Repair, paraesophageal hiatal	090	569	582	13	2%	23.97	26.13	2.16	9%	0				2			2	2	1	1	
43336	Repair, paraesophageal hiatal	090	695	710	15	2%	25.81	28.19	2.38	9%	0			1	2			2	2	1	1	
43337	Repair, paraesophageal hiatal	090	715	730	15	2%	27.65	30.03	2.38	9%	0			1	2			2	2	1	1	
43340	Esophagojejunostomy (withou	090	770	778	8	1%	22.99	25.97	2.98	13%	0			1	2			2	3	2	1	
43341	Esophagojejunostomy (withou	090	770	778	8	1%	24.23	27.21	2.98	12%	0			1	2			2	3	2	1	
43351	Esophagostomy, fistulization o	090	778	793	15	2%	22.05	25.36	3.31	15%	0			1	3			2	3	2	1	
43352	Esophagostomy, fistulization o	090	570	582	12	2%	17.81	20.59	2.78	16%	0			1	2			2	2	2	1	
43360	Gastrointestinal reconstructio	090	830	852	22	3%	40.11	43.75	3.64	9%	-2			1	2	1		3	3	2	1	
43361	Gastrointestinal reconstructio	090	1108	1120	12	1%	45.68	49.39	3.71	8%	0			1	3			2	3	3	1	
43400	Ligation, direct, esophageal va	090	835	843	8	1%	25.60	28.58	2.98	12%	0			1	2			2	3	2	1	
43405	Ligation or stapling at gastroe	090	873	888	15	2%	24.73	28.04	3.31	13%	0			1	3			2	3	2	1	
43410	Suture of esophageal wound o	090	590	597	7	1%	16.41	18.95	2.54	15%	0			1	2			1	2	2	1	
43415	Suture of esophageal wound o	090	842	863	21	2%	44.88	47.53	2.65	6%	-4			1	1	2		1	2	1	1	
43420	Closure of esophagostomy or	090	520	527	7	1%	16.78	19.32	2.54	15%	0			1	2			1	2	2	1	
43425	Closure of esophagostomy or	090	845	858	13	2%	25.04	28.26	3.22	13%	0			1	2			3	3	2	1	
43496	Free jejunum transfer with mi	090	902	979	77	9%	0.00	N/A	N/A	N/A	0			2	4			9			1	
43497	Lower esophageal myotomy, t	090	281	295	14	5%	13.29	14.06	0.77	6%	0				2						0.5	
43500	Gastrotomy; with exploration	090	402	410	8	2%	12.79	14.84	2.05	16%	0			1	1			2	2	1	1	
43501	Gastrotomy; with suture repa	090	555	570	15	3%	22.60	24.98	2.38	11%	0			1	2			2	2	1	1	
43502	Gastrotomy; with suture repa	090	555	570	15	3%	25.69	28.07	2.38	9%	0			1	2			2	2	1	1	
43510	Gastrotomy; with esophageal	090	485	500	15	3%	15.14	17.52	2.38	16%	0			1	2			2	2	1	1	
43520	Pyloromyotomy, cutting of py	090	342	349	7	2%	11.29	12.90	1.61	14%	0			1	1			1	1	1	1	
43605	Biopsy of stomach, by laparot	090	402	410	8	2%	13.72	15.77	2.05	15%	0			1	1			2	2	1	1	
43610	Excision, local; ulcer or benign	090	432	440	8	2%	16.34	18.39	2.05	13%	0			1	1			2	2	1	1	
43611	Excision, local; malignant tum	090	520	532	12	2%	20.38	23.16	2.78	14%	0			1	2			2	2	2	1	
43620	Gastrectomy, total; with esop	090	695	711	16	2%	34.04	36.86	2.82	8%	0			1	2			3	3	1	1	
43621	Gastrectomy, total; with Roux	090	790	803	13	2%	39.53	42.75	3.22	8%	0			1	2			3	3	2	1	
43622	Gastrectomy, total; with form	090	790	803	13	2%	40.03	43.25	3.22	8%	0			1	2			3	3	2	1	
43631	Gastrectomy, partial, distal; w	090	535	568	33	6%	24.51	27.21	2.70	11%	0			1	2			5	2		1	
43632	Gastrectomy, partial, distal; w	090	725	743	18	2%	35.14	38.60	3.46	10%	0			1	2			4	3	2	1	
43633	Gastrectomy, partial, distal; w	090	740	758	18	2%	33.14	36.60	3.46	10%	0			1	2			4	3	2	1	
43634	Gastrectomy, partial, distal; w	090	740	758	18	2%	36.64	40.10	3.46	9%	0			1	2			4	3	2	1	
43640	Vagotomy including pyloropla	090	540	552	12	2%	19.56	22.34	2.78	14%	0			1	2			2	2	2	1	
43641	Vagotomy including pyloropla	090	570	582	12	2%	19.81	22.59	2.78	14%	0			1	2			2	2	2	1	
43644	Laparoscopy, surgical, gastric	090	502	517	15	3%	29.40	31.23	1.83	6%	-2			1	1	1		1	2		1	
43645	Laparoscopy, surgical, gastric	090	537	552	15	3%	31.53	33.36	1.83	6%	-2			1	1	1		1	2		1	
43653	Laparoscopy, surgical; gastros	090	264	283	19	7%	8.48	9.60	1.12	13%	0				2			1			1	
43770	Laparoscopy, surgical, gastric	090	367	384	17	5%	18.00	19.41	1.41	8%	0				3				1		1	
43771	Laparoscopy, surgical, gastric	090	377	394	17	5%	20.79	22.20	1.41	7%	0				3				1		1	
43772	Laparoscopy, surgical, gastric	090	317	322	5	2%	15.70	16.67	0.97	6%	0			1	1				1		1	

43773	Laparoscopy, surgical, gastric	090	377	394	17	5%	20.79	22.20	1.41	7%	0				3				1		1	
43774	Laparoscopy, surgical, gastric	090	304	323	19	6%	15.76	16.88	1.12	7%	0				2			1			1	
43775	Laparoscopy, surgical, gastric	090	412	431	19	5%	20.38	22.01	1.63	8%	-2			1	1	1		1	1		1	
43800	Pyloroplasty	090	432	440	8	2%	15.43	17.48	2.05	13%	0			1	1			2	2	1	1	
43810	Gastroduodenostomy	090	502	507	5	1%	16.88	19.33	2.45	15%	0			1	1			2	2	2	1	
43820	Gastrojejunostomy; without v	090	545	561	16	3%	22.53	25.35	2.82	13%	0			1	2			3	3	1	1	
43825	Gastrojejunostomy; with vago	090	540	552	12	2%	21.76	24.54	2.78	13%	0			1	2			2	2	2	1	
43830	Gastrostomy, open; without c	090	319	344	25	8%	10.85	12.65	1.80	17%	0				2			3	1		1	
43831	Gastrostomy, open; neonatal,	090	293	320	27	9%	8.49	10.44	1.95	23%	0			3.5				4			1	
43832	Gastrostomy, open; with cons	090	417	425	8	2%	17.34	19.39	2.05	12%	0			1	1			2	2	1	1	
43840	Gastrorrhaphy, suture of perf	090	565	590	25	4%	22.83	25.69	2.86	13%	0			1	2			4	2	1	1	
43842	Gastric restrictive procedure,	090	585	600	15	3%	21.03	23.41	2.38	11%	0			1	2			2	2	1	1	
43843	Gastric restrictive procedure,	090	585	600	15	3%	21.21	23.59	2.38	11%	0			1	2			2	2	1	1	
43845	Gastric restrictive procedure v	090	628	648	20	3%	33.30	35.37	2.07	6%	0			1	3			1	2		1	
43846	Gastric restrictive procedure,	090	693	712	19	3%	27.41	30.52	3.11	11%	0			1	3			2	2	2	1	
43847	Gastric restrictive procedure,	090	733	752	19	3%	30.28	33.39	3.11	10%	0			1	3			2	2	2	1	
43848	Revision, open, of gastric rest	090	708	727	19	3%	32.75	35.86	3.11	9%	0			1	3			2	2	2	1	
43860	Revision of gastrojejunal anas	090	675	702	27	4%	27.89	31.39	3.50	13%	0			1	2			5	2	2	1	
43865	Revision of gastrojejunal anas	090	615	627	12	2%	29.05	31.83	2.78	10%	0			1	2			2	2	2	1	
43870	Closure of gastrostomy, surgic	090	402	410	8	2%	11.44	13.49	2.05	18%	0			1	1			2	2	1	1	
43880	Closure of gastrocolic fistula	090	540	552	12	2%	27.18	29.96	2.78	10%	0			1	2			2	2	2	1	
43886	Gastric restrictive procedure,	090	155	169	14	9%	4.64	5.41	0.77	17%	0				2						0.5	
43887	Gastric restrictive procedure,	090	148	157	9	6%	4.32	4.98	0.66	15%	0			1	1						0.5	
43888	Gastric restrictive procedure,	090	180	194	14	8%	6.44	7.21	0.77	12%	0				2						0.5	
44005	Enterolysis (freeing of intestin	090	517	522	5	1%	18.46	20.91	2.45	13%	0			1	1			2	2	2	1	
44010	Duodenotomy, for exploration	090	432	440	8	2%	14.26	16.31	2.05	14%	0			1	1			2	2	1	1	
44020	Enterotomy, small intestine, c	090	487	492	5	1%	16.22	18.67	2.45	15%	0			1	1			2	2	2	1	
44021	Enterotomy, small intestine, c	090	487	492	5	1%	16.31	18.76	2.45	15%	0			1	1			2	2	2	1	
44025	Colotomy, for exploration, bio	090	487	492	5	1%	16.51	18.96	2.45	15%	0			1	1			2	2	2	1	
44050	Reduction of volvulus, intussu	090	409.5	430.5	21	5%	15.52	17.65	2.13	14%	0			1	1			4	2		1	
44055	Correction of malrotation by l	090	663	659	-4	-1%	25.63	28.15	2.52	10%	0				2			1	5	1	1	
44110	Excision of 1 or more lesions c	090	487	492	5	1%	14.04	16.49	2.45	17%	0			1	1			2	2	2	1	
44111	Excision of 1 or more lesions c	090	517	522	5	1%	16.52	18.97	2.45	15%	0			1	1			2	2	2	1	
44120	Enterectomy, resection of sma	090	611	622	11	2%	20.82	23.95	3.13	15%	0			1	1			4	3	2	1	
44125	Enterectomy, resection of sma	090	524	534	10	2%	20.03	22.59	2.56	13%	0				2			2	2	2	1	
44126	Enterectomy, resection of sma	090	1125	1167	42	4%	42.23	48.55	6.32	15%	-2			1	2	1		10	6	3	1	
44127	Enterectomy, resection of sma	090	1357	1416	59	4%	49.30	56.97	7.67	16%	-2			1	2	1		13	7	4		1
44130	Enteroenterostomy, anastom	090	516	550	34	7%	22.11	25.01	2.90	13%	0			1	2			5	1	1	1	
44140	Colectomy, partial; with anast	090	480	517	37	8%	22.59	25.09	2.50	11%	0			1	2			5	1		1	
44141	Colectomy, partial; with skin l	090	672	696	24	4%	29.91	33.26	3.35	11%	-2			1	1	1		4	2	2	1	
44143	Colectomy, partial; with end c	090	607	626	19	3%	27.79	30.90	3.11	11%	-2			1	1	1		3	2	2	1	
44144	Colectomy, partial; with resec	090	677	701	24	4%	29.91	33.26	3.35	11%	-2			1	1	1		4	2	2	1	
44145	Colectomy, partial; with colop	090	615	635	20	3%	28.58	31.20	2.62	9%	0			1	2			3	2	1	1	
44146	Colectomy, partial; with colop	090	692	714	22	3%	35.30	38.01	2.71	8%	-2			1	1	1		3	2	1	1	
44147	Colectomy, partial; abdomina	090	710	727	17	2%	33.69	36.71	3.02	9%	0			1	2			3	2	2	1	
44150	Colectomy, total, abdominal,	090	638	658	20	3%	30.18	33.31	3.13	10%	-2			2	1	1		3	3	1	1	
44151	Colectomy, total, abdominal,	090	738	768	30	4%	34.92	38.53	3.61	10%	-2			2	1	1		5	3	1	1	
44155	Colectomy, total, abdominal,	090	738	768	30	4%	34.42	38.03	3.61	10%	-2			2	1	1		5	3	1	1	
44156	Colectomy, total, abdominal,	090	798	828	30	4%	37.42	41.03	3.61	10%	-2			2	1	1		5	3	1	1	
44157	Colectomy, total, abdominal,	090	705	743	38	5%	35.70	39.02	3.32	9%	-2			1	2	1		5	3		1	
44158	Colectomy, total, abdominal,	090	725	763	38	5%	36.70	40.02	3.32	9%	-2			1	2	1		5	3		1	
44160	Colectomy, partial, with remo	090	551	558	7	1%	20.89	23.56	2.67	13%	0			2	1			2	2	2	1	
44180	Laparoscopy, surgical, enterol	090	407	436	29	7%	15.27	17.00	1.73	11%	0			1	1			4			1	
44186	Laparoscopy, surgical; jejunos	090	267	286	19	7%	10.38	11.63	1.25	12%	0			1	1			2			1	
44187	Laparoscopy, surgical; ileostor	090	385	398	13	3%	17.40	19.14	1.74	10%	0			1	2			1	2		1	
44188	Laparoscopy, surgical, colosto	090	407	425	18	4%	19.35	21.20	1.85	10%	0				3			1	2		1	
44202	Laparoscopy, surgical; entere	090	505	532	27	5%	23.39	25.41	2.02	9%	0			1	2			3	1		1	
44204	Laparoscopy, surgical; colecto	090	455	482	27	6%	26.42	28.44	2.02	8%	0			1	2			3	1		1	
44205	Laparoscopy, surgical; colecto	090	428.5	459.5	31	7%	22.95	25.03	2.08	9%	0			3				5			1	
44206	Laparoscopy, surgical; colecto	090	647	662	15	2%	29.79	32.86	3.07	10%	-2			1	1	1		2	1	3	1	
44207	Laparoscopy, surgical; colecto	090	560	570	10	2%	31.92	34.06	2.14	7%	0			1	2			1	2	1	1	
44208	Laparoscopy, surgical; colecto	090	595	614	19	3%	33.99	36.41	2.42	7%	0			1	2			3	3		1	
44210	Laparoscopy, surgical; colecto	090	630	662	32	5%	30.09	32.73	2.64	9%	-2			1	2	1		3	2		1	
44211	Laparoscopy, surgical; colecto	090	695	727	32	5%	37.08	39.72	2.64	7%	-2			1	2	1		3	2		1	
44212	Laparoscopy, surgical; colecto	090	660	692	32	5%	34.58	37.22	2.64	8%	-2			1	2	1		3	2		1	
44227	Laparoscopy, surgical, closure	090	530	541	11	2%	28.62	30.96	2.34	8%	0			1	2			1	1	2	1	
44300	Placement, enterostomy or ce	090	389	410	21	5%	13.75	15.75	2.00	15%	0				2			3	2		1	

44310	Ileostomy or jejunostomy, nor	090	391.5	412.5	21	5%	17.59	19.59	2.00	11%	0				2			3	2		1
44312	Revision of ileostomy; simple	090	349	360	11	3%	9.43	10.95	1.52	16%	0				2			1	2		1
44314	Revision of ileostomy; compli	090	465	488	23	5%	16.74	18.96	2.22	13%	0			1	2			3	2		1
44316	Continent ileostomy (Kock pro	090	590	606	16	3%	23.59	26.41	2.82	12%	0			1	2			3	3	1	1
44320	Colostomy or skin level cecost	090	507	529	22	4%	19.91	22.62	2.71	14%	-2			1	1	1		3	2	1	1
44322	Colostomy or skin level cecost	090	483	539	56	12%	13.32	16.91	3.59	27%	0			5.5				9			1
44340	Revision of colostomy; simple	090	382	397	15	4%	9.28	11.11	1.83	20%	-2			1	1	1		1	2		1
44345	Revision of colostomy; compli	090	482	507	25	5%	17.22	19.53	2.31	13%	-2			1	1	1		3	2		1
44346	Revision of colostomy; with re	090	572	586	14	2%	19.63	22.50	2.87	15%	-2			1	1	1		2	2	2	1
44602	Suture of small intestine (ente	090	562	571	9	2%	24.72	27.21	2.49	10%	0			1	1			3	3	1	1
44603	Suture of small intestine (ente	090	635	656	21	3%	28.16	31.22	3.06	11%	0			1	2			4	3	1	1
44604	Suture of large intestine (colo	090	459	477	18	4%	18.16	20.56	2.40	13%	0				2			3	2	1	1
44605	Suture of large intestine (colo	090	562	563	1	0%	22.08	24.73	2.65	12%	0			1	1			2	3	2	1
44615	Intestinal stricturoplasty (ente	090	502	507	5	1%	18.16	20.61	2.45	13%	0			1	1			2	2	2	1
44620	Closure of enterostomy, large	090	487	492	5	1%	14.43	16.88	2.45	17%	0			1	1			2	2	2	1
44625	Closure of enterostomy, large	090	517	522	5	1%	17.28	19.73	2.45	14%	0			1	1			2	2	2	1
44626	Closure of enterostomy, large	090	587	588	1	0%	27.90	30.55	2.65	9%	0			1	1			2	3	2	1
44640	Closure of intestinal cutaneou	090	587	588	1	0%	24.20	26.85	2.65	11%	0			1	1			2	3	2	1
44650	Closure of enteroenteric or en	090	587	588	1	0%	25.12	27.77	2.65	11%	0			1	1			2	3	2	1
44660	Closure of enterovesical fistul	090	587	588	1	0%	23.91	26.56	2.65	11%	0			1	1			2	3	2	1
44661	Closure of enterovesical fistul	090	617	618	1	0%	27.35	30.00	2.65	10%	0			1	1			2	3	2	1
44680	Intestinal plication (separate p	090	602	603	1	0%	17.96	20.61	2.65	15%	0			1	1			2	3	2	1
44700	Exclusion of small intestine fro	090	402	418	16	4%	17.48	19.37	1.89	11%	0			1	1			3	2		1
44800	Excision of Meckel's diverticul	090	366	400.5	34.5	9%	12.05	14.36	2.31	19%	0			3.5				5.5			1
44820	Excision of lesion of mesenter	090	404	425	21	5%	13.73	15.73	2.00	15%	0				2			3	2		1
44850	Suture of mesentery (separat	090	367	383	16	4%	12.11	14.00	1.89	16%	0			1	1			3	2		1
44900	Incision and drainage of appe	090	450	457	7	2%	12.57	15.11	2.54	20%	0			1	2			1	2	2	1
44950	Appendectomy;	090	252	271	19	8%	10.60	11.85	1.25	12%	0			1	1			2			1
44960	Appendectomy; for ruptured a	090	458	460	2	0%	14.50	16.93	2.43	17%	0			2	1			1	2	2	1
44970	Laparoscopy, surgical, append	090	242	261	19	8%	9.45	10.57	1.12	12%	0				2			1			1
45000	Transrectal drainage of pelvic	090	384	387	3	1%	6.30	7.98	1.68	27%	0				2				2	1	1
45005	Incision and drainage of subm	010	54	55	1	2%	2.02	2.13	0.11	5%	0			0.5							
45020	Incision and drainage of deep	090	255	276	21	8%	8.56	9.90	1.34	16%	0			1	2			1			1
45100	Biopsy of anorectal wall, anal	090	178	187	9	5%	4.04	4.70	0.66	16%	0			1	1						0.5
45108	Anorectal myomectomy	090	193	202	9	5%	5.12	5.78	0.66	13%	0			1	1						0.5
45110	Proctectomy; complete, comb	090	678	703	25	4%	30.76	34.13	3.37	11%	-2			2	1	1		4	3	1	1
45111	Proctectomy; partial resection	090	496	539	43	9%	18.01	20.79	2.78	15%	0			4				7			1
45112	Proctectomy, combined abdo	090	675	692	17	3%	33.18	36.20	3.02	9%	0			1	2			3	2	2	1
45113	Proctectomy, partial, with rec	090	675	692	17	3%	33.22	36.24	3.02	9%	0			1	2			3	2	2	1
45114	Proctectomy, partial, with ana	090	792	802	10	1%	30.79	33.86	3.07	10%	-2			1	1	1		2	3	2	1
45116	Proctectomy, partial, with ana	090	702	716	14	2%	27.72	30.59	2.87	10%	-2			1	1	1		2	2	2	1
45119	Proctectomy, combined abdo	090	685	702	17	2%	33.48	36.50	3.02	9%	0			1	2			3	2	2	1
45120	Proctectomy, complete (for co	090	689	744	55	8%	26.40	29.88	3.48	13%	0			5				9			1
45121	Proctectomy, complete (for co	090	741	806	65	9%	29.08	33.04	3.96	14%	0			5				11			1
45123	Proctectomy, partial, without	090	687	704	17	2%	18.86	21.33	2.47	13%	-2			1	1	1		2	2	1	1
45126	Pelvic exenteration for colore	090	755	776	21	3%	49.10	52.30	3.20	7%	-2			1	2	1		2	2	2	1
45130	Excision of rectal procidentia,	090	520	535	15	3%	18.50	20.88	2.38	13%	0			1	2			2	2	1	1
45135	Excision of rectal procidentia,	090	735	761	26	4%	22.36	25.80	3.44	15%	-2			1	2	1		3	2	2	1
45136	Excision of ileoanal reservoir v	090	783	795	12	2%	30.82	34.11	3.29	11%	-2			2	1	1		2	3	2	1
45150	Division of stricture of rectum	090	184	191.5	7.5	4%	5.85	6.74	0.89	15%	0			2.5				0.5			1
45160	Excision of rectal tumor by pr	090	342	370	28	8%	16.33	18.00	1.67	10%	-2			1	1	1		2			1
45171	Excision of rectal tumor, trans	090	209	225	16	8%	8.13	9.12	0.99	12%	0			1	2						0.5
45172	Excision of rectal tumor, trans	090	290	311	21	7%	12.13	13.47	1.34	11%	0			1	2			1			1
45190	Destruction of rectal tumor (e	090	266	282	16	6%	10.42	11.41	0.99	10%	0			1	2						0.5
45395	Laparoscopy, surgical; procte	090	645	669	24	4%	33.00	35.80	2.80	8%	-2			1	2	1		2	2	1	1
45397	Laparoscopy, surgical; procte	090	675	699	24	4%	36.50	39.30	2.80	8%	-2			1	2	1		2	2	1	1
45400	Laparoscopy, surgical; proctop	090	410	437	27	7%	19.44	21.46	2.02	10%	0			1	2			3	1		1
45402	Laparoscopy, surgical; proctop	090	470	483	13	3%	26.51	28.25	1.74	7%	0			1	2			1	2		1
45500	Proctoplasty; for stenosis	090	266	284.5	18.5	7%	7.73	9.21	1.48	19%	0			3				2.5			1
45505	Proctoplasty; for prolapse of r	090	300.5	318.5	18	6%	8.36	9.44	1.08	13%	-2			1	1	1					0.5
45540	Proctopexy (eg, for prolapse);	090	481.5	493.5	12	2%	18.12	20.08	1.96	11%	0				2			2	3		1
45541	Proctopexy (eg, for prolapse);	090	420	433	13	3%	14.85	16.59	1.74	12%	0			1	2			1	2		1
45550	Proctopexy (eg, for prolapse);	090	540	568	28	5%	24.80	27.26	2.46	10%	0			1	2			4	2		1
45560	Repair of rectocele (separate	090	367	382	15	4%	11.50	12.95	1.45	13%	0			1	1			2	1		1
45562	Exploration, repair, and presa	090	561	575	14	2%	17.98	20.98	3.00	17%	0			2	2			2	2	2	1
45563	Exploration, repair, and presa	090	636	646	10	2%	26.38	29.58	3.20	12%	0			2	2			2	3	2	1
45800	Closure of rectovesical fistula;	090	570	582	12	2%	20.31	23.09	2.78	14%	0			1	2			2	2	2	1

45805	Closure of rectovesical fistula;	090	595	607	12	2%	23.32	26.10	2.78	12%	0			1	2			2	2	2	1	
45820	Closure of rectourethral fistul	090	480	494	14	3%	20.37	22.55	2.18	11%	0			1	2			2	3		1	
45825	Closure of rectourethral fistul	090	646	656	10	2%	24.17	27.37	3.20	13%	0			2	2			2	3	2	1	
45900	Reduction of procidentia (sep	010	219	217	-2	-1%	2.99	3.63	0.64	21%	0			1					1		1	
45905	Dilation of anal sphincter (sep	010	130	132	2	2%	2.35	2.68	0.33	14%	0			1							0.5	
45910	Dilation of rectal stricture (se	010	130	132	2	2%	2.85	3.18	0.33	12%	0			1							0.5	
45915	Removal of fecal impaction or	010	145	147	2	1%	3.19	3.52	0.33	10%	0			1							0.5	
46040	Incision and drainage of ischic	090	184	195	11	6%	5.37	6.25	0.88	16%	0			2	1						0.5	
46045	Incision and drainage of intran	090	197	206	9	5%	5.87	6.64	0.77	13%	0			1	1						1	
46050	Incision and drainage, periana	010	59	61	2	3%	1.24	1.46	0.22	18%	0			1								
46060	Incision and drainage of ischic	090	201	217	16	8%	6.37	7.36	0.99	16%	0			1	2						0.5	
46070	Incision, anal septum (infant)	090	74	77	3	4%	2.79	3.12	0.33	12%	0			1.5								
46080	Sphincterotomy, anal, division	010	99	100	1	1%	2.52	2.74	0.22	9%	0			0.5							0.5	
46083	Incision of thrombosed hemor	010	51	53	2	4%	1.45	1.67	0.22	15%	0			1								
46200	Fissurectomy, including sphinc	090	171	178	7	4%	3.59	4.47	0.88	25%	0			3.5							0.5	
46220	Excision of single external pap	010	67	69	2	3%	1.61	1.83	0.22	14%	0			1								
46221	Hemorrhoidectomy, internal,	010	68	75	7	10%	2.36	2.69	0.33	14%	0				1							
46230	Excision of multiple external p	010	74	76	2	3%	2.62	2.84	0.22	8%	0			1								
46250	Hemorrhoidectomy, external,	090	188	197	9	5%	4.25	4.91	0.66	16%	0			1	1						0.5	
46255	Hemorrhoidectomy, internal a	090	193	202	9	5%	4.96	5.62	0.66	13%	0			1	1						0.5	
46257	Hemorrhoidectomy, internal a	090	203	212	9	4%	5.76	6.42	0.66	11%	0			1	1						0.5	
46258	Hemorrhoidectomy, internal a	090	241	257	16	7%	6.41	7.40	0.99	15%	0			1	2						0.5	
46260	Hemorrhoidectomy, internal a	090	208	217	9	4%	6.73	7.39	0.66	10%	0			1	1						0.5	
46261	Hemorrhoidectomy, internal a	090	241	257	16	7%	7.76	8.75	0.99	13%	0			1	2						0.5	
46262	Hemorrhoidectomy, internal a	090	179	190	11	6%	7.91	8.79	0.88	11%	0			2	1						0.5	
46270	Surgical treatment of anal fist	090	169	180	11	7%	4.92	5.80	0.88	18%	0			2	1						0.5	
46275	Surgical treatment of anal fist	090	184	195	11	6%	5.42	6.30	0.88	16%	0			2	1						0.5	
46280	Surgical treatment of anal fist	090	199	210	11	6%	6.39	7.27	0.88	14%	0			2	1						0.5	
46285	Surgical treatment of anal fist	090	184	195	11	6%	5.42	6.30	0.88	16%	0			2	1						0.5	
46288	Closure of anal fistula with rec	090	236	252	16	7%	7.81	8.80	0.99	13%	0			1	2						0.5	
46320	Excision of thrombosed hemo	010	55	56	1	2%	1.64	1.75	0.11	7%	0			0.5								
46500	Injection of sclerosing solution	010	61	68	7	11%	1.74	2.07	0.33	19%	0				1							
46505	Chemodenervation of interna	010	102	109	7	7%	3.18	3.62	0.44	14%	0				1						0.5	
46700	Anoplasty, plastic operation fo	090	283.5	299.5	16	6%	9.81	10.80	0.99	10%	0			1	2						0.5	
46705	Anoplasty, plastic operation fo	090	277	299	22	8%	7.43	9.14	1.71	23%	0			3.5				3			1	
46706	Repair of anal fistula with fibr	010	100	102	2	2%	2.44	2.77	0.33	14%	0			1							0.5	
46707	Repair of anorectal fistula wit	090	187	198	11	6%	6.39	7.27	0.88	14%	0			2	1						0.5	
46710	Repair of ileoanal pouch fistul	090	370	387	17	5%	17.14	18.68	1.54	9%	0			1	2			1	1		1	
46712	Repair of ileoanal pouch fistul	090	670	677	7	1%	36.45	38.99	2.54	7%	0			1	2			1	2	2	1	
46715	Repair of low imperforate anu	090	265	282.5	17.5	7%	7.62	8.99	1.37	18%	0			2.5				2.5			1	
46716	Repair of low imperforate anu	090	530	594	64	12%	17.54	20.37	2.83	16%	-10					5		2				1
46730	Repair of high imperforate an	090	775	832	57	7%	30.65	34.46	3.81	12%	-12					6		1	2	1		1
46735	Repair of high imperforate an	090	850	916	66	8%	36.14	40.23	4.09	11%	-12					6		3	3			1
46740	Repair of high imperforate an	090	775	832	57	7%	33.90	37.71	3.81	11%	-12					6		1	2	1		1
46742	Repair of high imperforate an	090	895	953	58	6%	40.14	44.39	4.25	11%	-12					6		2	3	1		1
46744	Repair of cloacal anomaly by a	090	1303	1355	52	4%	58.94	63.99	5.05	9%	-12					6		2	3	3		1
46746	Repair of cloacal anomaly by a	090	1566	1625	59	4%	65.44	71.20	5.76	9%	-11					5	1	3	4	3		1
46748	Repair of cloacal anomaly by a	090	1686	1745	59	3%	71.42	77.18	5.76	8%	-11					5	1	3	4	3		1
46750	Sphincteroplasty, anal, for inc	090	475	489	14	3%	12.15	14.33	2.18	18%	0			1	2			2	3		1	
46751	Sphincteroplasty, anal, for inc	090	299	321	22	7%	9.30	11.01	1.71	18%	0			3.5				3			1	
46753	Graft (Thiersch operation) for	090	297	316	19	6%	8.89	10.14	1.25	14%	0			1	1			2			1	
46754	Removal of Thiersch wire or s	010	175	196	21	12%	3.01	4.35	1.34	45%	0			1	2			1			1	
46760	Sphincteroplasty, anal, for inc	090	676	699	23	3%	17.45	20.87	3.42	20%	-2			2	2	1		2	2	2	1	
46761	Sphincteroplasty, anal, for inc	090	410	423	13	3%	15.29	17.03	1.74	11%	0			1	2			1	2		1	
46900	Destruction of lesion(s), anus	010	63	70	7	11%	1.91	2.24	0.33	17%	0				1							
46910	Destruction of lesion(s), anus	010	73	75	2	3%	1.91	2.13	0.22	12%	0			1								
46916	Destruction of lesion(s), anus	010	67	69	2	3%	1.91	2.13	0.22	12%	0			1								
46917	Destruction of lesion(s), anus	010	73	75	2	3%	1.91	2.13	0.22	12%	0			1								
46922	Destruction of lesion(s), anus	010	83	85	2	2%	1.91	2.13	0.22	12%	0			1								
46924	Destruction of lesion(s), anus	010	93	95	2	2%	2.81	3.03	0.22	8%	0			1								
46930	Destruction of internal hemor	090	46	53	7	15%	1.61	1.94	0.33	20%	0				1							
46940	Curettage or cautery of anal f	010	63	64	1	2%	2.35	2.46	0.11	5%	0			0.5								
46942	Curettage or cautery of anal f	010	67	68	1	1%	2.07	2.18	0.11	5%	0			0.5								
46945	Hemorrhoidectomy, internal,	090	133	142	9	7%	3.69	4.35	0.66	18%	0			1	1						0.5	
46946	Hemorrhoidectomy, internal,	090	148	157	9	6%	4.50	5.16	0.66	15%	0			1	1						0.5	
46947	Hemorrhoidopexy (eg, for prol	090	170	179	9	5%	5.57	6.23	0.66	12%	0			1	1						0.5	
46948	Hemorrhoidectomy, internal,	090	163	172	9	6%	5.57	6.23	0.66	12%	0			1	1						0.5	

47010	Hepatotomy, for open drainag	090	645	653	8	1%	19.40	22.38	2.98	15%	0			1	2			2	3	2	1	
47015	Laparotomy, with aspiration a	090	665	673	8	1%	18.50	21.48	2.98	16%	0			1	2			2	3	2	1	
47100	Biopsy of liver, wedge	090	345	367	22	6%	12.91	14.69	1.78	14%	0			1	2			2	1		1	
47120	Hepatectomy, resection of liv	090	803	815	12	1%	39.01	42.30	3.29	8%	-2			2	1	1		2	3	2	1	
47122	Hepatectomy, resection of liv	090	1000	1008	8	1%	59.48	62.46	2.98	5%	0			1	2			2	3	2	1	
47125	Hepatectomy, resection of liv	090	855	863	8	1%	53.04	56.02	2.98	6%	0			1	2			2	3	2	1	
47130	Hepatectomy, resection of liv	090	870	878	8	1%	57.19	60.17	2.98	5%	0			1	2			2	3	2	1	
47135	Liver allotransplantation, orth	090	1648	1708	60	4%	90.00	97.03	7.03	8%	-13				1	6	1	1	3	6		1
47140	Donor hepatectomy (including	090	1073	1088	15	1%	59.40	63.95	4.55	8%	0			1	3			3	2	5	1	
47141	Donor hepatectomy (including	090	1101	1135	34	3%	71.50	76.02	4.52	6%	0			1	4			4	1	4	1	
47142	Donor hepatectomy (including	090	1221	1256	35	3%	79.44	84.40	4.96	6%	0			1	4			5	2	4	1	
47300	Marsupialization of cyst or ab	090	605	617	12	2%	18.14	20.92	2.78	15%	0			1	2			2	2	2	1	
47350	Management of liver hemorrh	090	575	582	7	1%	22.49	25.03	2.54	11%	0			1	2			1	2	2	1	
47360	Management of liver hemorrh	090	857.5	865.5	8	1%	31.31	34.29	2.98	10%	0			1	2			2	3	2	1	
47361	Management of liver hemorrh	090	1035	1045	10	1%	52.60	56.22	3.62	7%	0			1	2			3	3	3	1	
47362	Management of liver hemorrh	090	880	893	13	1%	23.54	26.76	3.22	14%	0			1	2			3	3	2	1	
47370	Laparoscopy, surgical, ablatio	090	450	467	17	4%	20.80	22.34	1.54	7%	0			1	2			1	1		1	
47371	Laparoscopy, surgical, ablatio	090	455	472	17	4%	20.80	22.34	1.54	7%	0			1	2			1	1		1	
47380	Ablation, open, of 1 or more l	090	550	568	18	3%	24.56	26.54	1.98	8%	0			1	2			2	2		1	
47381	Ablation, open, of 1 or more l	090	576	596	20	3%	24.88	27.08	2.20	9%	0			2	2			2	2		1	
47382	Ablation, 1 or more liver tumo	010	265	267	2	1%	14.97	15.30	0.33	2%	0			1							0.5	
47383	Ablation, 1 or more liver tumo	010	196	198	2	1%	8.88	9.21	0.33	4%	0			1							0.5	
47400	Hepaticotomy or hepaticostor	090	810	818	8	1%	36.36	39.34	2.98	8%	0			1	2			2	3	2	1	
47420	Choledochotomy or choledoch	090	588	590	2	0%	22.03	24.46	2.43	11%	0			2	1			1	2	2	1	
47425	Choledochotomy or choledoch	090	628	626	-2	0%	22.31	24.94	2.63	12%	0			2	1			1	3	2	1	
47460	Transduodenal sphincterotom	090	578	576	-2	0%	20.52	23.15	2.63	13%	0			2	1			1	3	2	1	
47480	Cholecystotomy or cholecysto	090	495	502	7	1%	13.25	15.79	2.54	19%	0			1	2			1	2	2	1	
47490	Cholecystostomy, percutaneo	010	133	143	10	8%	4.76	5.24	0.48	10%	0							2				
47562	Laparoscopy, surgical; cholec	090	251	267	16	6%	10.47	11.46	0.99	9%	0			1	2						0.5	
47563	Laparoscopy, surgical; cholec	090	238	247	9	4%	11.47	12.13	0.66	6%	0			1	1						0.5	
47564	Laparoscopy, surgical; cholec	090	415	428	13	3%	18.00	19.74	1.74	10%	0			1	2			1	2		1	
47600	Cholecystectomy;	090	475	485	10	2%	17.48	19.62	2.14	12%	0			1	2			1	2	1	1	
47605	Cholecystectomy; with cholan	090	490	500	10	2%	18.48	20.62	2.14	12%	0			1	2			1	2	1	1	
47610	Cholecystectomy with explora	090	512	512	0	0%	20.92	23.13	2.21	11%	0			1	1			1	2	2	1	
47612	Cholecystectomy with explora	090	597	593	-4	-1%	21.21	23.62	2.41	11%	0			1	1			1	3	2	1	
47620	Cholecystectomy with explora	090	627	623	-4	-1%	23.07	25.48	2.41	10%	0			1	1			1	3	2	1	
47700	Exploration for congenital atr	090	456	493	37	8%	16.50	18.93	2.43	15%	0			3.5				6			1	
47701	Portoenterostomy (eg, Kasai p	090	498	537.5	39.5	8%	28.73	31.28	2.55	9%	0			3.5				6.5			1	
47711	Excision of bile duct tumor, w	090	670	678	8	1%	25.90	28.88	2.98	12%	0			1	2			2	3	2	1	
47712	Excision of bile duct tumor, w	090	790	803	13	2%	33.72	36.94	3.22	10%	0			1	2			3	3	2	1	
47715	Excision of choledochal cyst	090	650	653	3	0%	21.55	24.29	2.74	13%	0			1	2			1	3	2	1	
47720	Cholecystoenterostomy; direc	090	520	527	7	1%	18.34	20.88	2.54	14%	0			1	2			1	2	2	1	
47721	Cholecystoenterostomy; with	090	610	618	8	1%	21.99	24.97	2.98	14%	0			1	2			2	3	2	1	
47740	Cholecystoenterostomy; Roux	090	590	593	3	1%	21.23	23.97	2.74	13%	0			1	2			1	3	2	1	
47741	Cholecystoenterostomy; Roux	090	640	648	8	1%	24.21	27.19	2.98	12%	0			1	2			2	3	2	1	
47760	Anastomosis, of extrahepatic	090	759	783	24	3%	38.32	41.54	3.22	8%	-2				2	1		3	2	2	1	
47765	Anastomosis, of intrahepatic	090	882	911	29	3%	52.19	55.65	3.46	7%	-2				2	1		4	2	2	1	
47780	Anastomosis, Roux-en-Y, of ex	090	799	823	24	3%	42.32	45.54	3.22	8%	-2				2	1		3	2	2	1	
47785	Anastomosis, Roux-en-Y, of in	090	939	968	29	3%	56.19	59.65	3.46	6%	-2				2	1		4	2	2	1	
47800	Reconstruction, plastic, of ext	090	652.5	660.5	8	1%	26.17	29.15	2.98	11%	0			1	2			2	3	2	1	
47801	Placement of choledochal ste	090	525	532	7	1%	17.60	20.14	2.54	14%	0			1	2			1	2	2	1	
47802	U-tube hepaticoenterostomy	090	705	713	8	1%	24.93	27.91	2.98	12%	0			1	2			2	3	2	1	
47900	Suture of extrahepatic biliary	090	570	582	12	2%	22.44	25.22	2.78	12%	0			1	2			2	2	2	1	
48000	Placement of drains, peripanc	090	743	751	8	1%	31.95	34.93	2.98	9%	0			1	2			2	3	2	1	
48001	Placement of drains, peripanc	090	815.5	815.5	0	0%	39.69	42.83	3.14	8%	0			1	2			1	3	3	1	
48020	Removal of pancreatic calculu	090	678	686	8	1%	19.09	22.07	2.98	16%	0			1	2			2	3	2	1	
48100	Biopsy of pancreas, open (eg,	090	497.5	502.5	5	1%	14.46	16.91	2.45	17%	0			1	1			2	2	2	1	
48102	Biopsy of pancreas, percutane	010	120	121	1	1%	4.70	4.92	0.22	5%	0			0.5							0.5	
48105	Resection or debridement of p	090	1220	1250.5	30.5	2%	49.26	55.18	5.92	12%	-2			1	2	1		7.5	5	4	1	
48120	Excision of lesion of pancreas	090	595	596	1	0%	18.41	21.06	2.65	14%	0			1	1			2	3	2	1	
48140	Pancreatectomy, distal subtot	090	725	733	8	1%	26.32	29.30	2.98	11%	0			1	2			2	3	2	1	
48145	Pancreatectomy, distal subtot	090	762.5	770.5	8	1%	27.39	30.37	2.98	11%	0			1	2			2	3	2	1	
48146	Pancreatectomy, distal, near-	090	893	908	15	2%	30.60	33.91	3.31	11%	0			1	3			2	3	2	1	
48148	Excision of ampulla of Vater	090	700	712	12	2%	20.39	23.17	2.78	14%	0			1	2			2	2	2	1	
48150	Pancreatectomy, proximal sub	090	1110	1133	23	2%	52.84	56.92	4.08	8%	-2			1	2	1		4	4	2	1	
48152	Pancreatectomy, proximal sub	090	1063	1085	22	2%	48.65	52.84	4.19	9%	0			1	3			4	3	3	1	
48153	Pancreatectomy, proximal sub	090	1078	1100	22	2%	52.79	56.98	4.19	8%	0			1	3			4	3	3	1	

48154	Pancreatectomy, proximal sub	090	1033	1050	17	2%	48.88	52.83	3.95	8%	0			1	3			3	3	3	1	
48155	Pancreatectomy, total	090	1043	1060	17	2%	29.45	33.40	3.95	13%	0			1	3			3	3	3	1	
48500	Marsupialization of pancreatic	090	603	611	8	1%	18.16	21.14	2.98	16%	0			1	2			2	3	2	1	
48510	External drainage, pseudocyst	090	580.5	588.5	8	1%	17.19	20.17	2.98	17%	0			1	2			2	3	2	1	
48520	Internal anastomosis of pancr	090	580	581	1	0%	18.15	20.80	2.65	15%	0			1	1			2	3	2	1	
48540	Internal anastomosis of pancr	090	560	565	5	1%	21.94	24.39	2.45	11%	0			1	1			2	2	2	1	
48545	Pancreatorrhaphy for injury	090	773	782	9	1%	22.23	25.41	3.18	14%	0			1	2			2	2	3	1	
48547	Duodenal exclusion with gastr	090	903	912	9	1%	30.38	33.56	3.18	10%	0			1	2			2	2	3	1	
48548	Pancreaticojejunostomy, side-	090	765	773	8	1%	28.09	31.07	2.98	11%	0			1	2			2	3	2	1	
48554	Transplantation of pancreatic	090	1237	1337	100	8%	37.80	42.45	4.65	12%	-9				4	3	3					
48556	Removal of transplanted panc	090	952	1011	59	6%	19.47	24.06	4.59	24%	-2				3	1		9	4		1	
49000	Exploratory laparotomy, explo	090	304	328	24	8%	12.54	13.90	1.36	11%	0				2			2			1	
49002	Reopening of recent laparoto	090	437	450	13	3%	17.63	19.92	2.29	13%	0			1	1			3	2	1	1	
49010	Exploration, retroperitoneal a	090	357	377	20	6%	16.06	17.75	1.69	11%	0			1	1			3	1		1	
49020	Drainage of peritoneal absces	090	710	746	36	5%	26.67	30.59	3.92	15%	-2			1	2	1		5	2	2	1	
49040	Drainage of subdiaphragmatic	090	603	601	-2	0%	16.52	19.15	2.63	16%	0			2	1			1	3	2	1	
49060	Drainage of retroperitoneal ab	090	563	565	2	0%	18.53	20.96	2.43	13%	0			2	1			1	2	2	1	
49062	Drainage of extraperitoneal ly	090	334	358	24	7%	12.22	13.58	1.36	11%	0				2			2			1	
49203	Excision or destruction, open,	090	420	447	27	6%	20.13	22.15	2.02	10%	0			1	2			3	1		1	
49204	Excision or destruction, open,	090	511	548	37	7%	26.13	28.63	2.50	10%	0			1	2			5	1		1	
49205	Excision or destruction, open,	090	645	670	25	4%	30.13	32.99	2.86	9%	0			1	2			4	2	1	1	
49215	Excision of presacral or sacroc	090	855	859	4	0%	37.81	40.62	2.81	7%	0				3				2	3	1	
49250	Umbilectomy, omphalectomy	090	292	319.5	27.5	9%	9.01	10.86	1.85	21%	0			2.5				4.5			1	
49255	Omentectomy, epiploectomy,	090	345	386	41	12%	12.56	14.73	2.17	17%	0				3			4			1	
49320	Laparoscopy, abdomen, perito	010	157	164	7	4%	5.14	5.58	0.44	9%	0				1						0.5	
49321	Laparoscopy, surgical; with bi	010	201	213	12	6%	5.44	6.23	0.79	15%	0				1			1			1	
49322	Laparoscopy, surgical; with as	010	133	140	7	5%	6.01	6.34	0.33	5%	0				1							
49323	Laparoscopy, surgical; with dr	090	299	318	19	6%	10.23	11.35	1.12	11%	0				2			1			1	
49324	Laparoscopy, surgical; with ins	010	162	169	7	4%	6.32	6.76	0.44	7%	0				1						0.5	
49325	Laparoscopy, surgical; with re	010	162	169	7	4%	6.82	7.26	0.44	6%	0				1						0.5	
49402	Removal of peritoneal foreign	090	422	421	-1	0%	14.09	16.10	2.01	14%	0			1	1			1	3	1	1	
49419	Insertion of tunneled intraper	090	231	243	12	5%	7.08	7.87	0.79	11%	0				1			1			1	
49425	Insertion of peritoneal-venous	090	367	403	36	10%	12.22	14.54	2.32	19%	0			3				6			1	
49426	Revision of peritoneal-venous	090	330	362.5	32.5	10%	10.41	12.50	2.09	20%	0			2.5				5.5			1	
49428	Ligation of peritoneal-venous	010	239.5	249.5	10	4%	6.87	8.08	1.21	18%	0			1	1			1	1		1	
49429	Removal of peritoneal-venous	010	317	349	32	10%	7.44	9.32	1.88	25%	0			1				6			1	
49436	Delayed creation of exit site fr	010	93	95	2	2%	2.72	3.05	0.33	12%	0			1							0.5	
49440	Insertion of gastrostomy tube	010	116	121	5	4%	3.93	4.17	0.24	6%	0							1				
49441	Insertion of duodenostomy or	010	123	128	5	4%	4.52	4.76	0.24	5%	0							1				
49442	Insertion of cecostomy or oth	010	108	113	5	5%	3.75	3.99	0.24	6%	0							1				
49491	Repair, initial inguinal hernia,	090	398	406	8	2%	12.53	13.92	1.39	11%	0			2	1					1	1	
49492	Repair, initial inguinal hernia,	090	398	406	8	2%	15.43	16.82	1.39	9%	0			2	1					1	1	
49495	Repair, initial inguinal hernia,	090	148	155	7	5%	6.20	6.53	0.33	5%	0				1							
49496	Repair, initial inguinal hernia,	090	246	260	14	6%	9.42	10.08	0.66	7%	0				2							
49500	Repair initial inguinal hernia, a	090	178	187	9	5%	5.84	6.50	0.66	11%	0			1	1						0.5	
49501	Repair initial inguinal hernia, a	090	232	246	14	6%	9.36	10.37	1.01	11%	0			1	1			1			1	
49505	Repair initial inguinal hernia, a	090	198	207	9	5%	7.96	8.62	0.66	8%	0			1	1						0.5	
49507	Repair initial inguinal hernia, a	090	231	240	9	4%	9.09	9.75	0.66	7%	0			1	1						0.5	
49520	Repair recurrent inguinal herr	090	185.5	194.5	9	5%	9.99	10.65	0.66	7%	0			1	1						0.5	
49521	Repair recurrent inguinal herr	090	251	260	9	4%	11.48	12.14	0.66	6%	0			1	1						0.5	
49525	Repair inguinal hernia, sliding	090	193	202	9	5%	8.93	9.59	0.66	7%	0			1	1						0.5	
49540	Repair lumbar hernia	090	218	227	9	4%	10.74	11.40	0.66	6%	0			1	1						0.5	
49550	Repair initial femoral hernia, a	090	193	202	9	5%	8.99	9.65	0.66	7%	0			1	1						0.5	
49553	Repair initial femoral hernia, a	090	247	261	14	6%	9.92	10.93	1.01	10%	0			1	1			1			1	
49555	Repair recurrent femoral herr	090	218	227	9	4%	9.39	10.05	0.66	7%	0			1	1						0.5	
49557	Repair recurrent femoral herr	090	262	276	14	5%	11.62	12.63	1.01	9%	0			1	1			1			1	
49600	Repair of small omphalocele,	090	286	311	25	9%	11.55	13.28	1.73	15%	0			2.5				4			1	
49605	Repair of large omphalocele o	090	1720	1746	26	2%	87.09	92.80	5.71	7%	-6					3		5	5	5		1
49606	Repair of large omphalocele o	090	297	314.5	17.5	6%	19.00	20.37	1.37	7%	0			2.5				2.5			1	
49610	Repair of omphalocele (Gross	090	282	299.5	17.5	6%	10.91	12.28	1.37	13%	0			2.5				2.5			1	
49611	Repair of omphalocele (Gross	090	270	287.5	17.5	6%	9.34	10.71	1.37	15%	0			2.5				2.5			1	
49650	Laparoscopy, surgical; repair i	090	147	151	4	3%	6.36	6.80	0.44	7%	0			2								
49651	Laparoscopy, surgical; repair r	090	193	199	6	3%	8.38	9.04	0.66	8%	0			3								
49900	Suture, secondary, of abdomi	090	567	658	91	16%	12.41	16.98	4.57	37%	0				3			14			1	
49904	Omental flap, extra-abdomina	090	670	703	33	5%	22.35	25.69	3.34	15%	0			3	2			5	3		1	
49906	Free omental flap with microv	090	892	964	72	8%	0.00	N/A	N/A	N/A	0			2	4			8			1	
50010	Renal exploration, not necess	090	341	377	36	11%	12.28	14.21	1.93	16%	0				3			3			1	

50020	Drainage of perirenal or renal	090	650	697	47	7%	18.08	22.10	4.02	22%	0				4			7	4		1	
50040	Nephrostomy, nephrotomy w	090	405	453	48	12%	16.68	19.18	2.50	15%	0				4			4			1	
50045	Nephrotomy, with exploration	090	382	420.5	38.5	10%	16.82	18.87	2.05	12%	0				3			3.5			1	
50060	Nephrolithotomy; removal of	090	440	491	51	12%	20.95	23.60	2.65	13%	0				3			6			1	
50065	Nephrolithotomy; secondary s	090	471	517	46	10%	22.32	24.73	2.41	11%	0				3			5			1	
50070	Nephrolithotomy; complicate	090	482	528	46	10%	21.85	24.26	2.41	11%	0				3			5			1	
50075	Nephrolithotomy; removal of	090	569.5	621.5	52	9%	27.09	29.79	2.70	10%	0				3.5			5.5			1	
50080	Percutaneous nephrolithotom	090	244	258	14	6%	13.50	14.27	0.77	6%	0				2						0.5	
50081	Percutaneous nephrolithotom	090	302	316	14	5%	22.00	22.77	0.77	3%	0				2						0.5	
50100	Transection or repositioning o	090	400	438.5	38.5	10%	17.45	19.50	2.05	12%	0				3			3.5			1	
50120	Pyelotomy; with exploration	090	362	398	36	10%	17.21	19.14	1.93	11%	0				3			3			1	
50125	Pyelotomy; with drainage, pye	090	364	400	36	10%	17.82	19.75	1.93	11%	0				3			3			1	
50130	Pyelotomy; with removal of ca	090	427	473	46	11%	18.82	21.23	2.41	13%	0				3			5			1	
50135	Pyelotomy; complicated (eg, s	090	443	484	41	9%	20.59	22.76	2.17	11%	0				3			4			1	
50205	Renal biopsy; by surgical expo	090	324	353	29	9%	12.29	13.89	1.60	13%	0				2			3			1	
50220	Nephrectomy, including partia	090	432	478	46	11%	18.68	21.09	2.41	13%	0				3			5			1	
50225	Nephrectomy, including partia	090	512	563	51	10%	21.88	24.53	2.65	12%	0				3			6			1	
50230	Nephrectomy, including partia	090	573.5	631	57.5	10%	23.81	26.78	2.97	12%	0				2.5			8			1	
50234	Nephrectomy with total urete	090	512	563	51	10%	24.05	26.70	2.65	11%	0				3			6			1	
50236	Nephrectomy with total urete	090	570	633	63	11%	26.94	30.16	3.22	12%	0				4			7			1	
50240	Nephrectomy, partial	090	605	673	68	11%	24.21	27.67	3.46	14%	0				4			8			1	
50250	Ablation, open, 1 or more ren	090	541	563	22	4%	22.22	25.06	2.84	13%	0			2	2			3	2	1	1	
50280	Excision or unroofing of cyst(s	090	379	420	41	11%	17.09	19.26	2.17	13%	0				3			4			1	
50290	Excision of perinephric cyst	090	386	427	41	11%	16.15	18.32	2.17	13%	0				3			4			1	
50320	Donor nephrectomy (including	090	524	554	30	6%	22.43	24.71	2.28	10%	0			5				4			1	
50340	Recipient nephrectomy (separ	090	436.5	493.5	57	13%	14.04	16.98	2.94	21%	0				3.5			6.5			1	
50360	Renal allotransplantation, imp	090	774	805	31	4%	39.88	43.40	3.52	9%	-5				1	2	1	1	2	2	1	
50365	Renal allotransplantation, imp	090	1446	1455	9	1%	46.13	52.02	5.89	13%	0				9				13.5		1	
50370	Removal of transplanted rena	090	898	961	63	7%	18.88	22.10	3.22	17%	0				4			7			1	
50380	Renal autotransplantation, re	090	1469	1478	9	1%	30.11	36.00	5.89	20%	0				9				13.5		1	
50400	Pyeloplasty (Foley Y-pyeloplas	090	483	539	56	12%	21.27	24.16	2.89	14%	0				3			7			1	
50405	Pyeloplasty (Foley Y-pyeloplas	090	550.5	610	59.5	11%	25.86	28.92	3.06	12%	0				3.5			7			1	
50500	Nephrorrhaphy, suture of kidn	090	463	514	51	11%	21.22	23.87	2.65	12%	0				3			6			1	
50520	Closure of nephrocutaneous c	090	465	516	51	11%	18.88	21.53	2.65	14%	0				3			6			1	
50525	Closure of nephrovisceral fistu	090	569.5	636.5	67	12%	24.39	27.81	3.42	14%	0				3.5			8.5			1	
50526	Closure of nephrovisceral fistu	090	624.5	699	74.5	12%	26.31	30.09	3.78	14%	0				3.5			10			1	
50540	Symphysiotomy for horseshoe	090	421	452	31	7%	21.10	22.79	1.69	8%	0				3			2			1	
50541	Laparoscopy, surgical; ablatio	090	319	343	24	8%	16.86	18.22	1.36	8%	0				2			2			1	
50542	Laparoscopy, surgical; ablatio	090	449	468	19	4%	21.36	22.86	1.50	7%	-2				2	1			1		1	
50543	Laparoscopy, surgical; partial	090	557	593	36	6%	27.41	29.72	2.31	8%	-2				3	1		2	1		1	
50544	Laparoscopy, surgical; pyelopl	090	459	488	29	6%	23.37	24.97	1.60	7%	0				2			3			1	
50545	Laparoscopy, surgical; radical	090	491	522	31	6%	25.06	26.75	1.69	7%	-2				1	1		3			1	
50546	Laparoscopy, surgical; nephre	090	466.5	504.5	38	8%	21.87	23.89	2.02	9%	-2				2	1		3			1	
50547	Laparoscopy, surgical; donor n	090	501.5	525.5	24	5%	26.34	27.70	1.36	5%	0				2			2			1	
50548	Laparoscopy, surgical; nephre	090	494	523	29	6%	25.36	26.96	1.60	6%	0				2			3			1	
50562	Renal endoscopy through esta	090	187.5	187.5	0	0%	10.90	11.01	0.11	1%	0										0.5	
50590	Lithotripsy, extracorporeal sh	090	207	223	16	8%	9.77	10.76	0.99	10%	0			1	2						0.5	
50592	Ablation, 1 or more renal tum	010	145	147	2	1%	6.55	6.88	0.33	5%	0			1							0.5	
50593	Ablation, renal tumor(s), unila	010	207	214	7	3%	8.88	9.32	0.44	5%	0				1						0.5	
50600	Ureterotomy with exploration	090	361.5	401.5	40	11%	17.17	19.30	2.13	12%	0				2.5			4.5			1	
50605	Ureterotomy for insertion of i	090	361.5	401.5	40	11%	16.79	18.92	2.13	13%	0				2.5			4.5			1	
50610	Ureterolithotomy; upper one-	090	354.5	394.5	40	11%	17.25	19.38	2.13	12%	0				2.5			4.5			1	
50620	Ureterolithotomy; middle one	090	330.5	368	37.5	11%	16.43	18.44	2.01	12%	0				2.5			4			1	
50630	Ureterolithotomy; lower one-	090	339.5	377	37.5	11%	16.21	18.22	2.01	12%	0				2.5			4			1	
50650	Ureterectomy, with bladder c	090	387	428	41	11%	18.82	20.99	2.17	12%	0				3			4			1	
50660	Ureterectomy, total, ectopic u	090	434	477.5	43.5	10%	21.02	23.31	2.29	11%	0				3			4.5			1	
50688	Change of ureterostomy tube	010	52	53	1	2%	1.20	1.31	0.11	9%	0			0.5								
50700	Ureteroplasty, plastic operati	090	415	458.5	43.5	10%	16.69	18.98	2.29	14%	0				3			4.5			1	
50715	Ureterolysis, with or without t	090	467	504	37	8%	20.64	23.01	2.37	11%	0				3			4	1		1	
50722	Ureterolysis for ovarian vein s	090	423	471.5	48.5	11%	17.95	20.48	2.53	14%	0				3			5.5			1	
50725	Ureterolysis for retrocaval ure	090	486	539.5	53.5	11%	20.20	22.97	2.77	14%	0				3			6.5			1	
50727	Revision of urinary-cutaneous	090	225	241	16	7%	8.28	9.51	1.23	15%	0			2	1			1			1	
50728	Revision of urinary-cutaneous	090	286	314	28	10%	12.18	13.85	1.67	14%	0			1	3			1			1	
50740	Ureteropyelostomy, anastom	090	465	516	51	11%	20.07	22.72	2.65	13%	0				3			6			1	
50750	Ureterocalycostomy, anastom	090	507	560.5	53.5	11%	21.22	23.99	2.77	13%	0				3			6.5			1	
50760	Ureteroureterostomy	090	451	502	51	11%	20.07	22.72	2.65	13%	0				3			6			1	
50770	Transureteroureterostomy, an	090	489	542.5	53.5	11%	21.22	23.99	2.77	13%	0				3			6.5			1	

50780	Ureteroneocystostomy; anast	090	413	461.5	48.5	12%	19.95	22.48	2.53	13%	0				3			5.5			1	
50782	Ureteroneocystostomy; anast	090	384	415	31	8%	19.66	21.35	1.69	9%	0				3			2			1	
50783	Ureteroneocystostomy; with	090	427	460	33	8%	20.70	22.61	1.91	9%	0			1	3			2			1	
50785	Ureteroneocystostomy; with	090	485	538.5	53.5	11%	22.23	25.00	2.77	12%	0				3			6.5			1	
50800	Ureteroenterostomy, direct a	090	470.5	527.5	57	12%	16.41	19.35	2.94	18%	0				3.5			6.5			1	
50810	Ureterosigmoidostomy, with	090	731.5	810.5	79	11%	22.61	26.60	3.99	18%	0				4.5			9.5			1	
50815	Ureterocolon conduit, includi	090	630	703	73	12%	22.26	25.96	3.70	17%	0				4			9			1	
50820	Ureteroileal conduit (ileal blad	090	606.5	676	69.5	11%	24.07	27.61	3.54	15%	0				3.5			9			1	
50825	Continent diversion, including	090	761	841.5	80.5	11%	30.68	34.74	4.06	13%	0				4			10.5			1	
50830	Urinary undiversion (eg, takin	090	761	841.5	80.5	11%	33.77	37.83	4.06	12%	0				4			10.5			1	
50840	Replacement of all or part of	090	678	753.5	75.5	11%	22.39	26.21	3.82	17%	0				4			9.5			1	
50845	Cutaneous appendico-vesicos	090	613	673	60	10%	22.46	25.53	3.07	14%	0				5			5			1	
50860	Ureterostomy, transplantatio	090	434	487.5	53.5	12%	17.08	19.85	2.77	16%	0				3			6.5			1	
50900	Ureterorrhaphy, suture of ure	090	363	404	41	11%	15.04	17.21	2.17	14%	0				3			4			1	
50920	Closure of ureterocutaneous f	090	409	452.5	43.5	11%	15.81	18.10	2.29	14%	0				3			4.5			1	
50930	Closure of ureterovisceral fist	090	438	481.5	43.5	10%	20.19	22.48	2.29	11%	0				3			4.5			1	
50940	Deligation of ureter	090	383	424	41	11%	15.93	18.10	2.17	14%	0				3			4			1	
50945	Laparoscopy, surgical; ureterc	090	341.5	370.5	29	8%	17.97	19.57	1.60	9%	0				2			3			1	
50947	Laparoscopy, surgical; ureterc	090	512	548	36	7%	25.78	27.71	1.93	7%	0				3			3			1	
50948	Laparoscopy, surgical; ureterc	090	506	524	18	4%	23.82	25.43	1.61	7%	-2				1	1		1		1	1	
51020	Cystotomy or cystostomy; wit	090	266.5	291.5	25	9%	7.69	9.10	1.41	18%	0				2.5			1.5			1	
51030	Cystotomy or cystostomy; wit	090	284.5	312	27.5	10%	7.81	9.34	1.53	20%	0				2.5			2			1	
51040	Cystostomy, cystotomy with c	090	139	143	4	3%	4.49	5.04	0.55	12%	0			2							0.5	
51045	Cystotomy, with insertion of u	090	271.5	299	27.5	10%	7.81	9.34	1.53	20%	0				2.5			2			1	
51050	Cystolithotomy, cystotomy wi	090	276	307.5	31.5	11%	7.97	9.69	1.72	22%	0				2			3.5			1	
51060	Transvesical ureterolithotomy	090	319.5	349.5	30	9%	9.95	11.60	1.65	17%	0				2.5			2.5			1	
51065	Cystotomy, with calculus bask	090	318.5	348.5	30	9%	9.95	11.60	1.65	17%	0				2.5			2.5			1	
51080	Drainage of perivesical or pre	090	238	257	19	8%	6.71	7.83	1.12	17%	0				2			1			1	
51500	Excision of urachal cyst or sin	090	290.5	313	22.5	8%	11.05	12.34	1.29	12%	0				2.5			1			1	
51520	Cystotomy; for simple excisio	090	271.5	294	22.5	8%	10.21	11.50	1.29	13%	0				2.5			1			1	
51525	Cystotomy; for excision of bla	090	386.5	431.5	45	12%	15.42	17.79	2.37	15%	0				2.5			5.5			1	
51530	Cystotomy; for excision of bla	090	357.5	397.5	40	11%	13.71	15.84	2.13	15%	0				2.5			4.5			1	
51535	Cystotomy for excision, incisio	090	374.5	414.5	40	11%	13.90	16.03	2.13	15%	0				2.5			4.5			1	
51550	Cystectomy, partial; simple	090	419.5	469.5	50	12%	17.23	19.84	2.61	15%	0				2.5			6.5			1	
51555	Cystectomy, partial; complica	090	534	597.5	63.5	12%	23.18	26.43	3.25	14%	0				3			8.5			1	
51565	Cystectomy, partial, with reim	090	571.5	636	64.5	11%	23.68	26.98	3.30	14%	0				3.5			8			1	
51570	Cystectomy, complete; (separ	090	710	773.5	63.5	9%	27.46	30.71	3.25	12%	0				3			8.5			1	
51575	Cystectomy, complete; with b	090	863.5	945.5	82	9%	34.18	38.32	4.14	12%	0				3.5			11.5			1	
51580	Cystectomy, complete, with u	090	987.5	1086.5	99	10%	35.37	40.32	4.95	14%	0				4.5			13.5			1	
51585	Cystectomy, complete, with u	090	1073.5	1177.5	104	10%	39.64	44.83	5.19	13%	0				4.5			14.5			1	
51590	Cystectomy, complete, with u	090	990.5	1070	79.5	8%	36.33	40.35	4.02	11%	0				3.5			11			1	
51595	Cystectomy, complete, with u	090	1039	1137	98	9%	41.32	46.22	4.90	12%	0				4			14			1	
51596	Cystectomy, complete, with c	090	1231	1346	115	9%	44.26	49.97	5.71	13%	0				5			16			1	
51597	Pelvic exenteration, complete	090	1023	1093	70	7%	42.86	48.37	5.51	13%	0				5			11	5		1	
51800	Cystoplasty or cystourethropl	090	434	477.5	43.5	10%	18.89	21.18	2.29	12%	0				3			4.5			1	
51820	Cystourethroplasty with unila	090	511.5	561	49.5	10%	19.59	22.17	2.58	13%	0				3.5			5			1	
51840	Anterior vesicourethropexy, c	090	319	346.5	27.5	9%	11.36	13.21	1.85	16%	0			2.5				4.5			1	
51841	Anterior vesicourethropexy, c	090	354	381.5	27.5	8%	13.68	15.53	1.85	14%	0			2.5				4.5			1	
51845	Abdomino-vaginal vesical nec	090	265	282.5	17.5	7%	10.15	11.52	1.37	13%	0			2.5				2.5			1	
51860	Cystorrhaphy, suture of bladd	090	308	332.5	24.5	8%	12.60	14.43	1.83	15%	0			3.5				3.5			1	
51865	Cystorrhaphy, suture of bladd	090	398	430	32	8%	15.80	17.99	2.19	14%	0			3.5				5			1	
51880	Closure of cystostomy (separa	090	216	225	9	4%	7.87	8.77	0.90	11%	0			2				1			1	
51900	Closure of vesicovaginal fistul	090	487	538	51	10%	14.63	17.28	2.65	18%	0				3			6			1	
51920	Closure of vesicouterine fistul	090	458	506.5	48.5	11%	13.41	15.94	2.53	19%	0				3			5.5			1	
51925	Closure of vesicouterine fistul	090	536.5	596	59.5	11%	17.53	20.59	3.06	17%	0				3.5			7			1	
51940	Closure, exstrophy of bladder	090	671.5	743.5	72	11%	30.66	34.32	3.66	12%	0				3.5			9.5			1	
51960	Enterocystoplasty, including ir	090	663	738.5	75.5	11%	25.40	29.22	3.82	15%	0				4			9.5			1	
51980	Cutaneous vesicostomy	090	320.5	355.5	35	11%	12.57	14.46	1.89	15%	0				2.5			3.5			1	
51990	Laparoscopy, surgical; urethra	090	324	348	24	7%	13.36	14.72	1.36	10%	0				2			2			1	
51992	Laparoscopy, surgical; sling op	090	324	348	24	7%	14.87	16.23	1.36	9%	0				2			2			1	
52301	Cystourethroscopy; with rese	000	183	183	0	0%	5.50	5.72	0.22	4%	0										1	
52400	Cystourethroscopy with incisi	090	197.5	199.5	2	1%	8.69	9.02	0.33	4%	0			1							0.5	
52450	Transurethral incision of prost	090	209	230	21	10%	7.78	8.88	1.10	14%	0				3						0.5	
52500	Transurethral resection of bla	090	230.5	251.5	21	9%	8.14	9.24	1.10	14%	0				3						0.5	
52601	Transurethral electrosurgical	090	236	250	14	6%	13.16	13.93	0.77	6%	0				2						0.5	
52630	Transurethral resection; resid	090	222	233	11	5%	6.55	7.43	0.88	13%	0			2	1						0.5	
52640	Transurethral resection; of po	090	184	200	16	9%	4.79	5.78	0.99	21%	0			1	2						0.5	

52647	Laser coagulation of prostate,	090	219	240	21	10%	11.30	12.29	0.99	9%	0				3							
52648	Laser vaporization of prostate	090	249	270	21	8%	12.15	13.14	0.99	8%	0				3							
52649	Laser enucleation of the prost	090	279	295	16	6%	14.56	15.55	0.99	7%	0			1	2						0.5	
52700	Transurethral drainage of pro	090	201	217.5	16.5	8%	7.49	8.49	1.00	13%	0				2			0.5			1	
53000	Urethrotomy or urethrostomy	010	138	140	2	1%	2.33	2.77	0.44	19%	0			1							1	
53010	Urethrotomy or urethrostomy	090	228	249.5	21.5	9%	4.45	5.69	1.24	28%	0				2			1.5			1	
53040	Drainage of deep periurethral	090	179	185.5	6.5	4%	6.55	7.33	0.78	12%	0			2				0.5			1	
53060	Drainage of Skene's gland abs	010	68	70	2	3%	2.68	2.90	0.22	8%	0			1								
53080	Drainage of perineal urinary e	090	193	207	14	7%	6.92	7.80	0.88	13%	0				2						1	
53085	Drainage of perineal urinary e	090	254.5	277	22.5	9%	11.18	12.47	1.29	11%	0				2.5			1			1	
53210	Urethrectomy, total, including	090	325.5	358	32.5	10%	13.72	15.49	1.77	13%	0				2.5			3			1	
53215	Urethrectomy, total, including	090	371.5	409	37.5	10%	16.85	18.86	2.01	12%	0				2.5			4			1	
53220	Excision or fulguration of carc	090	201	215	14	7%	7.63	8.51	0.88	12%	0				2						1	
53230	Excision of urethral diverticulu	090	267.5	287.5	20	7%	10.44	11.61	1.17	11%	0				2.5			0.5			1	
53235	Excision of urethral diverticulu	090	281.5	301.5	20	7%	10.99	12.16	1.17	11%	0				2.5			0.5			1	
53240	Marsupialization of urethral d	090	199	213	14	7%	7.08	7.96	0.88	12%	0				2						1	
53250	Excision of bulbourethral glan	090	153	167	14	9%	6.52	7.18	0.66	10%	0				2							
53260	Excision or fulguration; urethr	010	74	76	2	3%	3.03	3.25	0.22	7%	0			1								
53265	Excision or fulguration; urethr	010	76	78	2	3%	3.17	3.39	0.22	7%	0			1								
53270	Excision or fulguration; Skene	010	93	95	2	2%	3.14	3.47	0.33	11%	0			1							0.5	
53275	Excision or fulguration; urethr	010	121	123	2	2%	4.57	4.90	0.33	7%	0			1							0.5	
53400	Urethroplasty; first stage, for	090	343	381.5	38.5	11%	14.13	16.18	2.05	15%	0				3			3.5			1	
53405	Urethroplasty; second stage (	090	330	361	31	9%	15.66	17.35	1.69	11%	0				3			2			1	
53410	Urethroplasty, 1-stage recons	090	364	397.5	33.5	9%	17.68	19.49	1.81	10%	0				3			2.5			1	
53415	Urethroplasty, transpubic or p	090	424	460	36	8%	20.70	22.63	1.93	9%	0				3			3			1	
53420	Urethroplasty, 2-stage recons	090	340.5	370.5	30	9%	15.17	16.82	1.65	11%	0				2.5			2.5			1	
53425	Urethroplasty, 2-stage recons	090	349.5	379.5	30	9%	17.07	18.72	1.65	10%	0				2.5			2.5			1	
53430	Urethroplasty, reconstruction	090	344.5	374.5	30	9%	17.43	19.08	1.65	9%	0				2.5			2.5			1	
53431	Urethroplasty with tubularizat	090	426	462	36	8%	21.18	23.11	1.93	9%	0				3			3			1	
53440	Sling operation for correction	090	248	264	16	6%	13.36	14.35	0.99	7%	0			1	2						0.5	
53442	Removal or revision of sling fo	090	395	415	20	5%	13.49	15.43	1.94	14%	0				4				2		1	
53444	Insertion of tandem cuff (dual	090	320	341	21	7%	14.19	15.53	1.34	9%	0			1	2			1			1	
53445	Insertion of inflatable urethra	090	314	337	23	7%	13.00	14.32	1.32	10%	0			1	3						0.5	
53446	Removal of inflatable urethral	090	300	321	21	7%	11.02	12.36	1.34	12%	0			1	2			1			1	
53447	Removal and replacement of i	090	340	361	21	6%	14.28	15.62	1.34	9%	0			1	2			1			1	
53448	Removal and replacement of i	090	564	604	40	7%	23.44	26.34	2.90	12%	-2				2	1		5	2		1	
53449	Repair of inflatable urethral/b	090	280.5	300.5	20	7%	10.56	11.73	1.17	11%	0				2.5			0.5			1	
53450	Urethromeatoplasty, with mu	090	202	216	14	7%	6.77	7.65	0.88	13%	0				2						1	
53460	Urethromeatoplasty, with par	090	205	219	14	7%	7.75	8.63	0.88	11%	0				2						1	
53500	Urethrolysis, transvaginal, sec	090	289	310	21	7%	13.00	14.34	1.34	10%	0			1	2			1			1	
53502	Urethrorrhaphy, suture of ure	090	212	226	14	7%	8.26	9.14	0.88	11%	0				2						1	
53505	Urethrorrhaphy, suture of ure	090	218	232	14	6%	8.26	9.14	0.88	11%	0				2						1	
53510	Urethrorrhaphy, suture of ure	090	270.5	290.5	20	7%	10.96	12.13	1.17	11%	0				2.5			0.5			1	
53515	Urethrorrhaphy, suture of ure	090	322.5	345	22.5	7%	14.22	15.51	1.29	9%	0				2.5			1			1	
53520	Closure of urethrostomy or ur	090	250.5	268	17.5	7%	9.48	10.53	1.05	11%	0				2.5						1	
53850	Transurethral destruction of p	090	151	172	21	14%	5.42	6.41	0.99	18%	0				3							
53852	Transurethral destruction of p	090	142	163	21	15%	5.93	6.92	0.99	17%	0				3							
53854	Transurethral destruction of p	090	137	158	21	15%	5.93	6.92	0.99	17%	0				3							
53860	Transurethral radiofrequency	090	98	112	14	14%	3.97	4.63	0.66	17%	0				2							
54000	Slitting of prepuce, dorsal or l	010	54	56	2	4%	1.59	1.81	0.22	14%	0			1								
54001	Slitting of prepuce, dorsal or l	010	69	71	2	3%	2.24	2.46	0.22	10%	0			1								
54015	Incision and drainage of penis	010	119	121	2	2%	5.36	5.69	0.33	6%	0			1							0.5	
54050	Destruction of lesion(s), penis	010	54	56	2	4%	1.29	1.51	0.22	17%	0			1								
54055	Destruction of lesion(s), penis	010	44	45	1	2%	1.25	1.36	0.11	9%	0			0.5								
54056	Destruction of lesion(s), penis	010	56	58	2	4%	1.29	1.51	0.22	17%	0			1								
54057	Destruction of lesion(s), penis	010	73	75	2	3%	1.29	1.51	0.22	17%	0			1								
54060	Destruction of lesion(s), penis	010	66	68	2	3%	1.98	2.20	0.22	11%	0			1								
54065	Destruction of lesion(s), penis	010	68	70	2	3%	2.47	2.69	0.22	9%	0			1								
54105	Biopsy of penis; deep structur	010	102	104	2	2%	3.54	3.76	0.22	6%	0			1								
54110	Excision of penile plaque (Pey	090	256.5	274	17.5	7%	10.92	11.97	1.05	10%	0				2.5						1	
54111	Excision of penile plaque (Pey	090	318.5	338.5	20	6%	14.42	15.59	1.17	8%	0				2.5			0.5			1	
54112	Excision of penile plaque (Pey	090	368	396.5	28.5	8%	16.98	18.55	1.57	9%	0				3			1.5			1	
54115	Removal foreign body from de	090	207.5	225	17.5	8%	6.95	8.00	1.05	15%	0				2.5						1	
54120	Amputation of penis; partial	090	272.5	300	27.5	10%	11.01	12.54	1.53	14%	0				2.5			2			1	
54125	Amputation of penis; complet	090	298.5	326	27.5	9%	14.56	16.09	1.53	10%	0				2.5			2			1	
54130	Amputation of penis, radical;	090	502.5	552	49.5	10%	21.84	24.42	2.58	12%	0				3.5			5			1	
54135	Amputation of penis, radical;	090	599.5	654	54.5	9%	28.17	30.99	2.82	10%	0				3.5			6			1	

54160	Circumcision, surgical excision	010	83	85	2	2%	2.53	2.75	0.22	9%	0			1								
54161	Circumcision, surgical excision	010	88	90	2	2%	3.32	3.54	0.22	7%	0			1								
54162	Lysis or excision of penile pos	010	107	114	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
54163	Repair incomplete circumcisio	010	107	114	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
54164	Frenulotomy of penis	010	97	104	7	7%	2.82	3.26	0.44	16%	0				1						0.5	
54200	Injection procedure for Peyro	010	71	73	2	3%	1.11	1.33	0.22	20%	0			1								
54205	Injection procedure for Peyro	090	262.5	290	27.5	10%	8.97	10.50	1.53	17%	0				2.5			2			1	
54300	Plastic operation of penis for	090	268.5	286	17.5	7%	11.20	12.14	0.94	8%	0				2.5						0.5	
54304	Plastic operation on penis for	090	273.5	291	17.5	6%	13.28	14.22	0.94	7%	0				2.5						0.5	
54308	Urethroplasty for second stag	090	234.5	252	17.5	7%	12.62	13.45	0.83	7%	0				2.5							
54312	Urethroplasty for second stag	090	317	338	21	7%	14.51	15.61	1.10	8%	0				3						0.5	
54316	Urethroplasty for second stag	090	401	434.5	33.5	8%	18.05	19.86	1.81	10%	0				3			2.5			1	
54318	Urethroplasty for third stage I	090	309	340	31	10%	12.43	14.12	1.69	14%	0				3			2			1	
54322	1-stage distal hypospadias rep	090	307.5	332.5	25	8%	13.98	15.39	1.41	10%	0				2.5			1.5			1	
54324	1-stage distal hypospadias rep	090	374	407.5	33.5	9%	17.55	19.36	1.81	10%	0				3			2.5			1	
54326	1-stage distal hypospadias rep	090	437	473	36	8%	17.02	18.95	1.93	11%	0				3			3			1	
54328	1-stage distal hypospadias rep	090	395	428.5	33.5	8%	16.89	18.70	1.81	11%	0				3			2.5			1	
54332	1-stage proximal penile or per	090	421	457	36	9%	18.37	20.30	1.93	11%	0				3			3			1	
54336	1-stage perineal hypospadias	090	450.5	495	44.5	10%	21.62	23.96	2.34	11%	0				3.5			4			1	
54340	Repair of hypospadias compli	090	234.5	252	17.5	7%	9.71	10.65	0.94	10%	0				2.5						0.5	
54344	Repair of hypospadias compli	090	371	399.5	28.5	8%	17.06	18.63	1.57	9%	0				3			1.5			1	
54348	Repair of hypospadias compli	090	408	439	31	8%	18.32	20.01	1.69	9%	0				3			2			1	
54352	Revision of prior hypospadias	090	497.5	534.5	37	7%	26.13	28.11	1.98	8%	0				3.5			2.5			1	
54360	Plastic operation on penis to c	090	280.5	300.5	20	7%	12.78	13.95	1.17	9%	0				2.5			0.5			1	
54380	Plastic operation on penis for	090	337	360.5	23.5	7%	14.18	15.51	1.33	9%	0				3			0.5			1	
54385	Plastic operation on penis for	090	424.5	451.5	27	6%	16.56	18.06	1.50	9%	0				3.5			0.5			1	
54390	Plastic operation on penis for	090	464.5	491.5	27	6%	22.77	24.27	1.50	7%	0				3.5			0.5			1	
54400	Insertion of penile prosthesis;	090	237	244.5	7.5	3%	9.17	10.06	0.89	10%	0			2.5				0.5			1	
54401	Insertion of penile prosthesis;	090	248	271	23	9%	10.44	11.63	1.19	11%	-2				2	1					0.5	
54405	Insertion of multi-component	090	272.5	290	17.5	6%	14.52	15.46	0.94	6%	0				2.5						0.5	
54406	Removal of all components of	090	295	316	21	7%	12.89	14.23	1.34	10%	0			1	2			1			1	
54408	Repair of component(s) of a n	090	334	362	28	8%	13.91	15.45	1.54	11%	-2				2	1		1			1	
54410	Removal and replacement of	090	329	352	23	7%	15.18	16.50	1.32	9%	0			1	3						0.5	
54411	Removal and replacement of	090	580	622	42	7%	18.35	21.47	3.12	17%	-2			1	2	1		5	2		1	
54415	Removal of non-inflatable (se	090	221	237	16	7%	8.88	9.87	0.99	11%	0			1	2						0.5	
54416	Removal and replacement of	090	315	345	30	10%	12.08	13.84	1.76	15%	-2			1	2	1		1			1	
54417	Removal and replacement of	090	465	495	30	6%	16.10	18.65	2.55	16%	-2			1	1	1		4	2		1	
54420	Corpora cavernosa-saphenou	090	324.5	349.5	25	8%	12.39	13.80	1.41	11%	0				2.5			1.5			1	
54430	Corpora cavernosa-corpus spo	090	273.5	296	22.5	8%	11.06	12.35	1.29	12%	0				2.5			1			1	
54435	Corpora cavernosa-glans peni	090	193	209.5	16.5	9%	6.81	7.81	1.00	15%	0				2			0.5			1	
54437	Repair of traumatic corporeal	090	264	287	23	9%	11.50	12.93	1.43	12%	0			1	3						1	
54438	Replantation, penis, complete	090	531	548	17	3%	24.50	26.84	2.34	10%	0				4				2	1	1	
54440	Plastic operation of penis for	090	386	407	21	5%	0.00	N/A	N/A	N/A	0			3				3			1	
54505	Biopsy of testis, incisional (se	010	97	99	2	2%	3.50	3.72	0.22	6%	0			1								
54512	Excision of extraparenchymal	090	216	235	19	9%	9.33	10.23	0.90	10%	0				2			1				
54520	Orchiectomy, simple (includin	090	144	147	3	2%	5.30	5.74	0.44	8%	0			1.5							0.5	
54522	Orchiectomy, partial	090	211	230	19	9%	10.25	11.15	0.90	9%	0				2			1				
54530	Orchiectomy, radical, for tum	090	246.5	257.5	11	4%	8.46	9.34	0.88	10%	0			2	1						0.5	
54535	Orchiectomy, radical, for tum	090	298.5	326	27.5	9%	13.19	14.72	1.53	12%	0				2.5			2			1	
54550	Exploration for undescended t	090	228	242	14	6%	8.41	9.29	0.88	10%	0				2						1	
54560	Exploration for undescended t	090	303.5	328.5	25	8%	12.10	13.51	1.41	12%	0				2.5			1.5			1	
54600	Reduction of torsion of testis,	090	202	216	14	7%	7.64	8.52	0.88	12%	0				2						1	
54620	Fixation of contralateral testis	010	127	134	7	6%	5.21	5.65	0.44	8%	0				1						0.5	
54640	Orchiopexy, inguinal or scrota	090	162	169	7	4%	7.73	8.17	0.44	6%	0				1						0.5	
54650	Orchiopexy, abdominal appro	090	301	322	21	7%	12.39	13.38	0.99	8%	0				3							
54660	Insertion of testicular prosthe	090	163	177	14	9%	5.74	6.51	0.77	13%	0				2						0.5	
54670	Suture or repair of testicular i	090	230	240	10	4%	6.65	7.66	1.01	15%	0			2.5				1			1	
54680	Transplantation of testis(es) t	090	364.5	407	42.5	12%	14.04	16.29	2.25	16%	0				2.5			5			1	
54690	Laparoscopy, surgical; orchiec	090	329	348	19	6%	11.70	12.82	1.12	10%	0				2			1			1	
54692	Laparoscopy, surgical; orchiop	090	319	343	24	8%	13.74	15.10	1.36	10%	0				2			2			1	
54700	Incision and drainage of epidi	010	97	99	2	2%	3.47	3.69	0.22	6%	0			1								
54830	Excision of local lesion of epid	090	170	184	14	8%	6.01	6.78	0.77	13%	0				2						0.5	
54840	Excision of spermatocele, with	090	146	149	3	2%	5.27	5.71	0.44	8%	0			1.5							0.5	
54860	Epididymectomy; unilateral	090	194	208	14	7%	6.95	7.72	0.77	11%	0				2						0.5	
54861	Epididymectomy; bilateral	090	245.5	263	17.5	7%	9.70	10.64	0.94	10%	0				2.5						0.5	
54865	Exploration of epididymis, wit	090	182	196	14	8%	5.77	6.65	0.88	15%	0				2						1	
54900	Epididymovasostomy, anastor	090	345	368.5	23.5	7%	14.20	15.53	1.33	9%	0				3			0.5			1	

54901	Epididymovasostomy, anastor	090	445.5	472.5	27	6%	19.10	20.60	1.50	8%	0				3.5			0.5			1	
55040	Excision of hydrocele; unilater	090	162	166	4	2%	5.45	6.00	0.55	10%	0			2							0.5	
55041	Excision of hydrocele; bilatera	090	232.5	250	17.5	8%	8.54	9.48	0.94	11%	0				2.5						0.5	
55060	Repair of tunica vaginalis hydr	090	185	199	14	8%	6.15	6.92	0.77	13%	0				2						0.5	
55100	Drainage of scrotal wall absce	010	90	97	7	8%	2.45	2.78	0.33	13%	0				1							
55110	Scrotal exploration	090	194	208	14	7%	6.33	7.21	0.88	14%	0				2						1	
55120	Removal of foreign body in sc	090	165	179	14	8%	5.72	6.49	0.77	13%	0				2						0.5	
55150	Resection of scrotum	090	279.5	302	22.5	8%	8.14	9.43	1.29	16%	0				2.5			1			1	
55175	Scrotoplasty; simple	090	186	200	14	8%	5.87	6.64	0.77	13%	0				2						0.5	
55180	Scrotoplasty; complicated	090	297	323	26	9%	11.78	13.23	1.45	12%	0				3			1			1	
55200	Vasotomy, cannulization with	090	98	105	7	7%	4.55	4.88	0.33	7%	0				1							
55250	Vasectomy, unilateral or bilat	090	105	108	3	3%	3.37	3.70	0.33	10%	0			1.5								
55400	Vasovasostomy, vasovasorrha	090	186	191	5	3%	8.61	9.27	0.66	8%	0			2.5							0.5	
55500	Excision of hydrocele of spern	090	184	198	14	8%	6.22	6.99	0.77	12%	0				2						0.5	
55520	Excision of lesion of spermatic	090	188	202	14	7%	6.66	7.43	0.77	12%	0				2						0.5	
55530	Excision of varicocele or ligati	090	152	156	4	3%	5.75	6.30	0.55	10%	0			2							0.5	
55535	Excision of varicocele or ligati	090	187	201	14	7%	7.19	7.96	0.77	11%	0				2						0.5	
55540	Excision of varicocele or ligati	090	224	238	14	6%	8.30	9.18	0.88	11%	0				2						1	
55550	Laparoscopy, surgical, with lig	090	196	210	14	7%	7.20	7.86	0.66	9%	0				2							
55600	Vesiculotomy;	090	204	218	14	7%	7.01	7.78	0.77	11%	0				2						0.5	
55605	Vesiculotomy; complicated	090	198.5	216	17.5	9%	8.76	9.70	0.94	11%	0				2.5						0.5	
55650	Vesiculectomy, any approach	090	304.5	324.5	20	7%	12.65	13.82	1.17	9%	0				2.5			0.5			1	
55680	Excision of Mullerian duct cyst	090	206.5	217	10.5	5%	5.67	6.39	0.72	13%	0				1.5						1	
55705	Biopsy, prostate; incisional, ar	010	122	124	2	2%	4.61	4.94	0.33	7%	0			1							0.5	
55706	Biopsies, prostate, needle, tra	010	195	211	16	8%	6.28	7.14	0.86	14%	-2				1	1					0.5	
55720	Prostatotomy, external draina	090	150	154	4	3%	7.73	8.17	0.44	6%	0			2								
55725	Prostatotomy, external draina	090	305	343.5	38.5	13%	10.05	12.10	2.05	20%	0				3			3.5			1	
55801	Prostatectomy, perineal, subt	090	497.5	559.5	62	12%	19.80	22.98	3.18	16%	0				3.5			7.5			1	
55810	Prostatectomy, perineal radic	090	515	568.5	53.5	10%	24.29	27.06	2.77	11%	0				3			6.5			1	
55812	Prostatectomy, perineal radic	090	684	759.5	75.5	11%	29.89	33.71	3.82	13%	0				4			9.5			1	
55815	Prostatectomy, perineal radic	090	771	851.5	80.5	10%	32.95	37.01	4.06	12%	0				4			10.5			1	
55821	Prostatectomy (including cont	090	315	325	10	3%	15.18	16.26	1.08	7%	0				2				1		1	
55831	Prostatectomy (including cont	090	322	332	10	3%	15.60	16.68	1.08	7%	0				2				1		1	
55840	Prostatectomy, retropubic rad	090	448	472	24	5%	21.36	23.10	1.74	8%	-2				2	1		1	1		1	
55842	Prostatectomy, retropubic rad	090	448	472	24	5%	21.36	23.10	1.74	8%	-2				2	1		1	1		1	
55845	Prostatectomy, retropubic rad	090	466	490	24	5%	25.18	26.92	1.74	7%	-2				2	1		1	1		1	
55860	Exposure of prostate, any app	090	371.5	414	42.5	11%	15.84	18.09	2.25	14%	0				2.5			5			1	
55862	Exposure of prostate, any app	090	450	501	51	11%	20.04	22.69	2.65	13%	0				3			6			1	
55865	Exposure of prostate, any app	090	492.5	542	49.5	10%	24.57	27.15	2.58	10%	0				3.5			5			1	
55866	Laparoscopy, surgical prostate	090	362	376	14	4%	22.46	23.23	0.77	3%	0				2						0.5	
55873	Cryosurgical ablation of the pr	090	274	295	21	8%	13.60	14.70	1.10	8%	0				3						0.5	
55875	Transperineal placement of ne	090	249	270	21	8%	13.46	14.45	0.99	7%	0				3							
55880	Ablation of malignant prostate	090	373	396	23	6%	17.73	18.92	1.19	7%	-2				2	1					0.5	
56405	Incision and drainage of vulva	010	56	58	2	4%	1.49	1.71	0.22	15%	0			1								
56420	Incision and drainage of Barth	010	56	58	2	4%	1.44	1.66	0.22	15%	0			1								
56440	Marsupialization of Bartholin'	010	93	95	2	2%	2.89	3.11	0.22	8%	0			1								
56441	Lysis of labial adhesions	010	67	69	2	3%	2.02	2.24	0.22	11%	0			1								
56501	Destruction of lesion(s), vulva	010	55	57	2	4%	1.58	1.80	0.22	14%	0			1								
56515	Destruction of lesion(s), vulva	010	157	164	7	4%	3.08	3.52	0.44	14%	0				1						0.5	
56620	Vulvectomy simple; partial	090	239	262	23	10%	7.53	8.85	1.32	18%	0			1	3						0.5	
56625	Vulvectomy simple; complete	090	341.5	379	37.5	11%	9.68	11.69	2.01	21%	0				2.5			4			1	
56630	Vulvectomy, radical, partial;	090	562.5	627.5	65	12%	14.80	18.13	3.33	22%	0				2.5			9.5			1	
56631	Vulvectomy, radical, partial; w	090	658.5	680.5	22	3%	18.99	21.56	2.57	14%	-2				2	1		1	3	1		1
56632	Vulvectomy, radical, partial; w	090	683	753	70	10%	21.86	25.41	3.55	16%	0				5			7			1	
56633	Vulvectomy, radical, complete	090	602	615	13	2%	19.62	22.71	3.09	16%	0				3			2	3	2	1	
56634	Vulvectomy, radical, complete	090	686	708	22	3%	20.66	23.23	2.57	12%	-2				2	1		1	3	1		1
56637	Vulvectomy, radical, complete	090	726	748	22	3%	24.75	27.32	2.57	10%	-2				2	1		1	3	1		1
56640	Vulvectomy, radical, complete	090	640.5	713	72.5	11%	24.78	28.47	3.69	15%	0				2.5			11			1	
56700	Partial hymenectomy or revisi	010	94	101	7	7%	2.84	3.17	0.33	12%	0				1							
56740	Excision of Bartholin's gland o	010	176	183	7	4%	4.88	5.43	0.55	11%	0				1						1	
56800	Plastic repair of introitus	010	116	118	2	2%	3.93	4.26	0.33	8%	0			1							0.5	
56805	Clitoroplasty for intersex state	090	460	491	31	7%	19.88	21.70	1.82	9%	0			1	2			3			1	
56810	Perineoplasty, repair of perine	010	119	126	7	6%	4.29	4.86	0.57	13%	0			1				1			0.5	
57000	Colpotomy; with exploration	010	79	81	2	3%	3.02	3.24	0.22	7%	0			1								
57010	Colpotomy; with drainage of p	090	229	250.5	21.5	9%	6.84	8.08	1.24	18%	0				2			1.5			1	
57022	Incision and drainage of vagin	010	116	123	7	6%	2.73	3.19	0.46	17%	0			1				1				
57023	Incision and drainage of vagin	010	201	213	12	6%	5.18	5.97	0.79	15%	0				1			1			1	

57061	Destruction of vaginal lesion(s	010	55	57	2	4%	1.30	1.52	0.22	17%	0			1								
57065	Destruction of vaginal lesion(s	010	78	80	2	3%	2.66	2.88	0.22	8%	0			1								
57105	Biopsy of vaginal mucosa; ext	010	79	81	2	3%	1.74	1.96	0.22	13%	0			1								
57106	Vaginectomy, partial removal	090	239	265	26	11%	7.50	8.95	1.45	19%	0				3			1			1	
57107	Vaginectomy, partial removal	090	515	533	18	3%	24.56	26.54	1.98	8%	0			1	2			2	2		1	
57109	Vaginectomy, partial removal	090	539.5	580.5	41	8%	28.40	30.57	2.17	8%	0				3			4			1	
57110	Vaginectomy, complete remo	090	386	406	20	5%	15.48	17.04	1.56	10%	0				2			2	1		1	
57111	Vaginectomy, complete remo	090	554.5	595.5	41	7%	28.40	30.57	2.17	8%	0				3			4			1	
57120	Colpocleisis (Le Fort type)	090	253	277	24	9%	8.28	9.64	1.36	16%	0				2			2			1	
57130	Excision of vaginal septum	010	54	55	1	2%	2.46	2.57	0.11	4%	0			0.5								
57135	Excision of vaginal cyst or tum	010	56	57	1	2%	2.70	2.81	0.11	4%	0			0.5								
57180	Introduction of any hemostati	010	59	61	2	3%	1.63	1.85	0.22	13%	0			1								
57200	Colporrhaphy, suture of injury	090	138.5	149	10.5	8%	4.42	5.03	0.61	14%	0				1.5						0.5	
57210	Colpoperineorrhaphy, suture	090	190.5	203.5	13	7%	5.71	6.55	0.84	15%	0				1.5			0.5			1	
57220	Plastic operation on urethral s	090	194.5	207.5	13	7%	4.85	5.69	0.84	17%	0				1.5			0.5			1	
57230	Plastic repair of urethrocele	090	209.5	227.5	18	9%	6.30	7.38	1.08	17%	0				1.5			1.5			1	
57240	Anterior colporrhaphy, repair	090	211	225	14	7%	10.08	10.85	0.77	8%	0				2						0.5	
57250	Posterior colporrhaphy, repai	090	211	225	14	7%	10.08	10.85	0.77	8%	0				2						0.5	
57260	Combined anteroposterior co	090	241	255	14	6%	13.25	14.02	0.77	6%	0				2						0.5	
57265	Combined anteroposterior co	090	271	285	14	5%	15.00	15.77	0.77	5%	0				2						0.5	
57268	Repair of enterocele, vaginal a	090	234	255.5	21.5	9%	7.57	8.81	1.24	16%	0				2			1.5			1	
57270	Repair of enterocele, abdomir	090	381	393	12	3%	13.67	15.39	1.72	13%	0				2			1	1	1	1	
57280	Colpopexy, abdominal approa	090	439	456	17	4%	16.72	18.68	1.96	12%	0				2			2	1	1	1	
57282	Colpopexy, vaginal; extra-peri	090	229	243	14	6%	11.63	12.40	0.77	7%	0				2						0.5	
57283	Colpopexy, vaginal; intra-peri	090	231	245	14	6%	11.66	12.43	0.77	7%	0				2						0.5	
57284	Paravaginal defect repair (incl	090	327	337	10	3%	14.33	15.54	1.21	8%	0			1	1			1	1		1	
57285	Paravaginal defect repair (incl	090	267	272	5	2%	11.60	12.57	0.97	8%	0			1	1				1		1	
57287	Removal or revision of sling fo	090	239	262	23	10%	11.15	12.47	1.32	12%	0			1	3						0.5	
57288	Sling operation for stress inco	090	246	269	23	9%	12.13	13.45	1.32	11%	0			1	3						0.5	
57289	Pereyra procedure, including	090	373	377	4	1%	12.80	14.39	1.59	12%	0			2	1				1	1	1	
57291	Construction of artificial vagir	090	248	264.5	16.5	7%	8.64	9.64	1.00	12%	0				2			0.5			1	
57292	Construction of artificial vagir	090	322	348.5	26.5	8%	14.01	15.49	1.48	11%	0				2			2.5			1	
57295	Revision (including removal) o	090	202	211	9	4%	7.82	8.59	0.77	10%	0			1	1						1	
57296	Revision (including removal) o	090	429	445	16	4%	16.56	18.32	1.76	11%	0				2			2	2		1	
57300	Closure of rectovaginal fistula	090	271.5	301.5	30	11%	8.71	10.36	1.65	19%	0				2.5			2.5			1	
57305	Closure of rectovaginal fistula	090	468	487	19	4%	15.35	17.66	2.31	15%	0			2	1			3	1	1	1	
57307	Closure of rectovaginal fistula	090	363	396.5	33.5	9%	17.17	18.98	1.81	11%	0				3			2.5			1	
57308	Closure of rectovaginal fistula	090	313	334	21	7%	10.59	12.06	1.47	14%	0			2	1			2			1	
57310	Closure of urethrovaginal fistu	090	259	283	24	9%	7.65	9.01	1.36	18%	0				2			2			1	
57311	Closure of urethrovaginal fistu	090	319	345.5	26.5	8%	8.91	10.39	1.48	17%	0				2			2.5			1	
57320	Closure of vesicovaginal fistul	090	277	301	24	9%	8.88	10.24	1.36	15%	0				2			2			1	
57330	Closure of vesicovaginal fistul	090	288	312	24	8%	13.21	14.57	1.36	10%	0				2			2			1	
57335	Vaginoplasty for intersex state	090	459	495	36	8%	20.02	21.73	1.71	9%	0				3			3				
57415	Removal of impacted vaginal	010	113	120	7	6%	2.49	2.82	0.33	13%	0				1							
57423	Paravaginal defect repair (incl	090	357	362	5	1%	16.08	17.05	0.97	6%	0			1	1				1		1	
57425	Laparoscopy, surgical, colpope	090	351	365	14	4%	17.03	17.80	0.77	5%	0				2						0.5	
57426	Revision (including removal) o	090	360	377	17	5%	14.30	15.71	1.41	10%	0				3				1		1	
57505	Endocervical curettage (not d	010	36	38	2	6%	1.19	1.41	0.22	18%	0			1								
57511	Cautery of cervix; cryocautery	010	55	57	2	4%	1.95	2.17	0.22	11%	0			1								
57513	Cautery of cervix; laser ablatio	010	88	90	2	2%	1.95	2.17	0.22	11%	0			1								
57520	Conization of cervix, with or w	090	110	113	3	3%	4.11	4.44	0.33	8%	0			1.5								
57522	Conization of cervix, with or w	090	178	185	7	4%	3.67	4.00	0.33	9%	0				1							
57530	Trachelectomy (cervicectomy)	090	180.5	191	10.5	6%	5.27	5.99	0.72	14%	0				1.5						1	
57531	Radical trachelectomy, with b	090	604	648	44	7%	29.95	32.65	2.70	9%	-2				2	1		5	1		1	
57540	Excision of cervical stump, abd	090	309	324	15	5%	13.29	14.61	1.32	10%	0				2			1	1		1	
57545	Excision of cervical stump, abd	090	364	379	15	4%	14.10	15.42	1.32	9%	0				2			1	1		1	
57550	Excision of cervical stump, vag	090	228	249.5	21.5	9%	6.34	7.58	1.24	20%	0				2			1.5			1	
57555	Excision of cervical stump, vag	090	311	340	29	9%	9.94	11.54	1.60	16%	0				2			3			1	
57556	Excision of cervical stump, vag	090	292	321	29	10%	9.36	10.96	1.60	17%	0				2			3			1	
57558	Dilation and curettage of cerv	010	55	57	2	4%	1.72	1.94	0.22	13%	0			1								
57700	Cerclage of uterine cervix, no	090	129.5	147	17.5	14%	4.35	5.18	0.83	19%	0				2.5							
57720	Trachelorrhaphy, plastic repai	090	136.5	147	10.5	8%	4.61	5.22	0.61	13%	0				1.5						0.5	
58120	Dilation and curettage, diagno	010	129	136	7	5%	3.59	4.03	0.44	12%	0				1						0.5	
58140	Myomectomy, excision of fibr	090	374	394	20	5%	15.79	17.35	1.56	10%	0				2			2	1		1	
58145	Myomectomy, excision of fibr	090	267	291	24	9%	8.91	10.27	1.36	15%	0				2			2			1	
58146	Myomectomy, excision of fibr	090	429	450	21	5%	20.34	22.10	1.76	9%	0				2			2		1	1	
58150	Total abdominal hysterectomy	090	394	419	25	6%	17.31	19.11	1.80	10%	0				2			3	1		1	

58152	Total abdominal hysterectom	090	373.5	411	37.5	10%	21.86	23.87	2.01	9%	0				2.5			4			1	
58180	Supracervical abdominal hyste	090	414	439	25	6%	16.60	18.40	1.80	11%	0				2			3	1		1	
58200	Total abdominal hysterectom	090	459	475	16	3%	23.10	24.86	1.76	8%	0				2			2	2		1	
58210	Radical abdominal hysterecto	090	627	660	33	5%	30.91	33.48	2.57	8%	0				3			4	2		1	
58240	Pelvic exenteration for gynec	090	1118	1157	39	3%	49.33	53.46	4.13	8%	-2			1	4	1		3	6			1
58260	Vaginal hysterectomy, for ute	090	311	328	17	5%	14.15	15.56	1.41	10%	-2				1	1		1	1		1	
58262	Vaginal hysterectomy, for ute	090	342	359	17	5%	15.94	17.35	1.41	9%	-2				1	1		1	1		1	
58263	Vaginal hysterectomy, for ute	090	363	380	17	5%	17.23	18.64	1.41	8%	-2				1	1		1	1		1	
58267	Vaginal hysterectomy, for ute	090	392.5	432.5	40	10%	18.36	20.49	2.13	12%	0				2.5			4.5			1	
58270	Vaginal hysterectomy, for ute	090	304	335.5	31.5	10%	15.30	17.02	1.72	11%	0				2			3.5			1	
58275	Vaginal hysterectomy, with to	090	365.5	403	37.5	10%	17.03	19.04	2.01	12%	0				2.5			4			1	
58280	Vaginal hysterectomy, with to	090	387.5	427.5	40	10%	18.33	20.46	2.13	12%	0				2.5			4.5			1	
58285	Vaginal hysterectomy, radical	090	499.5	505.5	6	1%	23.38	24.79	1.41	6%	0			1	1			1	2		1	
58290	Vaginal hysterectomy, for ute	090	389	395	6	2%	20.27	21.55	1.28	6%	0				2				2		1	
58291	Vaginal hysterectomy, for ute	090	410	416	6	1%	22.06	23.34	1.28	6%	0				2				2		1	
58292	Vaginal hysterectomy, for ute	090	423	429	6	1%	23.35	24.63	1.28	5%	0				2				2		1	
58294	Vaginal hysterectomy, for ute	090	405	411	6	1%	21.55	22.83	1.28	6%	0				2				2		1	
58345	Transcervical introduction of f	010	116	118	2	2%	4.70	5.03	0.33	7%	0			1							0.5	
58346	Insertion of Heyman capsules	090	267	277	10	4%	7.56	8.77	1.21	16%	0			1	1			1	1		1	
58350	Chromotubation of oviduct, in	010	53	55	2	4%	1.06	1.28	0.22	21%	0			1								
58353	Endometrial ablation, therma	010	151.5	153.5	2	1%	3.60	4.04	0.44	12%	0			1							1	
58356	Endometrial cryoablation with	010	167	174	7	4%	6.41	6.85	0.44	7%	0				1						0.5	
58400	Uterine suspension, with or w	090	241.5	264.5	23	10%	7.14	8.46	1.32	18%	0				1.5			2.5			1	
58410	Uterine suspension, with or w	090	354	369	15	4%	13.80	15.12	1.32	10%	0				2			1	1		1	
58520	Hysterorrhaphy, repair of rup	090	379	391	12	3%	13.48	15.20	1.72	13%	0				2			1	1	1	1	
58540	Hysteroplasty, repair of uterir	090	364	379	15	4%	15.71	17.03	1.32	8%	0				2			1	1		1	
58541	Laparoscopy, surgical, supraca	090	226	240	14	6%	12.29	13.06	0.77	6%	0				2						0.5	
58542	Laparoscopy, surgical, supraca	090	239	253	14	6%	14.16	14.93	0.77	5%	0				2						0.5	
58543	Laparoscopy, surgical, supraca	090	261	275	14	5%	14.39	15.16	0.77	5%	0				2						0.5	
58544	Laparoscopy, surgical, supraca	090	271	285	14	5%	15.60	16.37	0.77	5%	0				2						0.5	
58545	Laparoscopy, surgical, myome	090	334	344	10	3%	15.55	16.63	1.08	7%	0				2				1		1	
58546	Laparoscopy, surgical, myome	090	394	404	10	3%	19.94	21.02	1.08	5%	0				2				1		1	
58548	Laparoscopy, surgical, with ra	090	564	593	29	5%	31.63	33.61	1.98	6%	-2				2	1		2	1		1	
58550	Laparoscopy, surgical, with va	090	330	356	26	8%	15.10	16.68	1.58	10%	0			1	2			2			1	
58552	Laparoscopy, surgical, with va	090	350	376	26	7%	16.91	18.49	1.58	9%	0			1	2			2			1	
58553	Laparoscopy, surgical, with va	090	391.5	406.5	15	4%	20.06	21.38	1.32	7%	0				2			1	1		1	
58554	Laparoscopy, surgical, with va	090	425	442	17	4%	23.11	24.65	1.54	7%	0			1	2			1	1		1	
58565	Hysteroscopy, surgical; with b	090	191	195	4	2%	7.12	7.67	0.55	8%	0			2							0.5	
58570	Laparoscopy, surgical, with to	090	241	255	14	6%	13.36	14.13	0.77	6%	0				2						0.5	
58571	Laparoscopy, surgical, with to	090	241	255	14	6%	15.00	15.77	0.77	5%	0				2						0.5	
58572	Laparoscopy, surgical, with to	090	271	285	14	5%	17.71	18.48	0.77	4%	0				2						0.5	
58573	Laparoscopy, surgical, with to	090	281	295	14	5%	20.79	21.56	0.77	4%	0				2						0.5	
58575	Laparoscopy, surgical, total hy	090	510	529	19	4%	32.60	34.10	1.50	5%	-2				2	1			1		1	
58600	Ligation or transection of fallo	090	166	173	7	4%	5.91	6.46	0.55	9%	0				1						1	
58605	Ligation or transection of fallo	090	141	153	12	9%	5.28	5.98	0.70	13%	0			1				2				
58615	Occlusion of fallopian tube(s)	010	99	101	2	2%	3.94	4.16	0.22	6%	0			1								
58660	Laparoscopy, surgical; with lys	090	209.5	216.5	7	3%	11.59	12.03	0.44	4%	0				1						0.5	
58661	Laparoscopy, surgical; with re	010	217	224	7	3%	11.35	11.79	0.44	4%	0				1						0.5	
58662	Laparoscopy, surgical; with fu	090	186.5	194.5	8	4%	12.15	12.53	0.38	3%	-1				0.5	0.5						
58670	Laparoscopy, surgical; with fu	090	118	125	7	6%	5.91	6.24	0.33	6%	0				1							
58671	Laparoscopy, surgical; with oc	090	118	125	7	6%	5.91	6.24	0.33	6%	0				1							
58672	Laparoscopy, surgical; with fir	090	96	98	2	2%	12.91	13.13	0.22	2%	0			1								
58673	Laparoscopy, surgical; with sa	090	185	192	7	4%	14.04	14.37	0.33	2%	0				1							
58674	Laparoscopy, surgical, ablatio	090	266	280	14	5%	14.08	14.85	0.77	5%	0				2						0.5	
58700	Salpingectomy, complete or p	090	321.5	333.5	12	4%	12.95	14.25	1.30	10%	-2			1		1		1	1		1	
58720	Salpingo-oophorectomy, com	090	309	319	10	3%	12.16	13.37	1.21	10%	0			1	1			1	1		1	
58740	Lysis of adhesions (salpingoly	090	374	386	12	3%	14.90	16.20	1.30	9%	-2			1		1		1	1		1	
58750	Tubotubal anastomosis	090	357	367	10	3%	15.64	16.85	1.21	8%	0			1	1			1	1		1	
58752	Tubouterine implantation	090	377	387	10	3%	15.64	16.85	1.21	8%	0			1	1			1	1		1	
58760	Fimbrioplasty	090	357	367	10	3%	13.93	15.14	1.21	9%	0			1	1			1	1		1	
58770	Salpingostomy (salpingoneost	090	347	357	10	3%	14.77	15.98	1.21	8%	0			1	1			1	1		1	
58800	Drainage of ovarian cyst(s), un	090	159.5	170	10.5	7%	4.62	5.34	0.72	15%	0				1.5						1	
58805	Drainage of ovarian cyst(s), un	090	198.5	211.5	13	7%	6.42	7.26	0.84	13%	0				1.5			0.5			1	
58820	Drainage of ovarian abscess; v	090	131.5	142	10.5	8%	4.70	5.31	0.61	13%	0				1.5						0.5	
58822	Drainage of ovarian abscess; a	090	399	416	17	4%	11.81	13.77	1.96	17%	0				2			2	1	1	1	
58825	Transposition, ovary(s)	090	282	292	10	4%	11.78	12.99	1.21	10%	0			1	1			1	1		1	
58900	Biopsy of ovary, unilateral or l	090	205.5	221	15.5	8%	6.59	7.55	0.96	14%	0				1.5			1			1	

58920	Wedge resection or bisection	090	214.5	230	15.5	7%	11.95	12.91	0.96	8%	0				1.5			1			1	
58925	Ovarian cystectomy, unilatera	090	329	344	15	5%	12.43	13.75	1.32	11%	0				2			1	1		1	
58940	Oophorectomy, partial or tota	090	257	283.5	26.5	10%	8.22	9.70	1.48	18%	0				2			2.5			1	
58943	Oophorectomy, partial or tota	090	385	419	34	9%	19.52	21.36	1.84	9%	0				2			4			1	
58950	Resection (initial) of ovarian, t	090	420	433	13	3%	18.37	20.11	1.74	9%	0			1	2			1	2		1	
58951	Resection (initial) of ovarian, t	090	581.5	581.5	0	0%	24.26	26.16	1.90	8%	-2			1		1		1	4		1	
58952	Resection (initial) of ovarian, t	090	710	727	17	2%	27.29	30.13	2.84	10%	-2			2		1		4	4		1	
58953	Bilateral salpingo-oophorecto	090	712	729	17	2%	34.13	36.60	2.47	7%	-2			1	1	1		2	2	1	1	
58954	Bilateral salpingo-oophorecto	090	757	774	17	2%	37.13	39.60	2.47	7%	-2			1	1	1		2	2	1	1	
58956	Bilateral salpingo-oophorecto	090	534.5	558.5	24	4%	22.80	25.09	2.29	10%	0				3			2	1	1	1	
58957	Resection (tumor debulking) d	090	552	572	20	4%	26.22	28.29	2.07	8%	-2			1	1	1		2	2		1	
58958	Resection (tumor debulking) d	090	582	602	20	3%	29.22	31.29	2.07	7%	-2			1	1	1		2	2		1	
58960	Laparotomy, for staging or res	090	449	471	22	5%	15.79	17.57	1.78	11%	-2			1		1		3	1		1	
59100	Hysterotomy, abdominal (eg,	090	329	346	17	5%	13.37	14.91	1.54	12%	-2			1		1		2	1		1	
59120	Surgical treatment of ectopic	090	384	402	18	5%	12.67	14.41	1.74	14%	-2			1		1		2		1	1	
59121	Surgical treatment of ectopic	090	324	339	15	5%	12.74	14.06	1.32	10%	0				2			1	1		1	
59130	Surgical treatment of ectopic	090	349	373	24	7%	15.08	16.44	1.36	9%	0				2			2			1	
59136	Surgical treatment of ectopic	090	334	349	15	4%	14.25	15.57	1.32	9%	0				2			1	1		1	
59140	Surgical treatment of ectopic	090	186.5	197	10.5	6%	5.94	6.66	0.72	12%	0				1.5						1	
59150	Laparoscopic treatment of ect	090	225	239	14	6%	12.29	13.06	0.77	6%	0				2						0.5	
59151	Laparoscopic treatment of ect	090	235	249	14	6%	12.11	12.88	0.77	6%	0				2						0.5	
59160	Curettage, postpartum	010	79	81	2	3%	2.76	2.98	0.22	8%	0			1								
59410	Vaginal delivery only (with or	MMM	327.5	327.5	0	0%	18.34	18.34	-	0%	0											
59515	Cesarean delivery only; includ	MMM	392.5	392.5	0	0%	22.13	22.13	-	0%	0											
59614	Vaginal delivery only, after pr	MMM	327.5	327.5	0	0%	20.06	20.06	-	0%	0											
59622	Cesarean delivery only, follow	MMM	367.5	367.5	0	0%	22.66	22.66	-	0%	0											
59812	Treatment of incomplete abor	090	135.5	147.5	12	9%	4.44	5.01	0.57	13%	0				1			1				
59820	Treatment of missed abortion	090	162	180	18	11%	4.84	5.68	0.84	17%	-4					2						
59821	Treatment of missed abortion	090	148	161.5	13.5	9%	5.09	5.72	0.63	12%	-3					1.5						
59830	Treatment of septic abortion,	090	115.5	126	10.5	9%	6.59	7.09	0.50	8%	0				1.5							
59841	Induced abortion, by dilation a	010	203	212	9	4%	5.65	6.29	0.64	11%	-2					1					1	
59855	Induced abortion, by 1 or mor	090	158	165	7	4%	6.43	6.76	0.33	5%	0				1							
59856	Induced abortion, by 1 or mor	090	183	190	7	4%	7.79	8.12	0.33	4%	0				1							
59857	Induced abortion, by 1 or mor	090	301	303	2	1%	9.33	9.55	0.22	2%	0			1								
59870	Uterine evacuation and curett	090	256	271	15	6%	6.57	7.87	1.30	20%	-2			3		1					1	
60000	Incision and drainage of thyro	010	59	61	2	3%	1.81	2.03	0.22	12%	0			1								
60200	Excision of cyst or adenoma o	090	297	316.5	19.5	7%	10.02	11.61	1.59	16%	0			3.5				2.5			1	
60210	Partial thyroid lobectomy, uni	090	264	273	9	3%	11.23	11.78	0.55	5%	0			1	1							
60212	Partial thyroid lobectomy, uni	090	358	369	11	3%	16.43	17.20	0.77	5%	0			2	1							
60220	Total thyroid lobectomy, unila	090	267	281	14	5%	11.19	11.96	0.77	7%	0				2						0.5	
60225	Total thyroid lobectomy, unila	090	374	399.5	25.5	7%	14.79	16.73	1.94	13%	0			4				3.5			1	
60240	Thyroidectomy, total or comp	090	327	341	14	4%	15.04	15.81	0.77	5%	0				2						0.5	
60252	Thyroidectomy, total or subto	090	470	483	13	3%	22.01	23.75	1.74	8%	0			1	2			1	2		1	
60254	Thyroidectomy, total or subto	090	500	513	13	3%	28.42	30.16	1.74	6%	0			1	2			1	2		1	
60260	Thyroidectomy, removal of all	090	372	382	10	3%	18.26	19.47	1.21	7%	0			1	1			1	1		1	
60270	Thyroidectomy, including subs	090	650	657	7	1%	23.20	25.74	2.54	11%	0			1	2			1	2	2	1	
60271	Thyroidectomy, including subs	090	377	387	10	3%	17.62	18.83	1.21	7%	0			1	1			1	1		1	
60280	Excision of thyroglossal duct c	090	262	274	12	5%	6.16	7.39	1.23	20%	0			3.5				1			1	
60281	Excision of thyroglossal duct c	090	262	274	12	5%	8.82	10.05	1.23	14%	0			3.5				1			1	
60500	Parathyroidectomy or explora	090	313	329	16	5%	15.60	16.59	0.99	6%	0			1	2						0.5	
60502	Parathyroidectomy or explora	090	465	499	34	7%	21.15	23.56	2.41	11%	0			4.5				5			1	
60505	Parathyroidectomy or explora	090	636	681	45	7%	23.06	26.06	3.00	13%	0			5				7			1	
60520	Thymectomy, partial or total;	090	474	493	19	4%	17.16	18.41	1.25	7%	-2		1	1	1			2			1	
60521	Thymectomy, partial or total;	090	445	477	32	7%	19.18	20.93	1.75	9%	-4		2		1			5			1	
60522	Thymectomy, partial or total;	090	533	579	46	9%	23.48	26.15	2.67	11%	0			2	1			7			1	
60540	Adrenalectomy, partial or con	090	485	527	42	9%	18.02	20.69	2.67	15%	0			3.5				7			1	
60545	Adrenalectomy, partial or con	090	538	582.5	44.5	8%	20.93	23.72	2.79	13%	0			3.5				7.5			1	
60600	Excision of carotid body tumo	090	429	444	15	3%	25.09	26.41	1.32	5%	0				2			1	1		1	
60605	Excision of carotid body tumo	090	530	537	7	1%	31.96	33.44	1.48	5%	0				2				1	1	1	
60650	Laparoscopy, surgical, with ad	090	384	403	19	5%	20.73	21.85	1.12	5%	0				2			1			1	
61105	Twist drill hole for subdural or	090	152	159	7	5%	5.45	6.00	0.55	10%	0				1						1	
61108	Twist drill hole(s) for subdural	090	326.5	371.5	45	14%	11.64	14.01	2.37	20%	0				2.5			5.5			1	
61120	Burr hole(s) for ventricular pu	090	238.5	264	25.5	11%	9.60	11.04	1.44	15%	0				1.5			3			1	
61140	Burr hole(s) or trephine; with	090	367.5	407.5	40	11%	17.23	19.36	2.13	12%	0				2.5			4.5			1	
61150	Burr hole(s) or trephine; with	090	378	422	44	12%	18.90	21.22	2.32	12%	0				2			6			1	
61151	Burr hole(s) or trephine; with	090	312.5	348	35.5	11%	13.49	15.41	1.92	14%	0				1.5			5			1	
61154	Burr hole(s) with evacuation a	090	447	480	33	7%	17.07	19.64	2.57	15%	0				3			4	2		1	

61156	Burr hole(s); with aspiration o	090	339.5	377.5	38	11%	17.45	19.49	2.04	12%	0				1.5			5.5			1	
61215	Insertion of subcutaneous res	090	275.5	306	30.5	11%	5.85	7.53	1.68	29%	0				1.5			4			1	
61250	Burr hole(s) or trephine, supra	090	304.5	340	35.5	12%	11.49	13.41	1.92	17%	0				1.5			5			1	
61253	Burr hole(s) or trephine, infra	090	333.5	371.5	38	11%	13.49	15.53	2.04	15%	0				1.5			5.5			1	
61304	Craniectomy or craniotomy, e	090	493	542	49	10%	23.41	25.97	2.56	11%	0				2			7			1	
61305	Craniectomy or craniotomy, e	090	617.5	687.5	70	11%	28.64	32.21	3.57	12%	0				2.5			10.5			1	
61312	Craniectomy or craniotomy fo	090	689	714	25	4%	30.17	33.69	3.52	12%	0				2			6	4	1	1	
61313	Craniectomy or craniotomy fo	090	687	719	32	5%	28.09	31.70	3.61	13%	0				3			5	2	2	1	
61314	Craniectomy or craniotomy fo	090	540.5	595.5	55	10%	25.90	28.75	2.85	11%	0				2.5			7.5			1	
61315	Craniectomy or craniotomy fo	090	625.5	693	67.5	11%	29.65	33.10	3.45	12%	0				2.5			10			1	
61320	Craniectomy or craniotomy, d	090	570	634	64	11%	27.42	30.70	3.28	12%	0				2			10			1	
61321	Craniectomy or craniotomy, d	090	636.5	706.5	70	11%	30.53	34.10	3.57	12%	0				2.5			10.5			1	
61322	Craniectomy or craniotomy, d	090	893	927	34	4%	34.26	39.57	5.31	15%	0			1	3			7	3	4	1	
61323	Craniectomy or craniotomy, d	090	865	900	35	4%	35.06	39.88	4.82	14%	0			1	2			8	3	3	1	
61330	Decompression of orbit only,	090	597.5	665	67.5	11%	25.30	28.75	3.45	14%	0				2.5			10			1	
61333	Exploration of orbit (transcran	090	573	617	44	8%	29.27	31.59	2.32	8%	0				2			6			1	
61340	Subtemporal cranial decompr	090	445	494	49	11%	20.11	22.67	2.56	13%	0				2			7			1	
61343	Craniectomy, suboccipital with	090	669.5	742	72.5	11%	31.86	35.55	3.69	12%	0				2.5			11			1	
61345	Other cranial decompression,	090	622.5	692.5	70	11%	29.23	32.80	3.57	12%	0				2.5			10.5			1	
61450	Craniectomy, subtemporal, fo	090	541	602.5	61.5	11%	27.69	30.85	3.16	11%	0				2			9.5			1	
61458	Craniectomy, suboccipital; for	090	551.5	601.5	50	9%	28.84	31.45	2.61	9%	0				2.5			6.5			1	
61460	Craniectomy, suboccipital; for	090	609.5	672	62.5	10%	30.24	33.45	3.21	11%	0				2.5			9			1	
61500	Craniectomy; with excision of	090	412.5	450	37.5	9%	19.18	21.19	2.01	10%	0				2.5			4			1	
61501	Craniectomy; for osteomyeliti	090	438.5	486	47.5	11%	16.35	18.84	2.49	15%	0				2.5			6			1	
61510	Craniectomy, trephination, bo	090	635	675	40	6%	30.83	33.73	2.90	9%	0				4			4	2		1	
61512	Craniectomy, trephination, bo	090	652	685	33	5%	37.14	39.71	2.57	7%	0				3			4	2		1	
61514	Craniectomy, trephination, bo	090	599.5	667	67.5	11%	27.23	30.68	3.45	13%	0				2.5			10			1	
61516	Craniectomy, trephination, bo	090	598.5	666	67.5	11%	26.58	30.03	3.45	13%	0				2.5			10			1	
61518	Craniectomy for excision of br	090	755	783	28	4%	39.89	43.15	3.26	8%	0				4			3	3	1	1	
61519	Craniectomy for excision of br	090	732	765	33	5%	43.43	46.00	2.57	6%	0				3			4	2		1	
61520	Craniectomy for excision of br	090	815	869	54	7%	57.09	60.27	3.18	6%	0				4			6	1		1	
61521	Craniectomy for excision of br	090	928	1016.5	88.5	10%	46.99	51.44	4.45	9%	0				3			13.5			1	
61522	Craniectomy, infratentorial or	090	654.5	727	72.5	11%	31.54	35.23	3.69	12%	0				2.5			11			1	
61524	Craniectomy, infratentorial or	090	625.5	695.5	70	11%	29.89	33.46	3.57	12%	0				2.5			10.5			1	
61526	Craniectomy, bone flap cranio	090	789	833	44	6%	54.08	56.78	2.70	5%	-2				2	1		5	1		1	
61530	Craniectomy, bone flap cranio	090	869.5	927	57.5	7%	45.56	48.53	2.97	7%	0				2.5			8			1	
61531	Subdural implantation of strip	090	511	530	19	4%	16.41	18.46	2.05	12%	-2				1	1		2	1	1	1	
61533	Craniotomy with elevation of	090	537	598.5	61.5	11%	21.46	24.62	3.16	15%	0				2			9.5			1	
61534	Craniotomy with elevation of	090	619.5	689.5	70	11%	23.01	26.58	3.57	15%	0				2.5			10.5			1	
61535	Craniotomy with elevation of	090	414	465.5	51.5	12%	13.15	15.83	2.68	20%	0				2			7.5			1	
61536	Craniotomy with elevation of	090	759.5	837	77.5	10%	37.72	41.65	3.93	10%	0				2.5			12			1	
61537	Craniotomy with elevation of	090	614	644	30	5%	36.45	38.49	2.04	6%	0				2			4	1		1	
61538	Craniotomy with elevation of	090	679	709	30	4%	39.45	41.49	2.04	5%	0				2			4	1		1	
61539	Craniotomy with elevation of	090	758.5	836	77.5	10%	34.28	38.21	3.93	11%	0				2.5			12			1	
61540	Craniotomy with elevation of	090	655	668	13	2%	31.43	33.17	1.74	6%	0			1	2			1	2		1	
61541	Craniotomy with elevation of	090	675.5	748	72.5	11%	30.94	34.63	3.69	12%	0				2.5			11			1	
61543	Craniotomy with elevation of	090	666.5	739	72.5	11%	31.31	35.00	3.69	12%	0				2.5			11			1	
61544	Craniotomy with elevation of	090	598	664.5	66.5	11%	27.36	30.76	3.40	12%	0				2			10.5			1	
61545	Craniotomy with elevation of	090	775	821	46	6%	46.43	49.77	3.34	7%	0				4			5	1	1	1	
61546	Craniotomy for hypophysecto	090	703.5	778.5	75	11%	33.44	37.25	3.81	11%	0				2.5			11.5			1	
61548	Hypophysectomy or excision o	090	553	597	44	8%	23.37	25.69	2.32	10%	0				2			6			1	
61550	Craniectomy for craniosynost	090	279	300	21	8%	15.59	16.69	1.10	7%	0				3						0.5	
61552	Craniectomy for craniosynost	090	345.5	365.5	20	6%	20.40	21.57	1.17	6%	0				2.5			0.5			1	
61556	Craniotomy for craniosynosto	090	692	701	9	1%	24.09	26.58	2.49	10%	-2		1	1	1			3	3	1	1	
61557	Craniotomy for craniosynosto	090	510	546	36	7%	23.31	25.24	1.93	8%	0				3			3			1	
61558	Extensive craniectomy for mu	090	661	707	46	7%	26.50	28.91	2.41	9%	0				3			5			1	
61559	Extensive craniectomy for mu	090	665	713	48	7%	34.02	36.52	2.50	7%	0				4			4			1	
61563	Excision, intra and extracrania	090	656	659	3	0%	28.44	30.25	1.81	6%	-2		1	1	1			1	2	1	1	
61564	Excision, intra and extracrania	090	623	664	41	7%	34.74	36.91	2.17	6%	0				3			4			1	
61566	Craniotomy with elevation of	090	610	642	32	5%	32.45	34.71	2.26	7%	0			1	2			4	1		1	
61567	Craniotomy with elevation of	090	681	715	34	5%	37.00	39.48	2.48	7%	0			2	2			4	1		1	
61570	Craniectomy or craniotomy; w	090	585.5	650.5	65	11%	26.51	29.84	3.33	13%	0				2.5			9.5			1	
61571	Craniectomy or craniotomy; w	090	635.5	705.5	70	11%	28.42	31.99	3.57	13%	0				2.5			10.5			1	
61575	Transoral approach to skull ba	090	762.5	840	77.5	10%	36.56	40.49	3.93	11%	0				2.5			12			1	
61576	Transoral approach to skull ba	090	915	974	59	6%	55.31	58.73	3.42	6%	0				4			7	1		1	
61580	Craniofacial approach to ante	090	1078.3	1072.3	-6	-1%	34.51	38.03	3.52	10%	-2		1	2	2				3	4	1	
61581	Craniofacial approach to ante	090	1214.4	1227.4	13	1%	39.13	43.31	4.18	11%	-4		1	2	2	1		1	1	5	1	

61582	Craniofacial approach to ante	090	1010.3	1040.3	30	3%	35.14	38.75	3.61	10%	0			2	3			4	3	1	1	
61583	Craniofacial approach to ante	090	906.4	952.4	46	5%	38.50	41.59	3.09	8%	-2		1	1	1			8		1	1	
61584	Orbitocranial approach to ant	090	842.4	843.4	1	0%	37.70	40.35	2.65	7%	-2		1	1	1			2	3	2	1	
61585	Orbitocranial approach to ant	090	1101.7	1096.7	-5	0%	42.57	45.60	3.03	7%	0			2	1			1	3	3	1	
61586	Bicoronal, transzygomatic and	090	720	760	40	6%	27.48	30.38	2.90	11%	0				4			4	2		1	
61590	Infratemporal pre-auricular ap	090	1418.4	1420.4	2	0%	47.04	51.40	4.36	9%	-2		1	2	2			1		7	1	
61591	Infratemporal post-auricular a	090	1254.85	1269.85	15	1%	47.02	49.64	2.62	6%	-4		2	1	2			3	4		1	
61592	Orbitocranial zygomatic approa	090	1002.8	998.8	-4	0%	43.08	45.49	2.41	6%	-4		2	1	1			1	3	2	1	
61595	Transtemporal approach to pa	090	1077.8	1071.8	-6	-1%	33.74	37.26	3.52	10%	-2		1	2	2				3	4	1	
61596	Transcochlear approach to po	090	1188.3	1179.3	-9	-1%	39.43	42.66	3.23	8%	-2		1	2	1			1	4	3	1	
61597	Transcondylar (far lateral) app	090	1041.4	1061.4	20	2%	40.82	43.70	2.88	7%	0			3				5	2	1	1	
61598	Transpetrosal approach to po	090	1048.1	1054.1	6	1%	36.53	39.00	2.47	7%	-2		1	2	1			2	3	1	1	
61600	Resection or excision of neopl	090	1101.4	1101.4	0	0%	30.01	33.73	3.72	12%	-2		1	2	2					6	1	
61601	Resection or excision of neopl	090	854.9	859.9	5	1%	31.14	33.59	2.45	8%	-4		2	1	1			2	2	2	1	
61605	Resection or excision of neopl	090	1052.6	1074.6	22	2%	32.57	35.41	2.84	9%	-2		1	2	2			3	2	1	1	
61606	Resection or excision of neopl	090	926.9	937.9	11	1%	42.05	44.76	2.71	6%	0			2	1			3	3	1	1	
61607	Resection or excision of neopl	090	1201.2	1190.2	-11	-1%	40.93	44.52	3.59	9%	0			2	1				1	6	1	
61608	Resection or excision of neopl	090	1042	1045	3	0%	45.54	48.54	3.00	7%	0			3				3	3	2	1	
61613	Obliteration of carotid aneury	090	1102	1095	-7	-1%	45.03	48.55	3.52	8%	0			3				1		6	1	
61615	Resection or excision of neopl	090	1092.2	1096.2	4	0%	35.77	38.95	3.18	9%	-2		1	1	2			2	4	2	1	
61616	Resection or excision of neopl	090	1116.8	1146.8	30	3%	46.74	49.84	3.10	7%	-2		1	1	2			5	2	1	1	
61618	Secondary repair of dura for c	090	573.1	574.1	1	0%	18.69	20.68	1.99	11%	0			2	1				1	2	1	
61619	Secondary repair of dura for c	090	587.6	587.6	0	0%	22.10	24.02	1.92	9%	0			3				1	2	1	1	
61630	Balloon angioplasty, intracran	XXX	394	409	15	4%	22.07	23.39	1.32	6%	0				2			1	1		1	
61635	Transcatheter placement of in	XXX	424	430	6	1%	24.28	25.56	1.28	5%	0				2				2		1	
61640	Balloon dilatation of intracran	000	233	230	-3	-1%	12.32	12.72	0.40	3%	0									1		
61680	Surgery of intracranial arterio	090	632	674	42	7%	32.55	35.16	2.61	8%	0				3			5	1		1	
61682	Surgery of intracranial arterio	090	874	924	50	6%	63.41	66.41	3.00	5%	0				2			8	1		1	
61684	Surgery of intracranial arterio	090	717	759	42	6%	41.64	44.25	2.61	6%	0				3			5	1		1	
61686	Surgery of intracranial arterio	090	1019	1065	46	5%	67.50	70.84	3.34	5%	-2				2	1		6	1	1	1	
61690	Surgery of intracranial arterio	090	672	688	16	2%	31.34	33.48	2.14	7%	-4					2		2	3		1	
61692	Surgery of intracranial arterio	090	896	919	23	3%	54.59	57.61	3.02	6%	-4					2		4	3	1	1	
61697	Surgery of complex intracrani	090	1194	1203	9	1%	63.40	69.10	5.70	9%	-2				2	1		5	6	5	1	
61698	Surgery of complex intracrani	090	1209	1221	12	1%	69.63	74.93	5.30	8%	-2				2	1		5	6	4	1	
61700	Surgery of simple intracranial	090	949	973	24	3%	50.62	55.32	4.70	9%	-2				2	1		5	3	4	1	
61702	Surgery of simple intracranial	090	1144	1157	13	1%	60.04	65.54	5.50	9%	-2				2	1		5	5	5	1	
61703	Surgery of intracranial aneury	090	377	421	44	12%	18.80	21.12	2.32	12%	0				2			6			1	
61705	Surgery of aneurysm, vascular	090	655.5	720.5	65	10%	38.10	41.43	3.33	9%	0				2.5			9.5			1	
61708	Surgery of aneurysm, vascular	090	647.5	712.5	65	10%	37.20	40.53	3.33	9%	0				2.5			9.5			1	
61710	Surgery of aneurysm, vascular	090	551	607.5	56.5	10%	31.29	34.21	2.92	9%	0				2			8.5			1	
61711	Anastomosis, arterial, extracra	090	665.5	730.5	65	10%	38.23	41.56	3.33	9%	0				2.5			9.5			1	
61720	Creation of lesion by stereota	090	384	408	24	6%	17.62	18.98	1.36	8%	0				2			2			1	
61735	Creation of lesion by stereota	090	576.5	641.5	65	11%	22.35	25.68	3.33	15%	0				2.5			9.5			1	
61737	Laser interstitial thermal thera	000	474	471	-3	-1%	22.67	23.07	0.40	2%	0									1		
61750	Stereotactic biopsy, aspiration	090	487	543.5	56.5	12%	19.83	22.75	2.92	15%	0				2			8.5			1	
61751	Stereotactic biopsy, aspiration	090	395	426	31	8%	18.79	20.48	1.69	9%	0				3			2			1	
61760	Stereotactic implantation of d	090	505	536	31	6%	22.39	24.08	1.69	8%	0				3			2			1	
61770	Stereotactic localization, inclu	090	517	578.5	61.5	12%	23.19	26.35	3.16	14%	0				2			9.5			1	
61790	Creation of lesion by stereota	090	282	301	19	7%	11.60	12.72	1.12	10%	0				2			1			1	
61791	Creation of lesion by stereota	090	328	349.5	21.5	7%	15.41	16.65	1.24	8%	0				2			1.5			1	
61796	Stereotactic radiosurgery (par	090	195	209	14	7%	13.93	14.70	0.77	6%	0				2						0.5	
61798	Stereotactic radiosurgery (par	090	225	239	14	6%	19.85	20.62	0.77	4%	0				2						0.5	
61850	Twist drill or burr hole(s) for i	090	306.5	337	30.5	10%	13.34	15.02	1.68	13%	0				1.5			4			1	
61860	Craniectomy or craniotomy fo	090	405	451.5	46.5	11%	22.26	24.70	2.44	11%	0				2			6.5			1	
61863	Twist drill, burr hole, craniotc	090	452	470	18	4%	20.71	22.56	1.85	9%	0				3			1	2		1	
61867	Twist drill, burr hole, craniotc	090	617	635	18	3%	33.03	34.88	1.85	6%	0				3			1	2		1	
61880	Revision or removal of intracr	090	213.5	231.5	18	8%	6.95	8.03	1.08	15%	0				1.5			1.5			1	
61885	Insertion or replacement of cr	090	181	195	14	8%	6.05	6.82	0.77	13%	0				2						0.5	
61886	Insertion or replacement of cr	090	385	405	20	5%	9.93	11.87	1.94	20%	0				4				2		1	
61888	Revision or removal of cranial	010	171	178	7	4%	5.23	5.91	0.68	13%	0			1				1			1	
62000	Elevation of depressed skull fr	090	408	454.5	46.5	11%	13.93	16.37	2.44	18%	0				2			6.5			1	
62005	Elevation of depressed skull fr	090	470	519	49	10%	17.63	20.19	2.56	15%	0				2			7			1	
62010	Elevation of depressed skull fr	090	519.5	572	52.5	10%	21.43	24.16	2.73	13%	0				2.5			7			1	
62100	Craniotomy for repair of dura	090	549.5	597	47.5	9%	23.53	26.02	2.49	11%	0				2.5			6			1	
62115	Reduction of craniomegalic sk	090	678	728.5	50.5	7%	22.91	25.53	2.62	11%	0				4			4.5			1	
62117	Reduction of craniomegalic sk	090	714	706	-8	-1%	28.35	30.43	2.08	7%	0			3					2	2	1	
62120	Repair of encephalocele, skull	090	523	566	43	8%	24.59	26.85	2.26	9%	0				4			3			1	

62121	Craniotomy for repair of ence	090	496	545	49	10%	23.03	25.59	2.56	11%	0				2			7			1	
62140	Cranioplasty for skull defect; u	090	383	414.5	31.5	8%	14.55	16.27	1.72	12%	0				2			3.5			1	
62141	Cranioplasty for skull defect; l	090	413	449.5	36.5	9%	16.07	18.03	1.96	12%	0				2			4.5			1	
62142	Removal of bone flap or prost	090	324	355.5	31.5	10%	11.83	13.55	1.72	15%	0				2			3.5			1	
62143	Replacement of bone flap or p	090	371	405	34	9%	14.15	15.99	1.84	13%	0				2			4			1	
62145	Cranioplasty for skull defect w	090	490	531.5	41.5	8%	20.09	22.29	2.20	11%	0				2			5.5			1	
62146	Cranioplasty with autograft (in	090	402	438.5	36.5	9%	17.28	19.24	1.96	11%	0				2			4.5			1	
62147	Cranioplasty with autograft (in	090	473	517	44	9%	20.67	22.99	2.32	11%	0				2			6			1	
62161	Neuroendoscopy, intracranial	090	400	422	22	5%	21.23	23.01	1.78	8%	0			1	2			2	1		1	
62162	Neuroendoscopy, intracranial	090	516	534	18	3%	26.80	28.78	1.98	7%	0			1	2			2	2		1	
62164	Neuroendoscopy, intracranial	090	571	587	16	3%	29.43	31.83	2.40	8%	0			2	2			2	3		1	
62165	Neuroendoscopy, intracranial	090	490	512	22	4%	23.23	25.01	1.78	8%	0			1	2			2	1		1	
62180	Ventriculocisternostomy (Torl	090	564	596	32	6%	22.58	24.71	2.13	9%	-2				1	1		4	1		1	
62190	Creation of shunt; subarachno	090	355	389	34	10%	12.17	14.01	1.84	15%	0				2			4			1	
62192	Creation of shunt; subarachno	090	351	385	34	10%	13.35	15.19	1.84	14%	0				2			4			1	
62194	Replacement or irrigation, sut	010	294	313	19	6%	5.78	6.90	1.12	19%	0				2			1			1	
62200	Ventriculocisternostomy, third	090	388	417	29	7%	19.29	20.89	1.60	8%	0				2			3			1	
62201	Ventriculocisternostomy, third	090	425	456	31	7%	16.04	17.73	1.69	11%	0				3			2			1	
62220	Creation of shunt; ventriculo-(	090	356	390	34	10%	14.10	15.94	1.84	13%	0				2			4			1	
62223	Creation of shunt; ventriculo-(	090	357	388	31	9%	14.05	15.74	1.69	12%	0				3			2			1	
62225	Replacement or irrigation, ver	090	230.5	253.5	23	10%	6.19	7.51	1.32	21%	0				1.5			2.5			1	
62230	Replacement or revision of ce	090	293.5	321.5	28	10%	11.43	12.99	1.56	14%	0				1.5			3.5			1	
62256	Removal of complete cerebro	090	233.5	256.5	23	10%	7.38	8.70	1.32	18%	0				1.5			2.5			1	
62258	Removal of complete cerebro	090	366	400	34	9%	15.64	17.48	1.84	12%	0				2			4			1	
62263	Percutaneous lysis of epidura	010	214	230	16	7%	5.00	5.99	0.99	20%	0			1	2						0.5	
62264	Percutaneous lysis of epidura	010	109	109	0	0%	4.42	4.53	0.11	2%	0										0.5	
62287	Decompression procedure, pe	090	248	269	21	8%	9.03	10.13	1.10	12%	0				3						0.5	
62292	Injection procedure for chemo	090	284	308	24	8%	9.24	10.60	1.36	15%	0				2			2			1	
62294	Injection procedure, arterial, i	090	336	367.5	31.5	9%	12.87	14.59	1.72	13%	0				2			3.5			1	
62350	Implantation, revision or repo	010	170	177	7	4%	6.05	6.49	0.44	7%	0				1						0.5	
62351	Implantation, revision or repo	090	449	448	-1	0%	11.66	13.96	2.30	20%	0			4						3	1	
62355	Removal of previously implan	010	140	147	7	5%	3.55	3.99	0.44	12%	0				1						0.5	
62360	Implantation or replacement c	010	170	177	7	4%	4.33	4.77	0.44	10%	0				1						0.5	
62361	Implantation or replacement c	010	170	177	7	4%	5.00	5.44	0.44	9%	0				1						0.5	
62362	Implantation or replacement c	010	170	177	7	4%	5.60	6.04	0.44	8%	0				1						0.5	
62365	Removal of subcutaneous res	010	155	162	7	5%	3.93	4.37	0.44	11%	0				1						0.5	
62380	Endoscopic decompression of	090	231	245	14	6%	0.00	N/A	N/A	N/A	0				2						0.5	
63001	Laminectomy with exploration	090	488	529.5	41.5	9%	17.61	19.81	2.20	12%	0				2			5.5			1	
63003	Laminectomy with exploration	090	485	526.5	41.5	9%	17.74	19.94	2.20	12%	0				2			5.5			1	
63005	Laminectomy with exploration	090	450	477	27	6%	16.43	18.32	1.89	12%	0				3			2	1		1	
63011	Laminectomy with exploration	090	415.5	458	42.5	10%	15.91	18.16	2.25	14%	0				2.5			5			1	
63012	Laminectomy with removal of	090	441.5	486.5	45	10%	16.85	19.22	2.37	14%	0				2.5			5.5			1	
63015	Laminectomy with exploration	090	465	492	27	6%	20.85	22.74	1.89	9%	0				3			2	1		1	
63016	Laminectomy with exploration	090	665.5	715.5	50	8%	22.03	24.64	2.61	12%	0				2.5			6.5			1	
63017	Laminectomy with exploration	090	437	459	22	5%	17.33	18.98	1.65	10%	0				3			1	1		1	
63020	Laminotomy (hemilaminectom	090	379	403	24	6%	15.95	17.69	1.74	11%	-2				2	1		1	1		1	
63030	Laminotomy (hemilaminectom	090	305	328	23	8%	13.18	14.37	1.19	9%	-2				2	1					0.5	
63040	Laminotomy (hemilaminectom	090	479.5	527	47.5	10%	20.31	22.80	2.49	12%	0				2.5			6			1	
63042	Laminotomy (hemilaminectom	090	400	436	36	9%	18.76	20.69	1.93	10%	0				3			3			1	
63045	Laminectomy, facetectomy an	090	395	417	22	6%	17.95	19.60	1.65	9%	0				3			1	1		1	
63046	Laminectomy, facetectomy an	090	395	417	22	6%	17.25	18.90	1.65	10%	0				3			1	1		1	
63047	Laminectomy, facetectomy an	090	362	384	22	6%	15.37	17.02	1.65	11%	0				3			1	1		1	
63050	Laminoplasty, cervical, with d	090	455	477	22	5%	22.01	23.79	1.78	8%	0			1	2			2	1		1	
63051	Laminoplasty, cervical, with d	090	495	517	22	4%	25.51	27.29	1.78	7%	0			1	2			2	1		1	
63055	Transpedicular approach with	090	520.5	570.5	50	10%	23.55	26.16	2.61	11%	0				2.5			6.5			1	
63056	Transpedicular approach with	090	490.5	538	47.5	10%	21.86	24.35	2.49	11%	0				2.5			6			1	
63064	Costovertebral approach with	090	592.5	645	52.5	9%	26.22	28.95	2.73	10%	0				2.5			7			1	
63075	Discectomy, anterior, with de	090	355	367	12	3%	19.60	20.90	1.30	7%	0			1	2				1		1	
63077	Discectomy, anterior, with de	090	517.5	562.5	45	9%	22.88	25.25	2.37	10%	0				2.5			5.5			1	
63081	Vertebral corpectomy (verteb	090	622.5	675	52.5	8%	26.10	28.83	2.73	10%	0				2.5			7			1	
63085	Vertebral corpectomy (verteb	090	721.5	781.5	60	8%	29.47	32.56	3.09	10%	0				2.5			8.5			1	
63087	Vertebral corpectomy (verteb	090	682	729	47	7%	37.53	40.38	2.85	8%	0				3			6	1		1	
63090	Vertebral corpectomy (verteb	090	741	807	66	9%	30.93	34.30	3.37	11%	0				3			9			1	
63101	Vertebral corpectomy (verteb	090	671	706	35	5%	34.10	36.89	2.79	8%	0			1	3			4	2		1	
63102	Vertebral corpectomy (verteb	090	658	693	35	5%	34.10	36.89	2.79	8%	0			1	3			4	2		1	
63170	Laminectomy with myelotomy	090	623.5	676	52.5	8%	22.21	24.94	2.73	12%	0				2.5			7			1	
63172	Laminectomy with drainage o	090	581	625	44	8%	19.76	22.08	2.32	12%	0				2			6			1	

63173	Laminectomy with drainage o	090	630.5	680.5	50	8%	24.31	26.92	2.61	11%	0				2.5			6.5			1	
63185	Laminectomy with rhizotomy;	090	451.5	496.5	45	10%	16.49	18.86	2.37	14%	0				2.5			5.5			1	
63190	Laminectomy with rhizotomy;	090	491.5	536.5	45	9%	18.89	21.26	2.37	13%	0				2.5			5.5			1	
63191	Laminectomy with section of s	090	468.5	511	42.5	9%	18.92	21.17	2.25	12%	0				2.5			5			1	
63197	Laminectomy with cordotomy	090	707.5	752.5	45	6%	24.08	26.45	2.37	10%	0				2.5			5.5			1	
63200	Laminectomy, with release of	090	589.5	637	47.5	8%	21.44	23.93	2.49	12%	0				2.5			6			1	
63250	Laminectomy for excision or d	090	941.5	1004	62.5	7%	43.86	47.07	3.21	7%	0				2.5			9			1	
63251	Laminectomy for excision or d	090	983	1056.5	73.5	7%	44.64	48.37	3.73	8%	0				3			10.5			1	
63252	Laminectomy for excision or d	090	981	1054.5	73.5	7%	44.63	48.36	3.73	8%	0				3			10.5			1	
63265	Laminectomy for excision or e	090	612.5	660	47.5	8%	23.82	26.31	2.49	10%	0				2.5			6			1	
63266	Laminectomy for excision or e	090	636.5	689	52.5	8%	24.68	27.41	2.73	11%	0				2.5			7			1	
63267	Laminectomy for excision or e	090	480.5	528	47.5	10%	19.45	21.94	2.49	13%	0				2.5			6			1	
63268	Laminectomy for excision or e	090	498.5	546	47.5	10%	20.02	22.51	2.49	12%	0				2.5			6			1	
63270	Laminectomy for excision of in	090	781.5	839	57.5	7%	29.80	32.77	2.97	10%	0				2.5			8			1	
63271	Laminectomy for excision of in	090	779.5	837	57.5	7%	29.92	32.89	2.97	10%	0				2.5			8			1	
63272	Laminectomy for excision of in	090	648.5	703.5	55	8%	27.50	30.35	2.85	10%	0				2.5			7.5			1	
63273	Laminectomy for excision of in	090	648.5	703.5	55	8%	26.47	29.32	2.85	11%	0				2.5			7.5			1	
63275	Laminectomy for biopsy/excis	090	654.5	709.5	55	8%	25.86	28.71	2.85	11%	0				2.5			7.5			1	
63276	Laminectomy for biopsy/excis	090	659.5	717	57.5	9%	25.69	28.66	2.97	12%	0				2.5			8			1	
63277	Laminectomy for biopsy/excis	090	544.5	594.5	50	9%	22.39	25.00	2.61	12%	0				2.5			6.5			1	
63278	Laminectomy for biopsy/excis	090	546.5	596.5	50	9%	22.12	24.73	2.61	12%	0				2.5			6.5			1	
63280	Laminectomy for biopsy/excis	090	669	732.5	63.5	9%	30.29	33.54	3.25	11%	0				3			8.5			1	
63281	Laminectomy for biopsy/excis	090	669	732.5	63.5	9%	29.99	33.24	3.25	11%	0				3			8.5			1	
63282	Laminectomy for biopsy/excis	090	623	679	56	9%	28.15	31.04	2.89	10%	0				3			7			1	
63283	Laminectomy for biopsy/excis	090	618	674	56	9%	26.76	29.65	2.89	11%	0				3			7			1	
63285	Laminectomy for biopsy/excis	090	762	830.5	68.5	9%	38.05	41.54	3.49	9%	0				3			9.5			1	
63286	Laminectomy for biopsy/excis	090	747	813	66	9%	37.62	40.99	3.37	9%	0				3			9			1	
63287	Laminectomy for biopsy/excis	090	931	1002	71	8%	40.08	43.69	3.61	9%	0				3			10			1	
63290	Laminectomy for biopsy/excis	090	960	1033.5	73.5	8%	40.82	44.55	3.73	9%	0				3			10.5			1	
63300	Vertebral corpectomy (verteb	090	638.5	691	52.5	8%	26.80	29.53	2.73	10%	0				2.5			7			1	
63301	Vertebral corpectomy (verteb	090	950	1023.5	73.5	8%	31.57	35.30	3.73	12%	0				3			10.5			1	
63302	Vertebral corpectomy (verteb	090	871	939.5	68.5	8%	31.15	34.64	3.49	11%	0				3			9.5			1	
63303	Vertebral corpectomy (verteb	090	809.5	869.5	60	7%	33.55	36.64	3.09	9%	0				2.5			8.5			1	
63304	Vertebral corpectomy (verteb	090	845	911	66	8%	33.85	37.22	3.37	10%	0				3			9			1	
63305	Vertebral corpectomy (verteb	090	1004	1077.5	73.5	7%	36.24	39.97	3.73	10%	0				3			10.5			1	
63306	Vertebral corpectomy (verteb	090	871	939.5	68.5	8%	35.55	39.04	3.49	10%	0				3			9.5			1	
63307	Vertebral corpectomy (verteb	090	863	931.5	68.5	8%	34.96	38.45	3.49	10%	0				3			9.5			1	
63600	Creation of lesion of spinal co	090	364	398	34	9%	15.12	16.96	1.84	12%	0				2			4			1	
63620	Stereotactic radiosurgery (par	090	195	209	14	7%	15.60	16.37	0.77	5%	0				2						0.5	
63650	Percutaneous implantation of	010	170	177	7	4%	7.15	7.59	0.44	6%	0				1						0.5	
63655	Laminectomy for implantation	090	254	270	16	6%	10.92	11.91	0.99	9%	0			1	2						0.5	
63661	Removal of spinal neurostimu	010	165	172	7	4%	5.08	5.52	0.44	9%	0				1						0.5	
63662	Removal of spinal neurostimu	090	243	259	16	7%	11.00	12.10	1.10	10%	0			1	2						1	
63663	Revision including replacemer	010	200	207	7	3%	7.75	8.19	0.44	6%	0				1						0.5	
63664	Revision including replacemer	090	273	289	16	6%	11.52	12.62	1.10	10%	0			1	2						1	
63685	Insertion or replacement of sp	010	170	177	7	4%	5.19	5.63	0.44	8%	0				1						0.5	
63688	Revision or removal of implan	010	165	172	7	4%	5.30	5.74	0.44	8%	0				1						0.5	
63700	Repair of meningocele; less th	090	401	437	36	9%	17.47	19.40	1.93	11%	0				3			3			1	
63702	Repair of meningocele; larger	090	463	499	36	8%	19.41	21.34	1.93	10%	0				3			3			1	
63704	Repair of myelomeningocele;	090	609	677	68	11%	22.43	25.89	3.46	15%	0				4			8			1	
63706	Repair of myelomeningocele;	090	679	747	68	10%	25.35	28.81	3.46	14%	0				4			8			1	
63707	Repair of dural/cerebrospinal	090	377.5	420	42.5	11%	12.65	14.90	2.25	18%	0				2.5			5			1	
63709	Repair of dural/cerebrospinal	090	426.5	466.5	40	9%	15.65	17.78	2.13	14%	0				2.5			4.5			1	
63710	Dural graft, spinal	090	407.5	447.5	40	10%	15.40	17.53	2.13	14%	0				2.5			4.5			1	
63740	Creation of shunt, lumbar, sub	090	378.5	416	37.5	10%	12.63	14.64	2.01	16%	0				2.5			4			1	
63741	Creation of shunt, lumbar, sub	090	289	313	24	8%	9.12	10.48	1.36	15%	0				2			2			1	
63744	Replacement, irrigation or rev	090	282.5	308	25.5	9%	8.94	10.38	1.44	16%	0				1.5			3			1	
63746	Removal of entire lumbosuba	090	254.5	282.5	28	11%	7.33	8.89	1.56	21%	0				1.5			3.5			1	
64553	Percutaneous implantation of	010	160	167	7	4%	6.13	6.57	0.44	7%	0				1						0.5	
64555	Percutaneous implantation of	010	145	152	7	5%	5.76	6.20	0.44	8%	0				1						0.5	
64561	Percutaneous implantation of	010	131	140	9	7%	5.44	5.86	0.42	8%	-2					1						
64568	Open implantation of cranial n	090	275	294	19	7%	9.00	10.12	1.12	12%	0				2			1			1	
64569	Revision or replacement of cra	090	312	331	19	6%	11.00	12.12	1.12	10%	0				2			1			1	
64570	Removal of cranial nerve (eg,	090	259	271	12	5%	9.10	9.89	0.79	9%	0				1			1			1	
64575	Open implantation of neurost	090	78	81	3	4%	4.42	4.75	0.33	7%	0			1.5								
64580	Open implantation of neurost	090	79	82	3	4%	4.19	4.52	0.33	8%	0			1.5								
64581	Open implantation of neurost	090	269	278	9	3%	12.20	12.73	0.53	4%	-2					1					0.5	

64582	Open implantation of hypoglo	090	294	308	14	5%	14.00	14.77	0.77	5%	0				2						0.5	
64583	Revision or replacement of hy	090	309	323	14	5%	14.50	15.27	0.77	5%	0				2						0.5	
64584	Removal of hypoglossal nerve	090	275	289	14	5%	12.00	12.77	0.77	6%	0				2						0.5	
64585	Revision or removal of periph	010	58	60	2	3%	2.11	2.33	0.22	10%	0			1								
64590	Insertion or replacement of pe	010	74	76	2	3%	2.45	2.67	0.22	9%	0			1								
64595	Revision or removal of periph	010	66	68	2	3%	1.78	2.00	0.22	12%	0			1								
64600	Destruction by neurolytic age	010	77	79	2	3%	3.49	3.71	0.22	6%	0			1								
64605	Destruction by neurolytic age	010	103	105	2	2%	5.65	5.87	0.22	4%	0			1								
64610	Destruction by neurolytic age	010	140	142	2	1%	7.20	7.42	0.22	3%	0			1								
64611	Chemodenervation of parotid	010	36	38	2	6%	1.03	1.25	0.22	21%	0			1								
64612	Chemodenervation of muscle	010	41	43	2	5%	1.41	1.63	0.22	16%	0			1								
64620	Destruction by neurolytic age	010	76	78	2	3%	2.89	3.11	0.22	8%	0			1								
64624	Destruction by neurolytic age	010	74	76	2	3%	2.50	2.72	0.22	9%	0			1								
64625	Radiofrequency ablation, nerv	010	98	105	7	7%	3.39	3.83	0.44	13%	0				1						0.5	
64628	Thermal destruction of intraos	010	178	185	7	4%	7.15	7.59	0.44	6%	0				1						0.5	
64630	Destruction by neurolytic age	010	78	80	2	3%	3.05	3.27	0.22	7%	0			1								
64632	Destruction by neurolytic age	010	36	38	2	6%	1.23	1.45	0.22	18%	0			1								
64633	Destruction by neurolytic age	010	100	107	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
64635	Destruction by neurolytic age	010	100	107	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
64640	Destruction by neurolytic age	010	64	66	2	3%	1.98	2.20	0.22	11%	0			1								
64680	Destruction by neurolytic age	010	98	100	2	2%	2.67	2.89	0.22	8%	0			1								
64681	Destruction by neurolytic age	010	122	132	10	8%	3.78	4.26	0.48	13%	0							2				
64702	Neuroplasty; digital, 1 or both	090	212	230	18	8%	6.26	7.47	1.21	19%	0			2	2						0.5	
64704	Neuroplasty; nerve of hand or	090	152	157	5	3%	4.69	5.24	0.55	12%	0			2.5								
64708	Neuroplasty, major peripheral	090	220	233	13	6%	6.36	7.46	1.10	17%	0			3	1						0.5	
64712	Neuroplasty, major peripheral	090	294	307.5	13.5	5%	8.07	9.31	1.24	15%	0			3				1.5			1	
64713	Neuroplasty, major peripheral	090	429	446	17	4%	11.40	12.87	1.47	13%	0			3.5				2			1	
64714	Neuroplasty, major peripheral	090	364	373.5	9.5	3%	10.55	11.66	1.11	11%	0			3.5				0.5			1	
64716	Neuroplasty and/or transposit	090	182	198	16	9%	6.99	7.87	0.88	13%	0			1	2							
64718	Neuroplasty and/or transposit	090	250	278	28	11%	7.26	8.69	1.43	20%	0				4						0.5	
64719	Neuroplasty and/or transposit	090	149	154	5	3%	4.97	5.52	0.55	11%	0			2.5								
64721	Neuroplasty and/or transposit	090	171	187	16	9%	4.97	5.96	0.99	20%	0			1	2						0.5	
64722	Decompression; unspecified n	090	159	164	5	3%	4.82	5.48	0.66	14%	0			2.5							0.5	
64726	Decompression; plantar digita	090	151	155	4	3%	4.27	4.82	0.55	13%	0			2							0.5	
64732	Transection or avulsion of; su	090	132.5	143	10.5	8%	4.89	5.50	0.61	12%	0				1.5						0.5	
64734	Transection or avulsion of; inf	090	186	200	14	8%	5.55	6.43	0.88	16%	0				2						1	
64736	Transection or avulsion of; me	090	139	153	14	10%	5.23	5.89	0.66	13%	0				2							
64738	Transection or avulsion of; inf	090	173	187	14	8%	6.36	7.13	0.77	12%	0				2						0.5	
64740	Transection or avulsion of; lin	090	166	180	14	8%	6.22	6.99	0.77	12%	0				2						0.5	
64742	Transection or avulsion of; fac	090	179	193	14	8%	6.85	7.62	0.77	11%	0				2						0.5	
64744	Transection or avulsion of; gre	090	192.5	203	10.5	5%	5.72	6.44	0.72	13%	0				1.5						1	
64746	Transection or avulsion of; ph	090	177	191	14	8%	6.56	7.33	0.77	12%	0				2						0.5	
64755	Transection or avulsion of; va	090	360	377	17	5%	15.05	17.14	2.09	14%	0			1	1			3	1	1	1	
64760	Transection or avulsion of; va	090	212	226	14	7%	7.59	8.47	0.88	12%	0				2						1	
64763	Transection or avulsion of obt	090	210	224	14	7%	7.56	8.33	0.77	10%	0				2						0.5	
64766	Transection or avulsion of obt	090	239.5	257	17.5	7%	9.47	10.41	0.94	10%	0				2.5						0.5	
64771	Transection or avulsion of oth	090	236.5	254	17.5	7%	8.15	9.09	0.94	11%	0				2.5						0.5	
64772	Transection or avulsion of oth	090	245	259	14	6%	7.84	8.72	0.88	11%	0				2						1	
64774	Excision of neuroma; cutaneo	090	174	188	14	8%	5.80	6.57	0.77	13%	0				2						0.5	
64776	Excision of neuroma; digital n	090	158.5	169	10.5	7%	5.60	6.21	0.61	11%	0				1.5						0.5	
64782	Excision of neuroma; hand or	090	235	249	14	6%	6.86	7.74	0.88	13%	0				2						1	
64784	Excision of neuroma; major pe	090	257.5	275	17.5	7%	10.62	11.56	0.94	9%	0				2.5						0.5	
64786	Excision of neuroma; sciatic n	090	291.5	309	17.5	6%	16.25	17.19	0.94	6%	0				2.5						0.5	
64788	Excision of neurofibroma or n	090	183	197	14	8%	5.24	6.01	0.77	15%	0				2						0.5	
64790	Excision of neurofibroma or n	090	331.5	349	17.5	5%	12.10	13.04	0.94	8%	0				2.5						0.5	
64792	Excision of neurofibroma or n	090	416	437	21	5%	15.86	17.07	1.21	8%	0				3						1	
64802	Sympathectomy, cervical	090	354.5	389.5	35	10%	10.37	12.26	1.89	18%	0				2.5			3.5			1	
64804	Sympathectomy, cervicothora	090	389.5	427	37.5	10%	15.91	17.92	2.01	13%	0				2.5			4			1	
64809	Sympathectomy, thoracolumb	090	336	367.5	31.5	9%	14.71	16.43	1.72	12%	0				2			3.5			1	
64818	Sympathectomy, lumbar	090	345	376.5	31.5	9%	11.34	13.06	1.72	15%	0				2			3.5			1	
64820	Sympathectomy; digital arteri	090	268	277	9	3%	10.74	11.29	0.55	5%	-4		2	1	1							
64821	Sympathectomy; radial artery	090	269	287	18	7%	9.33	10.78	1.45	16%	0			3	1			1			1	
64822	Sympathectomy; ulnar artery	090	269	287	18	7%	9.33	10.78	1.45	16%	0			3	1			1			1	
64823	Sympathectomy; superficial p	090	299	317	18	6%	10.94	12.39	1.45	13%	0			3	1			1			1	
64831	Suture of digital nerve, hand c	090	237	255	18	8%	9.16	10.37	1.21	13%	0			2	2						0.5	
64834	Suture of 1 nerve; hand or foo	090	226	240	14	6%	10.81	11.69	0.88	8%	0				2						1	
64835	Suture of 1 nerve; median mo	090	259.5	277	17.5	7%	11.73	12.78	1.05	9%	0				2.5						1	

64836	Suture of 1 nerve; ulnar moto	090	260.5	278	17.5	7%	11.73	12.78	1.05	9%	0				2.5						1	
64840	Suture of posterior tibial nerv	090	356	379.5	23.5	7%	14.02	15.35	1.33	9%	0				3			0.5			1	
64856	Suture of major peripheral ne	090	415.5	453	37.5	9%	15.07	17.08	2.01	13%	0				2.5			4			1	
64857	Suture of major peripheral ne	090	428.5	468.5	40	9%	15.82	17.95	2.13	13%	0				2.5			4.5			1	
64858	Suture of sciatic nerve	090	442.5	482.5	40	9%	17.82	19.95	2.13	12%	0				2.5			4.5			1	
64861	Suture of; brachial plexus	090	549	600	51	9%	20.89	23.54	2.65	13%	0				3			6			1	
64862	Suture of; lumbar plexus	090	531	582	51	10%	21.09	23.74	2.65	13%	0				3			6			1	
64864	Suture of facial nerve; extracr	090	321	345	24	7%	13.41	14.77	1.36	10%	0				2			2			1	
64865	Suture of facial nerve; infrate	090	365.5	385.5	20	5%	16.09	17.26	1.17	7%	0				2.5			0.5			1	
64866	Anastomosis; facial-spinal acc	090	391.5	421.5	30	8%	16.83	18.48	1.65	10%	0				2.5			2.5			1	
64868	Anastomosis; facial-hypogloss	090	351	375	24	7%	14.90	16.26	1.36	9%	0				2			2			1	
64885	Nerve graft (includes obtainin	090	325	339	14	4%	17.60	18.48	0.88	5%	0				2						1	
64886	Nerve graft (includes obtainin	090	411	426	15	4%	20.82	22.14	1.32	6%	0				2			1	1		1	
64890	Nerve graft (includes obtainin	090	403.5	433.5	30	7%	16.24	17.89	1.65	10%	0				2.5			2.5			1	
64891	Nerve graft (includes obtainin	090	424.5	459.5	35	8%	17.35	19.24	1.89	11%	0				2.5			3.5			1	
64892	Nerve graft (includes obtainin	090	396.5	426.5	30	8%	15.74	17.39	1.65	10%	0				2.5			2.5			1	
64893	Nerve graft (includes obtainin	090	439.5	477	37.5	9%	16.87	18.88	2.01	12%	0				2.5			4			1	
64895	Nerve graft (includes obtainin	090	458.5	491	32.5	7%	20.39	22.16	1.77	9%	0				2.5			3			1	
64896	Nerve graft (includes obtainin	090	523	566.5	43.5	8%	21.96	24.25	2.29	10%	0				3			4.5			1	
64897	Nerve graft (includes obtainin	090	480.5	513	32.5	7%	19.38	21.15	1.77	9%	0				2.5			3			1	
64898	Nerve graft (includes obtainin	090	531	574.5	43.5	8%	20.97	23.26	2.29	11%	0				3			4.5			1	
64905	Nerve pedicle transfer; first st	090	383.5	413.5	30	8%	15.11	16.76	1.65	11%	0				2.5			2.5			1	
64907	Nerve pedicle transfer; secon	090	404.5	439.5	35	9%	20.03	21.92	1.89	9%	0				2.5			3.5			1	
64910	Nerve repair; with synthetic c	090	257	280	23	9%	10.52	11.84	1.32	13%	0			1	3						0.5	
64911	Nerve repair; with autogenou	090	292	315	23	8%	14.00	15.32	1.32	9%	0			1	3						0.5	
64912	Nerve repair; with nerve allog	090	272	295	23	8%	12.00	13.32	1.32	11%	0			1	3						0.5	
65091	Evisceration of ocular content	090	164.5	182	17.5	11%	7.26	8.20	0.94	13%	0				2.5						0.5	
65093	Evisceration of ocular content	090	214	221	7	3%	7.04	8.03	0.99	14%	0			3.5							1	
65101	Enucleation of eye; without in	090	232	260	28	12%	8.30	9.73	1.43	17%	0				4						0.5	
65103	Enucleation of eye; with impla	090	237	265	28	12%	8.84	10.27	1.43	16%	0				4						0.5	
65105	Enucleation of eye; with impla	090	269.5	301	31.5	12%	9.93	11.53	1.60	16%	0				4.5						0.5	
65110	Exenteration of orbit (does no	090	370.5	409	38.5	10%	15.70	17.74	2.04	13%	0				5.5						1	
65112	Exenteration of orbit (does no	090	434.5	482.5	48	11%	18.51	21.00	2.49	13%	0				6.5			0.5			1	
65114	Exenteration of orbit (does no	090	446.5	494.5	48	11%	19.65	22.14	2.49	13%	0				6.5			0.5			1	
65125	Modification of ocular implant	090	148	154	6	4%	3.27	3.93	0.66	20%	0			3								
65130	Insertion of ocular implant se	090	200	228	28	14%	8.42	9.74	1.32	16%	0				4							
65135	Insertion of ocular implant se	090	207	235	28	14%	8.60	9.92	1.32	15%	0				4							
65140	Insertion of ocular implant se	090	255.5	287	31.5	12%	9.46	11.06	1.60	17%	0				4.5						0.5	
65150	Reinsertion of ocular implant;	090	187	194	7	4%	6.43	7.31	0.88	14%	0			3.5							0.5	
65155	Reinsertion of ocular implant;	090	259.5	291	31.5	12%	10.10	11.59	1.49	15%	0				4.5							
65175	Removal of ocular implant	090	174.5	199	24.5	14%	7.40	8.56	1.16	16%	0				3.5							
65235	Removal of foreign body, intra	090	185.5	217	31.5	17%	9.01	10.50	1.49	16%	0				4.5							
65260	Removal of foreign body, intra	090	270	305	35	13%	12.54	14.30	1.76	14%	0				5						0.5	
65265	Removal of foreign body, intra	090	291.5	330	38.5	13%	14.34	16.16	1.82	13%	0				5.5							
65270	Repair of laceration; conjuncti	010	67	69	2	3%	1.95	2.17	0.22	11%	0			1								
65272	Repair of laceration; conjuncti	090	115.5	133	17.5	15%	4.62	5.45	0.83	18%	0				2.5							
65273	Repair of laceration; conjuncti	090	164.5	182	17.5	11%	5.16	6.21	1.05	20%	0				2.5						1	
65275	Repair of laceration; cornea, r	090	146	167	21	14%	6.29	7.28	0.99	16%	0				3							
65280	Repair of laceration; cornea a	090	249.5	281	31.5	13%	9.10	10.70	1.60	18%	0				4.5						0.5	
65285	Repair of laceration; cornea a	090	353	397	44	12%	15.36	17.67	2.31	15%	0			1	6						0.5	
65286	Repair of laceration; applicati	090	172.5	197	24.5	14%	6.63	7.79	1.16	17%	0				3.5							
65290	Repair of wound, extraocular	090	178.5	203	24.5	14%	6.53	7.69	1.16	18%	0				3.5							
65400	Excision of lesion, cornea (ker	090	189.5	221	31.5	17%	7.50	8.99	1.49	20%	0				4.5							
65420	Excision or transposition of pt	090	149	157	8	5%	4.36	5.24	0.88	20%	0			4								
65426	Excision or transposition of pt	090	162.5	170.5	8	5%	6.05	7.04	0.99	16%	0			4							0.5	
65436	Removal of corneal epitheliun	090	101	115	14	14%	4.82	5.48	0.66	14%	0				2							
65450	Destruction of lesion of corne	090	117	125	8	7%	3.47	4.35	0.88	25%	0			4								
65600	Multiple punctures of anterio	090	115.5	133	17.5	15%	4.20	5.03	0.83	20%	0				2.5							
65710	Keratoplasty (corneal transpla	090	317	363	46	15%	14.45	16.61	2.16	15%	-4				4	2						
65730	Keratoplasty (corneal transpla	090	322	368	46	14%	16.35	18.51	2.16	13%	-4				4	2						
65750	Keratoplasty (corneal transpla	090	288	330	42	15%	16.90	18.88	1.98	12%	0				6							
65755	Keratoplasty (corneal transpla	090	288	330	42	15%	16.79	18.77	1.98	12%	0				6							
65756	Keratoplasty (corneal transpla	090	255	282	27	11%	16.84	18.60	1.76	10%	0			3	3						0.5	
65770	Keratoprosthesis	090	456.5	507	50.5	11%	19.74	22.35	2.61	13%	0				6.5			1			1	
65772	Corneal relaxing incision for c	090	128.5	146	17.5	14%	5.09	5.92	0.83	16%	0				2.5							
65775	Corneal wedge resection for c	090	168.5	193	24.5	15%	6.91	8.07	1.16	17%	0				3.5							
65780	Ocular surface reconstruction	090	230	254	24	10%	7.81	9.68	1.87	24%	0			5	2						0.5	

65781	Ocular surface reconstruction	090	354	374	20	6%	18.14	20.45	2.31	13%	0			10							0.5	
65782	Ocular surface reconstruction	090	331	349	18	5%	15.43	17.52	2.09	14%	0			9							0.5	
65785	Implantation of intrastromal c	090	134	147	13	10%	5.39	6.38	0.99	18%	0			3	1							
65810	Paracentesis of anterior cham	090	142	163	21	15%	5.82	6.81	0.99	17%	0				3							
65815	Paracentesis of anterior cham	090	152	173	21	14%	6.00	6.99	0.99	17%	0				3							
65820	Goniotomy	090	244	264	20	8%	8.91	10.23	1.32	15%	0			3	2							
65850	Trabeculotomy ab externo	090	233	243	10	4%	11.39	12.71	1.32	12%	0			5							1	
65855	Trabeculoplasty by laser surge	010	61	63	2	3%	3.00	3.22	0.22	7%	0			1								
65860	Severing adhesions of anterio	090	120	122	2	2%	3.59	3.81	0.22	6%	0			1								
65865	Severing adhesions of anterio	090	135	142	7	5%	5.77	6.54	0.77	13%	0			3.5								
65870	Severing adhesions of anterio	090	165.5	190	24.5	15%	7.39	8.55	1.16	16%	0				3.5							
65875	Severing adhesions of anterio	090	178	206	28	16%	7.81	9.13	1.32	17%	0				4							
65880	Severing adhesions of anterio	090	185	213	28	15%	8.36	9.68	1.32	16%	0				4							
65900	Removal of epithelial downgr	090	246	281	35	14%	12.51	14.16	1.65	13%	0				5							
65920	Removal of implanted materia	090	214	249	35	16%	9.99	11.64	1.65	17%	0				5							
65930	Removal of blood clot, anterio	090	176	197	21	12%	8.39	9.49	1.10	13%	0				3						0.5	
66020	Injection, anterior chamber of	010	52	54	2	4%	1.64	1.86	0.22	13%	0			1								
66030	Injection, anterior chamber of	010	51	53	2	4%	1.30	1.52	0.22	17%	0			1								
66130	Excision of lesion, sclera	090	131	137	6	5%	7.83	8.49	0.66	8%	0			3								
66150	Fistulization of sclera for glauc	090	269	318	49	18%	10.53	12.84	2.31	22%	0				7							
66155	Fistulization of sclera for glauc	090	284	333	49	17%	10.52	12.94	2.42	23%	0				7						0.5	
66160	Fistulization of sclera for glauc	090	266	315	49	18%	12.39	14.70	2.31	19%	0				7							
66170	Fistulization of sclera for glauc	090	278	321	43	15%	13.94	16.58	2.64	19%	0			4	5						0.5	
66172	Fistulization of sclera for glauc	090	325	372	47	14%	14.84	17.92	3.08	21%	0			6	5						0.5	
66174	Transluminal dilation of aqued	090	173	203	30	17%	7.62	9.27	1.65	22%	0			1	4						0.5	
66175	Transluminal dilation of aqued	090	184	214	30	16%	9.34	10.99	1.65	18%	0			1	4						0.5	
66179	Aqueous shunt to extraocular	090	272	313	41	15%	14.00	16.42	2.42	17%	0			3	5						0.5	
66180	Aqueous shunt to extraocular	090	277	318	41	15%	15.00	17.42	2.42	16%	0			3	5						0.5	
66183	Insertion of anterior segment	090	257	298	41	16%	13.20	15.62	2.42	18%	0			3	5						0.5	
66184	Revision of aqueous shunt to	090	254	288	34	13%	9.58	11.67	2.09	22%	0			3	4						0.5	
66185	Revision of aqueous shunt to	090	259	293	34	13%	10.58	12.67	2.09	20%	0			3	4						0.5	
66225	Repair of scleral staphyloma w	090	294	329	35	12%	12.63	14.28	1.65	13%	0				5							
66250	Revision or repair of operative	090	175.5	200	24.5	14%	7.10	8.26	1.16	16%	0				3.5							
66500	Iridotomy by stab incision (sep	090	103	108	5	5%	3.83	4.38	0.55	14%	0			2.5								
66505	Iridotomy by stab incision (sep	090	108	114	6	6%	4.22	4.88	0.66	16%	0			3								
66600	Iridectomy, with corneosclera	090	211.5	243	31.5	15%	10.12	11.61	1.49	15%	0				4.5							
66605	Iridectomy, with corneosclera	090	221.5	253	31.5	14%	14.22	15.71	1.49	10%	0				4.5							
66625	Iridectomy, with corneosclera	090	132	139	7	5%	5.30	6.07	0.77	15%	0			3.5								
66630	Iridectomy, with corneosclera	090	171.5	196	24.5	14%	7.28	8.44	1.16	16%	0				3.5							
66635	Iridectomy, with corneosclera	090	167.5	192	24.5	15%	7.37	8.53	1.16	16%	0				3.5							
66680	Repair of iris, ciliary body (as s	090	159	180	21	13%	6.39	7.38	0.99	15%	0				3							
66682	Suture of iris, ciliary body (sep	090	169.5	194	24.5	14%	7.33	8.49	1.16	16%	0				3.5							
66700	Ciliary body destruction; diath	090	146	155	9	6%	5.14	5.69	0.55	11%	0			1	1							
66710	Ciliary body destruction; cyclo	090	140	149	9	6%	5.14	5.69	0.55	11%	0			1	1							
66711	Ciliary body destruction; cyclo	090	191	221	30	16%	5.62	7.27	1.65	29%	0			1	4						0.5	
66720	Ciliary body destruction; cryot	090	146	155	9	6%	4.75	5.74	0.99	21%	0			4.5								
66740	Ciliary body destruction; cyclo	090	140	149	9	6%	5.14	5.69	0.55	11%	0			1	1							
66761	Iridotomy/iridectomy by laser	010	66	75	9	14%	3.00	3.55	0.55	18%	0			1	1							
66762	Iridoplasty by photocoagulatio	090	123.5	141	17.5	14%	5.38	6.21	0.83	15%	0				2.5							
66770	Destruction of cyst or lesion in	090	132	153	21	16%	6.13	7.12	0.99	16%	0				3							
66820	Discission of secondary memb	090	113	118	5	4%	4.01	4.56	0.55	14%	0			2.5								
66821	Discission of secondary memb	090	82	96	14	17%	3.42	4.08	0.66	19%	0				2							
66825	Repositioning of intraocular le	090	219	239	20	9%	9.01	10.33	1.32	15%	0			3	2							
66830	Removal of secondary membr	090	189	217	28	15%	9.47	10.79	1.32	14%	0				4							
66840	Removal of lens material; aspi	090	183	211	28	15%	9.18	10.50	1.32	14%	0				4							
66850	Removal of lens material; pha	090	207.5	239	31.5	15%	10.55	12.04	1.49	14%	0				4.5							
66852	Removal of lens material; pars	090	206.5	238	31.5	15%	11.41	12.90	1.49	13%	0				4.5							
66920	Removal of lens material; intr	090	188	216	28	15%	10.13	11.45	1.32	13%	0				4							
66930	Removal of lens material; intr	090	210.5	242	31.5	15%	11.61	13.10	1.49	13%	0				4.5							
66940	Removal of lens material; extr	090	198.5	230	31.5	16%	10.37	11.86	1.49	14%	0				4.5							
66982	Extracapsular cataract remova	090	175	198	23	13%	10.25	11.57	1.32	13%	0			1	3						0.5	
66984	Extracapsular cataract remova	090	126	142	16	13%	7.35	8.34	0.99	13%	0			1	2						0.5	
66985	Insertion of intraocular lens p	090	227	262	35	15%	9.98	11.63	1.65	17%	0				5							
66989	Extracapsular cataract remova	090	176	199	23	13%	12.13	13.45	1.32	11%	0			1	3						0.5	
66991	Extracapsular cataract remova	090	172	195	23	13%	9.23	10.55	1.32	14%	0			1	3						0.5	
67005	Removal of vitreous, anterior	090	147	155	8	5%	5.89	6.77	0.88	15%	0			4								
67010	Removal of vitreous, anterior	090	156	164	8	5%	7.06	7.94	0.88	12%	0			4								

67015	Aspiration or release of vitreo	090	171	180	9	5%	7.14	8.13	0.99	14%	0			4.5								
67025	Injection of vitreous substitut	090	190	218	28	15%	8.11	9.43	1.32	16%	0				4							
67027	Implantation of intravitreal dr	090	244	264	20	8%	11.62	12.94	1.32	11%	0			3	2							
67030	Discission of vitreous strands	090	167	195	28	17%	6.11	7.43	1.32	22%	0				4							
67031	Severing of vitreous strands, v	090	109.5	127	17.5	16%	4.47	5.30	0.83	18%	0				2.5							
67036	Vitrectomy, mechanical, pars	090	250	285	35	14%	12.13	13.89	1.76	15%	0				5						0.5	
67039	Vitrectomy, mechanical, pars	090	260	295	35	13%	13.20	14.96	1.76	13%	0				5						0.5	
67040	Vitrectomy, mechanical, pars	090	273	308	35	13%	14.50	16.26	1.76	12%	0				5						0.5	
67041	Vitrectomy, mechanical, pars	090	260	295	35	13%	16.33	18.09	1.76	11%	0				5						0.5	
67042	Vitrectomy, mechanical, pars	090	260	295	35	13%	16.33	18.09	1.76	11%	0				5						0.5	
67043	Vitrectomy, mechanical, pars	090	275	310	35	13%	17.40	19.16	1.76	10%	0				5						0.5	
67101	Repair of retinal detachment,	010	145	159	14	10%	3.50	4.27	0.77	22%	0				2						0.5	
67105	Repair of retinal detachment,	010	97	111	14	14%	3.39	4.05	0.66	19%	0				2							
67107	Repair of retinal detachment;	090	290	325	35	12%	16.00	17.76	1.76	11%	0				5						0.5	
67108	Repair of retinal detachment;	090	295	330	35	12%	17.13	18.89	1.76	10%	0				5						0.5	
67110	Repair of retinal detachment;	090	196	238	42	21%	10.25	12.23	1.98	19%	0				6							
67113	Repair of complex retinal deta	090	348	390	42	12%	19.00	21.09	2.09	11%	0				6						0.5	
67115	Release of encircling material	090	158.5	183	24.5	15%	6.11	7.27	1.16	19%	0				3.5							
67120	Removal of implanted materia	090	162.5	187	24.5	15%	7.10	8.26	1.16	16%	0				3.5							
67121	Removal of implanted materia	090	280	315	35	13%	12.25	13.90	1.65	13%	0				5							
67141	Prophylaxis of retinal detachn	010	77	91	14	18%	2.53	3.19	0.66	26%	0				2							
67145	Prophylaxis of retinal detachn	010	76	90	14	18%	2.53	3.19	0.66	26%	0				2							
67208	Destruction of localized lesion	090	137	158	21	15%	7.65	8.64	0.99	13%	0				3							
67210	Destruction of localized lesion	090	106	127	21	20%	6.36	7.35	0.99	16%	0				3							
67218	Destruction of localized lesion	090	464	476	12	3%	20.36	22.85	2.49	12%	0			3	1			2	2	1	1	
67220	Destruction of localized lesion	090	117.5	138.5	21	18%	6.36	7.35	0.99	16%	0				3							
67227	Destruction of extensive or pr	010	93	100	7	8%	3.50	3.94	0.44	13%	0				1						0.5	
67228	Treatment of extensive or pro	010	81	88	7	9%	4.39	4.72	0.33	8%	0				1							
67229	Treatment of extensive or pro	090	353.5	391.5	38	11%	16.30	18.70	2.40	15%	0				6				1		1	
67250	Scleral reinforcement (separa	090	210	231	21	10%	9.61	10.60	0.99	10%	0				3							
67255	Scleral reinforcement (separa	090	216	243	27	13%	8.38	10.14	1.76	21%	0			3	3						0.5	
67311	Strabismus surgery, recession	090	144	155	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67312	Strabismus surgery, recession	090	159	170	11	7%	9.50	10.38	0.88	9%	0			2	1						0.5	
67314	Strabismus surgery, recession	090	145	156	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67316	Strabismus surgery, recession	090	164	175	11	7%	10.31	11.19	0.88	9%	0			2	1						0.5	
67318	Strabismus surgery, any proce	090	166	182	16	10%	9.80	10.79	0.99	10%	0			1	2						0.5	
67343	Release of extensive scar tissu	090	167.5	192	24.5	15%	8.47	9.63	1.16	14%	0				3.5							
67345	Chemodenervation of extraoc	010	58	60	2	3%	3.01	3.23	0.22	7%	0			1								
67400	Orbitotomy without bone flap	090	255.5	287	31.5	12%	11.20	12.80	1.60	14%	0				4.5						0.5	
67405	Orbitotomy without bone flap	090	209	237	28	13%	9.20	10.63	1.43	16%	0				4						0.5	
67412	Orbitotomy without bone flap	090	234.5	252	17.5	7%	10.30	11.24	0.94	9%	0				2.5						0.5	
67413	Orbitotomy without bone flap	090	220	230	10	5%	10.24	11.34	1.10	11%	0			5								
67414	Orbitotomy without bone flap	090	347	361	14	4%	17.94	19.33	1.39	8%	-2			1	1	1			1		1	
67420	Orbitotomy with bone flap or	090	468	513	45	10%	21.87	24.22	2.35	11%	0				5			2			1	
67430	Orbitotomy with bone flap or	090	353	395	42	12%	15.29	17.27	1.98	13%	0				6							
67440	Orbitotomy with bone flap or	090	336.5	375	38.5	11%	14.84	16.77	1.93	13%	0				5.5						0.5	
67445	Orbitotomy with bone flap or	090	352	366	14	4%	19.12	20.51	1.39	7%	-2			1	1	1			1		1	
67450	Orbitotomy with bone flap or	090	366	408	42	11%	15.41	17.50	2.09	14%	0				6						0.5	
67550	Orbital implant (implant outsi	090	282	317	35	12%	11.77	13.42	1.65	14%	0				5							
67560	Orbital implant (implant outsi	090	276	311	35	13%	12.18	13.83	1.65	14%	0				5							
67570	Optic nerve decompression (e	090	294	314	20	7%	14.40	15.59	1.19	8%	-2			2	1	1						
67700	Blepharotomy, drainage of ab	010	59	61	2	3%	1.40	1.62	0.22	16%	0			1								
67710	Severing of tarsorrhaphy	010	39	41	2	5%	1.07	1.29	0.22	21%	0			1								
67715	Canthotomy (separate proced	010	41	43	2	5%	1.27	1.49	0.22	17%	0			1								
67800	Excision of chalazion; single	010	46	47	1	2%	1.41	1.52	0.11	8%	0			0.5								
67801	Excision of chalazion; multiple	010	48	49	1	2%	1.91	2.02	0.11	6%	0			0.5								
67805	Excision of chalazion; multiple	010	78	80	2	3%	2.27	2.49	0.22	10%	0			1								
67808	Excision of chalazion; under g	090	126.5	144	17.5	14%	4.60	5.43	0.83	18%	0				2.5							
67825	Correction of trichiasis; epilati	010	47	49	2	4%	1.43	1.65	0.22	15%	0			1								
67830	Correction of trichiasis; incisio	010	56	58	2	4%	1.75	1.97	0.22	13%	0			1								
67835	Correction of trichiasis; incisio	090	154	160	6	4%	5.70	6.36	0.66	12%	0			3								
67840	Excision of lesion of eyelid (ex	010	56	58	2	4%	2.09	2.31	0.22	11%	0			1								
67850	Destruction of lesion of lid ma	010	48	50	2	4%	1.74	1.96	0.22	13%	0			1								
67880	Construction of intermarginal	090	114.5	132	17.5	15%	4.60	5.43	0.83	18%	0				2.5							
67882	Construction of intermarginal	090	156	177	21	13%	6.02	7.01	0.99	16%	0				3							
67900	Repair of brow ptosis (supraci	090	177	193	16	9%	6.82	7.70	0.88	13%	0			1	2							
67901	Repair of blepharoptosis; fron	090	188	196	8	4%	7.59	8.58	0.99	13%	0			4							0.5	

67902	Repair of blepharoptosis; fron	090	221	234	13	6%	9.82	10.92	1.10	11%	0			3	1						0.5	
67903	Repair of blepharoptosis; (tars	090	145	151	6	4%	6.51	7.17	0.66	10%	0			3								
67904	Repair of blepharoptosis; (tars	090	185	198	13	7%	7.97	9.07	1.10	14%	0			3	1						0.5	
67906	Repair of blepharoptosis; supe	090	134	140	6	4%	6.93	7.59	0.66	10%	0			3								
67908	Repair of blepharoptosis; conj	090	136	143	7	5%	5.30	6.07	0.77	15%	0			3.5								
67909	Reduction of overcorrection o	090	136	143	7	5%	5.57	6.34	0.77	14%	0			3.5								
67911	Correction of lid retraction	090	183	191	8	4%	7.50	8.49	0.99	13%	0			4							0.5	
67912	Correction of lagophthalmos,	090	166	182	16	10%	6.36	7.35	0.99	16%	0			1	2						0.5	
67914	Repair of ectropion; suture	090	129	140	11	9%	3.75	4.63	0.88	23%	0			2	1						0.5	
67915	Repair of ectropion; thermoca	090	70	74	4	6%	2.03	2.47	0.44	22%	0			2								
67916	Repair of ectropion; excision t	090	134	145	11	8%	5.48	6.36	0.88	16%	0			2	1						0.5	
67917	Repair of ectropion; extensive	090	142	153	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67921	Repair of entropion; suture	090	124	135	11	9%	3.47	4.35	0.88	25%	0			2	1						0.5	
67922	Repair of entropion; thermoca	090	75	79	4	5%	2.03	2.47	0.44	22%	0			2								
67923	Repair of entropion; excision t	090	134	145	11	8%	5.48	6.36	0.88	16%	0			2	1						0.5	
67924	Repair of entropion; extensive	090	149	160	11	7%	5.93	6.81	0.88	15%	0			2	1						0.5	
67930	Suture of recent wound, eyeli	010	77	79	2	3%	3.65	3.87	0.22	6%	0			1								
67935	Suture of recent wound, eyeli	090	150	156	6	4%	6.36	7.02	0.66	10%	0			3								
67938	Removal of embedded foreign	010	48	50	2	4%	1.38	1.60	0.22	16%	0			1								
67950	Canthoplasty (reconstruction	090	144	151	7	5%	5.99	6.76	0.77	13%	0			3.5								
67961	Excision and repair of eyelid, i	090	167	174	7	4%	5.86	6.63	0.77	13%	0			3.5								
67966	Excision and repair of eyelid, i	090	200	213	13	6%	8.97	10.07	1.10	12%	0			3	1						0.5	
67971	Reconstruction of eyelid, full t	090	235	244	9	4%	10.01	11.00	0.99	10%	0			4.5								
67973	Reconstruction of eyelid, full t	090	253	264	11	4%	13.13	14.34	1.21	9%	0			5.5								
67974	Reconstruction of eyelid, full t	090	255	266	11	4%	13.10	14.31	1.21	9%	0			5.5								
67975	Reconstruction of eyelid, full t	090	197	206	9	5%	9.35	10.34	0.99	11%	0			4.5								
68020	Incision of conjunctiva, draina	010	41	43	2	5%	1.42	1.64	0.22	15%	0			1								
68110	Excision of lesion, conjunctiva	010	58	60	2	3%	1.82	2.04	0.22	12%	0			1								
68115	Excision of lesion, conjunctiva	010	68	70	2	3%	2.41	2.63	0.22	9%	0			1								
68130	Excision of lesion, conjunctiva	090	132	139	7	5%	5.10	5.87	0.77	15%	0			3.5								
68135	Destruction of lesion, conjunc	010	58	60	2	3%	1.89	2.11	0.22	12%	0			1								
68320	Conjunctivoplasty; with conju	090	209	237	28	13%	6.64	7.96	1.32	20%	0				4							
68325	Conjunctivoplasty; with bucca	090	217	245	28	13%	8.63	9.95	1.32	15%	0				4							
68326	Conjunctivoplasty, reconstruc	090	211	239	28	13%	8.42	9.74	1.32	16%	0				4							
68328	Conjunctivoplasty, reconstruc	090	231	259	28	12%	9.45	10.77	1.32	14%	0				4							
68330	Repair of symblepharon; conj	090	154	175	21	14%	5.78	6.77	0.99	17%	0				3							
68335	Repair of symblepharon; with	090	216	244	28	13%	8.46	9.78	1.32	16%	0				4							
68340	Repair of symblepharon; divis	090	134.5	152	17.5	13%	4.97	5.80	0.83	17%	0				2.5							
68360	Conjunctival flap; bridge or pa	090	138.5	156	17.5	13%	5.17	6.00	0.83	16%	0				2.5							
68362	Conjunctival flap; total (such a	090	203	231	28	14%	8.61	9.93	1.32	15%	0				4							
68371	Harvesting conjunctival allogr	010	150	158	8	5%	5.09	6.08	0.99	19%	0			4							0.5	
68400	Incision, drainage of lacrimal g	010	56	58	2	4%	1.74	1.96	0.22	13%	0			1								
68420	Incision, drainage of lacrimal s	010	61	63	2	3%	2.35	2.57	0.22	9%	0			1								
68440	Snip incision of lacrimal punct	010	35	37	2	6%	0.99	1.21	0.22	22%	0			1								
68500	Excision of lacrimal gland (dac	090	260.5	299	38.5	15%	12.77	14.59	1.82	14%	0				5.5							
68505	Excision of lacrimal gland (dac	090	262.5	301	38.5	15%	12.69	14.51	1.82	14%	0				5.5							
68520	Excision of lacrimal sac (dacry	090	212	240	28	13%	8.78	10.10	1.32	15%	0				4							
68530	Removal of foreign body or da	010	89	91	2	2%	3.70	3.92	0.22	6%	0			1								
68540	Excision of lacrimal gland tum	090	263	298	35	13%	12.18	13.83	1.65	14%	0				5							
68550	Excision of lacrimal gland tum	090	328	370	42	13%	15.16	17.14	1.98	13%	0				6							
68700	Plastic repair of canaliculi	090	201	229	28	14%	7.87	9.19	1.32	17%	0				4							
68705	Correction of everted punctur	010	55	57	2	4%	2.11	2.33	0.22	10%	0			1								
68720	Dacryocystorhinostomy (fistul	090	235	258	23	10%	9.96	11.17	1.21	12%	0			1	3							
68745	Conjunctivorhinostomy (fistul	090	212	240	28	13%	9.90	11.22	1.32	13%	0				4							
68750	Conjunctivorhinostomy (fistul	090	233.5	265	31.5	13%	10.10	11.59	1.49	15%	0				4.5							
68760	Closure of the lacrimal punctu	010	37	39	2	5%	1.78	2.00	0.22	12%	0			1								
68761	Closure of the lacrimal punctu	010	38	40	2	5%	1.41	1.63	0.22	16%	0			1								
68770	Closure of lacrimal fistula (sep	090	181	209	28	15%	8.29	9.61	1.32	16%	0				4							
68801	Dilation of lacrimal punctum,	010	33	35	2	6%	0.82	1.04	0.22	27%	0			1								
68810	Probing of nasolacrimal duct,	010	43	45	2	5%	1.54	1.76	0.22	14%	0			1								
68811	Probing of nasolacrimal duct,	010	74.5	74.5	0	0%	1.74	1.85	0.11	6%	-2		1								0.5	
68815	Probing of nasolacrimal duct,	010	108	112	4	4%	2.70	3.25	0.55	20%	0			2							0.5	
68816	Probing of nasolacrimal duct,	010	83	83	0	0%	2.10	2.21	0.11	5%	-2		1								0.5	
68840	Probing of lacrimal canaliculi,	010	39	41	2	5%	1.30	1.52	0.22	17%	0			1								
69000	Drainage external ear, absces	010	49	51	2	4%	1.50	1.72	0.22	15%	0			1								
69005	Drainage external ear, absces	010	62	64	2	3%	2.16	2.38	0.22	10%	0			1								
69020	Drainage external auditory ca	010	40	42	2	5%	1.53	1.75	0.22	14%	0			1								

69110	Excision external ear; partial,	090	91	95	4	4%	3.53	3.97	0.44	12%	0			2								
69120	Excision external ear; complet	090	109	113	4	4%	4.14	4.58	0.44	11%	0			2								
69140	Excision exostosis(es), externa	090	185	192	7	4%	8.14	9.02	0.88	11%	0			3.5							0.5	
69145	Excision soft tissue lesion, ext	090	72	75	3	4%	2.70	3.03	0.33	12%	0			1.5								
69150	Radical excision external audit	090	285	293	8	3%	13.61	14.71	1.10	8%	0			4							1	
69155	Radical excision external audit	090	745	805	60	8%	23.35	26.93	3.58	15%	-4			1	2	2		6	1		1	
69205	Removal foreign body from ex	010	25.5	25.5	0	0%	1.21	1.21	-	0%	-1		0.5									
69222	Debridement, mastoidectomy	010	48	50	2	4%	1.45	1.67	0.22	15%	0			1								
69300	Otoplasty, protruding ear, wit	YYY	227	236	9	4%	6.44	6.86	0.42	7%	-4		1			1						
69310	Reconstruction of external au	090	220	228	8	4%	10.97	11.85	0.88	8%	0			4								
69320	Reconstruction external audit	090	359	369	10	3%	17.18	18.39	1.21	7%	0			5							0.5	
69420	Myringotomy including aspira	010	37	39	2	5%	1.38	1.60	0.22	16%	0			1								
69421	Myringotomy including aspira	010	38	40	2	5%	1.78	2.00	0.22	12%	0			1								
69433	Tympanostomy (requiring ins	010	56	63	7	13%	1.57	1.90	0.33	21%	0				1							
69436	Tympanostomy (requiring ins	010	64	66	2	3%	2.01	2.23	0.22	11%	0			1								
69440	Middle ear exploration throug	090	185	191	6	3%	7.71	8.48	0.77	10%	0			3							0.5	
69450	Tympanolysis, transcanal	090	116	121	5	4%	5.69	6.24	0.55	10%	0			2.5								
69501	Transmastoid antrotomy (sim	090	206	212	6	3%	9.21	9.98	0.77	8%	0			3							0.5	
69502	Mastoidectomy; complete	090	299	307	8	3%	12.56	13.66	1.10	9%	0			4							1	
69505	Mastoidectomy; modified rad	090	321	329	8	2%	13.17	14.27	1.10	8%	0			4							1	
69511	Mastoidectomy; radical	090	318	326	8	3%	13.70	14.80	1.10	8%	0			4							1	
69530	Petrous apicectomy including	090	563	592	29	5%	20.38	22.55	2.17	11%	0			4.5				4			1	
69535	Resection temporal bone, ext	090	770	825	55	7%	37.42	40.90	3.48	9%	0			5				9			1	
69540	Excision aural polyp	010	43	45	2	5%	1.25	1.47	0.22	18%	0			1								
69550	Excision aural glomus tumor;	090	234	241	7	3%	11.15	12.03	0.88	8%	0			3.5							0.5	
69552	Excision aural glomus tumor;	090	396	411.5	15.5	4%	19.81	21.27	1.46	7%	0			4				1.5			1	
69554	Excision aural glomus tumor;	090	1024	1078	54	5%	35.97	39.53	3.56	10%	-4				2	2		6	2		1	
69601	Revision mastoidectomy; resu	090	330	339	9	3%	13.45	14.66	1.21	9%	0			4.5							1	
69602	Revision mastoidectomy; resu	090	325	333	8	2%	13.76	14.86	1.10	8%	0			4							1	
69603	Revision mastoidectomy; resu	090	319	327	8	3%	14.20	15.30	1.10	8%	0			4							1	
69604	Revision mastoidectomy; resu	090	336	344	8	2%	14.20	15.30	1.10	8%	0			4							1	
69610	Tympanic membrane repair, v	010	90	92	2	2%	4.47	4.69	0.22	5%	0			1								
69620	Myringoplasty (surgery confir	090	158	164	6	4%	6.03	6.69	0.66	11%	0			3								
69631	Tympanoplasty without mast	090	245	253	8	3%	10.05	11.04	0.99	10%	0			4							0.5	
69632	Tympanoplasty without mast	090	274	283	9	3%	12.96	14.06	1.10	8%	0			4.5							0.5	
69633	Tympanoplasty without mast	090	275	284	9	3%	12.31	13.41	1.10	9%	0			4.5							0.5	
69635	Tympanoplasty with antrotom	090	292	300	8	3%	13.51	14.50	0.99	7%	0			4							0.5	
69636	Tympanoplasty with antrotom	090	332	341	9	3%	15.43	16.53	1.10	7%	0			4.5							0.5	
69637	Tympanoplasty with antrotom	090	340	349	9	3%	15.32	16.42	1.10	7%	0			4.5							0.5	
69641	Tympanoplasty with mastoide	090	341	349	8	2%	12.89	13.99	1.10	9%	0			4							1	
69642	Tympanoplasty with mastoide	090	376	386	10	3%	17.06	18.38	1.32	8%	0			5							1	
69643	Tympanoplasty with mastoide	090	369	380.5	11.5	3%	15.59	16.92	1.33	9%	0			4.5				0.5			1	
69644	Tympanoplasty with mastoide	090	399	410.5	11.5	3%	17.23	18.56	1.33	8%	0			4.5				0.5			1	
69645	Tympanoplasty with mastoide	090	377	391	14	4%	16.71	18.16	1.45	9%	0			4.5				1			1	
69646	Tympanoplasty with mastoide	090	416	432.5	16.5	4%	18.37	19.94	1.57	9%	0			4.5				1.5			1	
69650	Stapes mobilization	090	181	187	6	3%	9.80	10.57	0.77	8%	0			3							0.5	
69660	Stapedectomy or stapedotom	090	202	208	6	3%	12.03	12.80	0.77	6%	0			3							0.5	
69661	Stapedectomy or stapedotom	090	276	284	8	3%	15.92	17.02	1.10	7%	0			4							1	
69662	Revision of stapedectomy or s	090	249	256	7	3%	15.60	16.59	0.99	6%	0			3.5							1	
69666	Repair oval window fistula	090	206	212	6	3%	9.89	10.77	0.88	9%	0			3							1	
69667	Repair round window fistula	090	206	212	6	3%	9.90	10.78	0.88	9%	0			3							1	
69670	Mastoid obliteration (separat	090	280	289.5	9.5	3%	11.73	12.84	1.11	9%	0			3.5				0.5			1	
69676	Tympanic neurectomy	090	196	203	7	4%	9.69	10.57	0.88	9%	0			3.5							0.5	
69700	Closure postauricular fistula, r	090	181	187	6	3%	8.37	9.14	0.77	9%	0			3							0.5	
69711	Removal or repair of electrom	090	249	257	8	3%	10.62	11.61	0.99	9%	0			4							0.5	
69714	Implantation, osseointegrated	090	146	155	9	6%	8.00	8.66	0.66	8%	0			1	1						0.5	
69716	Implantation, osseointegrated	090	168	177	9	5%	9.03	9.69	0.66	7%	0			1	1						0.5	
69717	Replacement (including remov	090	159	168	9	6%	8.48	9.14	0.66	8%	0			1	1						0.5	
69719	Replacement (including remov	090	174	183	9	5%	9.46	10.12	0.66	7%	0			1	1						0.5	
69720	Decompression facial nerve, i	090	357	371	14	4%	14.71	16.16	1.45	10%	0			4.5				1			1	
69725	Decompression facial nerve, i	090	695	730	35	5%	27.64	30.30	2.66	10%	0				4			3	2		1	
69726	Removal, entire osseointegrat	090	150	159	9	6%	7.50	8.16	0.66	9%	0			1	1						0.5	
69727	Removal, entire osseointegrat	090	170	179	9	5%	7.38	8.04	0.66	9%	0			1	1						0.5	
69740	Suture facial nerve, intratemp	090	374	387.5	13.5	4%	16.27	17.51	1.24	8%	0			3				1.5			1	
69745	Suture facial nerve, intratemp	090	435	449.5	14.5	3%	17.02	18.37	1.35	8%	0			3.5				1.5			1	
69805	Endolymphatic sac operation;	090	347	370	23	7%	14.71	16.14	1.43	10%	-2			1	1	1		1			1	
69806	Endolymphatic sac operation;	090	309	321	12	4%	12.63	13.86	1.23	10%	0			3.5				1			1	

69905	Labyrinthectomy; transcanal	090	233	240	7	3%	11.26	12.25	0.99	9%	0			3.5							1	
69910	Labyrinthectomy; with mastoi	090	315	327	12	4%	13.91	15.14	1.23	9%	0			3.5				1			1	
69915	Vestibular nerve section, tran	090	573	606	33	6%	22.77	25.07	2.30	10%	0			4				5			1	
69930	Cochlear device implantation,	090	387	403	16	4%	17.73	18.59	0.86	5%	-2				1	1					0.5	
69950	Vestibular nerve section, tran	090	669	701	32	5%	27.63	30.27	2.64	10%	-4			1		2		4	2		1	
69955	Total facial nerve decompress	090	755	795	40	5%	29.42	32.32	2.90	10%	0				4			4	2		1	
69960	Decompression internal audit	090	675	715	40	6%	29.42	32.32	2.90	10%	0				4			4	2		1	
69970	Removal of tumor, temporal b	090	793	833	40	5%	32.41	35.31	2.90	9%	0				4			4	2		1	
77427	Radiation treatment manager	XXX	101.39	105.23	3.84	4%	3.37	3.55	0.18	5%	-0.34				0.33	0.17						
77750	Infusion or instillation of radio	090	100	104	4	4%	5.00	5.44	0.44	9%	0			2								
77761	Intracavitary radiation source	090	82	84	2	2%	3.85	4.07	0.22	6%	0			1								
77762	Intracavitary radiation source	090	113	115	2	2%	5.76	5.98	0.22	4%	0			1								
77763	Intracavitary radiation source	090	160	164	4	2%	8.66	9.10	0.44	5%	0			2								
77789	Surface application of low dos	000	53	55	2	4%	1.14	1.36	0.22	19%	0			1								
92986	Percutaneous balloon valvulo	090	463	489	26	6%	22.60	24.05	1.45	6%	0				3			1			1	
92987	Percutaneous balloon valvulo	090	329	350	21	6%	23.38	24.37	0.99	4%	0				3							
92990	Percutaneous balloon valvulo	090	393	414	21	5%	18.27	19.26	0.99	5%	0				3							
157X1	Implantation of absorbable m	000	213	209	-4	-2%	8.00	8.20	0.20	2%	0								1			
49X06	Repair of anterior abdominal	000	310	307	-3	-1%	20.00	20.40	0.40	2%	0									1		
49X10	Repair of anterior abdominal	000	275	271	-4	-1%	16.50	16.70	0.20	1%	0								1			
49X11	Repair of anterior abdominal	000	288	284	-4	-1%	16.97	17.17	0.20	1%	0								1			
49X12	Repair of anterior abdominal	000	335	332	-3	-1%	24.00	24.40	0.40	2%	0									1		
49X13	Repair of parastomal hernia, a	000	235	240	5	2%	14.24	14.48	0.24	2%	0							1				
49X14	Repair of parastomal hernia, a	000	285	281	-4	-1%	18.00	18.20	0.20	1%	0								1			
558XX	Laparoscopy, surgical prostate	090	354	368	14	4%	19.53	20.30	0.77	4%	0				2						0.5	
69XX0	Implantation, osseointegrated	090	181	190	9	5%	9.97	10.63	0.66	7%	0			1	1						0.5	
69XX1	Replacement (including remov	090	186	195	9	5%	10.25	10.91	0.66	6%	0			1	1						0.5	
69XX2	Removal, entire osseointegrat	090	178	187	9	5%	8.50	9.16	0.66	8%	0			1	1						0.5	
G0342	Laparoscopy for islet cell trans	090	238	247	9	4%	11.92	12.58	0.66	6%	0			1	1						0.5	
G0343	Laparotomy for islet cell trans	090	588	590	2	0%	19.85	22.28	2.43	12%	0			2	1			1	2	2	1	
G0412	Open treatment of iliac spine(	090	388	405	17	4%	10.45	12.12	1.67	16%	0			2	1			2	1		1	
G0413	Percutaneous skeletal fixation	090	393	427	34	9%	15.73	18.08	2.35	15%	0			1	3			3	1		1	
G0414	Open treatment of anterior pe	090	443	477	34	8%	14.65	17.00	2.35	16%	0			1	3			3	1		1	
G0415	Open treatment of posterior p	090	543	587	44	8%	20.93	23.76	2.83	14%	0			1	3			5	1		1	

*Codes highlighted in blue were reviewed by the RUC for CPT 2023. The surgical procedure times and values included for these codes are the RUC recommendations for CPT 2023. Also, any code that is being deleted for CPT 2023 was removed from this analysis.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2022

Removal of Sutures or Staples – Tab 4

In October 2021, the CPT Editorial Panel approved the deletion of CPT code 15850 and revision of CPT code 15851 to clarify the intent of the phrase "requiring anesthesia" included in the code descriptor. Specifically, code 15851 may only be reported for suture/staple removal requiring general anesthesia or moderate sedation. These codes were also revised to allow reporting by any physician that performs suture/staple removal under general anesthesia or moderate sedation in the facility setting, even within a global period, as this would be covered as a take-back to the operating room and reported with an appropriate modifier.

In addition, two new add-on CPT codes, 158X1 and 158X2, were established for reporting the practice expense (PE) related to suture/staple removal when not inherent to a procedure code (ie, 000-day global codes). For the non-facility setting (eg, office, home), these add-on codes may only be reported in conjunction with an office visit E/M code to account for only the additional practice expense related to suture/staple removal and not the work related to the E/M service. It was noted that for 10-day and 90-day global codes, if the suture/staple removal were performed by a different provider not in the same group, then the related practice expense would be included in the payment for transferred postoperative care only using modifier–55.

Compelling Evidence (CPT Code 15851)
The RUC reviewed, and agreed, that flawed methodology was used in the previous valuation of this service. CPT code 15851 is a Harvard-based code. Fifteen plastic surgeons reviewed this code with a 30-day global period during the Harvard study. Pediatric surgeons, the likely provider of this service, were not included in the Harvard study. The RUC noted that the pre- and post-times that were assigned by the Harvard algorithm may have underestimated the total time by not including positioning time or scrub, dress, wait time resulting in an underestimation of relative physician work. Therefore, the RUC agreed that the Harvard study estimated times for this service are not valid for comparison to the current RUC survey. In addition, the Final Rule for the 1992 Medicare Physician Payment Schedule indicated the global period was 000-day, not 030-day, and the source of the work RVU was indicated as “established by HCFA,” not the Harvard study. The specialties also noted that there was prior miscoding of CPT code 15851 for suture removal in the office, and it was clear that “anesthesia other than local” and the intent of CPT code 15851 was misunderstood. **The RUC concurred that there is compelling evidence to support a change in physician work for CPT code 15851 based on flawed methodology.**

15851 ***Removal of sutures or staples requiring anesthesia (i.e., general anesthesia, moderate sedation)***
The RUC reviewed the survey results from 131 surgeons and determined that the survey median work RVU somewhat overestimated and the survey 25th percentile underestimated the physician work typically required to perform this service. The RUC also discussed the pre-service times and considered the challenges of selecting the correct pre-time package for this service. Ultimately, the committee agreed that the physician times from the robust survey should be supported with the exception of a decrease of 10 minutes in pre-service evaluation time for this post-operative procedure. The RUC agreed that pre-service time package 2 was appropriate with the amended survey times recommended: 10 minutes evaluation,

3 minutes positioning, 10 minutes scrub/dress/wait time, 15 minutes intra-service time, 15 minutes immediate post-service time. The RUC reiterated that the current times for this service are from the Harvard study and not valid for comparison.

The RUC recommends a direct work RVU crosswalk to CPT code 50431 *Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access* (work RVU= 1.10, 15 minutes intra-service time and 55 minutes total time), noting that both services involve an identical amount of intra-service time, identical amount of post-service time and similar total time. Further, it was noted that the crosswalk value falls appropriately between the survey median and 25th percentile and reflects a relative value of 15851 when compared with code 50431.

The RUC concurred that the recommended work RVU of 1.10 for CPT code 15851 is appropriately bracketed by the top key reference service MPC code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01, 15 minutes intra-service time and 36 minutes total time) and MPC code 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* (work RVU= 1.14, 15 minutes intra-service time and 27 minutes total time) and, additionally, CPT code 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* (work RVU= 1.15, 15 minutes intra-service time and 35 minutes total time). The RUC concluded that CPT code 15851 should be valued based on a direct work RVU crosswalk to CPT code 50431 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 1.10 for CPT code 15851.**

Practice Expense
CPT code 15851 is now a facility-only code and CPT codes 158X1 and 158X2 are non-facility PE-only add-on codes. The Practice Expense (PE) Subcommittee considered and supported compelling evidence for code 15851 as it has not been previously reviewed for direct inputs in the facility. The code family was reviewed by the PE Subcommittee and the direct practice expense inputs were approved as submitted by the specialty societies without modification. The PE Subcommittee discussed the potential for a change in specialty from surgical to primary care and therefore requested that the codes be re-reviewed in three years. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Relativity Assessment Workgroup Review
The RUC recommends that the Relativity Assessment Workgroup review CPT codes 158X1 and 158X2 when three years of claims data are available to assess if there is a shift in the specialty performing these services.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Integumentary System **Repair (Closure)** **Other Procedures**				
~~15850~~	-	~~Removal of sutures under anesthesia (other than local), same surgeon~~ (15850 has been deleted. To report, use 15851)	~~XXX~~	~~N/A~~
▲15851	W1	Removal of sutures or staples ~~under~~requiring anesthesia (ie, general anesthesia, moderate sedation) ~~(other than local), other surgeon~~ (Do not report 15851 for suture and/or staple removal to re-open a wound prior to performing another procedure through the same incision)	000	1.10
✚●158X1	W2	Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code) (Use 158X1 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350) (Do not report 158X1 in conjunction with 158X2)	ZZZ	(PE only)
✚●158X2	W3	Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code) (Use 158X2 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350) (Do not report 158X2 in conjunction with 158X1)	ZZZ	(PE only)

January 6, 2022

Ezequiel Silva III, MD
Chairperson, AMA/Specialty Society RVS Update Committee
Relative Value Systems, American Medical Association
330 N Wabash Ave, Suite 39300
Chicago, IL 60611

Re: Tab 4 Removal of Sutures or Staples (Codes 15851, 158X1, 158X2)

Dear Doctor Silva:

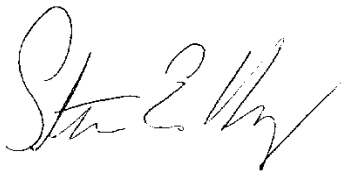
The American Academy of Pediatrics (AAP) would like to offer comments on codes 15851 (*Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)*) , 158X1 (*Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)*), and 158X2 (*Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code)*).

The valuation recommendations are reasonable, and it is clarifying that the codes are now linked to E/M services through their add-on designation.

The AAP is fully supportive of these recommendations.

Thank you for the opportunity to comment.

Sincerely,



Steven E. Krug, MD, FAAP
AAP RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:15851 Tracking Number W1 Original Specialty Recommended RVU: **1.20**
Presented Recommended RVU: **1.20**
Global Period: 000 Current Work RVU: **0.86** RUC Recommended RVU: **1.10**

CPT Descriptor: Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year-old male who is status post repair of multiple lacerations, now undergoes suture removal while under general anesthesia.

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 patient is reexamined to confirm that physical findings have not changed. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the family/caregiver. The site of suture removal is marked. Informed consent is reviewed and obtained, including witness confirmation. Review length and type of anesthesia with anesthesiologist.Verify that all required instruments and supplies are available. Monitor and assist when necessary in transfer of the patient from gurney to operating table. Coordinate with the anesthesia team with line placement to be certain operative field is clear. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. Assist with positioning of patient. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: The area surrounding the wound(s) is/are cleansed with normal saline or soaked if crusting inhibits access to sutures. The sutures are removed. The wound line(s) is/are observed for separation during the procedure. Hemostasis is obtained with pressure as needed. Steri-strips are applied as needed.

Description of Post-Service Work: Sterile dressings are applied. Postoperative recovery care is discussed with anesthesia and nursing staff. Procedure and outcome are discussed with family/caregiver in waiting area. A brief operative note and/or a postoperative note is written in the recovery area. An operative report is dictated, and a copy is sent to the referring physician(s). Home restrictions (eg, activity, bathing) are discussed with family/caregiver. Medications are reconciled. All appropriate medical records are completed, including day-of-discharge progress notes, discharge summary, discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Steve Sentovich, MD, MBA, FACS; Guy Orangio, MD, FACS; Ketan Sheth, MD, FACS; Anne Miller, MD					
Specialty Society(ies):	ACS, ASCRS, ASSH					
CPT Code:	15851					
Sample Size:	4300	**Resp N:**	131			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	3.00	100.00	
Survey RVW:	0.50	0.95	**1.20**	1.65	3.26	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	5.00	10.00	**15.00**	16.00	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)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	15851	**Recommended Physician Work RVU: 1.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**18.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**6.00**	**4.00**
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)

8A IV Sedation/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**25.00**	**-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 **0.0** 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
36555	000	1.93	**RUC Time**

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age

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
12002	000	1.14	**RUC Time**	

CPT Descriptor 1 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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54150	000	1.90	**RUC Time**	

CPT Descriptor 2 Circumcision, using clamp or other device with regional dorsal penile or ring block

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: 44 **% of respondents:** 33.5 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 18.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 15851	Top Key Reference CPT Code: 11042	2nd Key Reference CPT Code: **36555**
Median Pre-Service Time	23.00	11.00	23.00
Median Intra-Service Time	15.00	15.00	15.00
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	**53.00**	**36.00**	**48.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	59%	32%	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	27%	50%	23%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	23%	59%	18%
Physical effort required	5%	80%	16%

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%	64%	23%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	71%	13%	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	42%	54%	4%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	46%	21%
Physical effort required	4%	67%	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	21%	58%	21%

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

While reviewing the issue of reporting suture/staple removal for codes with a 000 global assignment, we discovered unusual reporting for code 15851 and recommended coding changes to more clearly represent the intent of suture removal requiring anesthesia.

It was clear that "anesthesia other than local" and the intent of code 15851 had not been understood since 80% of the Medicare claims for 15851 are in an office setting, with current practice expense inputs for suturing a wound, not removing sutures. The CPT Panel agreed that the intent of code 15851 is for instances where deep sedation is required to remove sutures for patients such as children or those who are intellectually disabled. The CPT Panel approved deletion of code 15850, with reference to use code 15851 along with revision of the Harvard-based code 15851 to indicate the type of anesthesia to be "general anesthesia or moderate sedation." Consistent with this revision, there will be no nonfacility practice expense inputs for this facility-only code.

In addition, it should be noted that prior miscoding of code 15851 for suture removal in the office was typically reported with an office visit code. Removal of sutures in the office, when correctly reportable, will not be reported with an add-on code (158X1) to and E/M code, eliminating the overlapping pre-and post-time. It is not expected that the revised code 15851 will be reported with an E/M code moving forward.

Compelling Evidence - Flawed methodology of previous review

Code 15851 is a Harvard-based code. Fifteen plastic surgeons reviewed this code with a 30-day global period during the Harvard study. Pediatric surgeons—the likely provider of this service—were not included in the Harvard study and other surgeons were additionally not included. We believe the pre- and post-times that were assigned by the Harvard algorithm underestimated the total time by not including positioning time and scrub, dress, wait time resulting in an underestimation of physician work. In addition, in the final rule for the 1992 fee schedule, the global period was indicated as 000 (not 030) and the source of the RVW was indicated as "established by HCFA," not the Harvard study. We believe that all of these factors provide compelling evidence of flawed methodology for what should be a relatively infrequent procedure.

Survey Process

The American College of Surgeons (ACS), American Society of Surgeon for the Hand (ASSH) and American Society of Colon and Rectal Surgeons (ASCRS) conducted a standard RUC survey for code 15851.

ASSH participated in the survey because hand surgeons perform congenital hand surgery in infants/children and some members would have experience with 15851. ASCRS participated in the survey because colorectal surgeons perform anal procedures on infants/children and some members would have experience with 15851. The ACS survey request was sent to 3,300 surgeons, including 615 ACS Fellows who self-identify as pediatric surgeons and 2,685 ACS Fellows independent of self-identified specialty. This resulted in survey responses from many surgical specialties, including, general surgeons, otolaryngologists, plastic surgeons, oral and maxillofacial surgeons, orthopaedic surgeons, and pediatric surgeons.

We believe the survey process resulted in robust survey data. In fact, only ten of all respondents indicated zero experience for both 12 months and 5 years and the median response for these ten surgeons was the identical or almost identical as the overall median of all respondents.

Recommendation

We recommend a work RVU of 1.20 for 15851. This minimally corrects the HCFA-based value for code 15851 that excluded positioning and scrub, dress, wait time and that will now clearly indicate the procedure as performed under moderate sedation or general anesthesia and only in a facility setting.

Pre-time

It is difficult to choose a correct package for this procedure. Package 2 could be chosen if considering the patient/procedure or package 3 could be chosen if considering type of anesthesia. Said another way, the times could be reduced from package 3 or added to package 2 so as not to exceed survey median.

Below is the Pre-time package chart. While we could have recommended additional minutes to package 2 for other activities that are mostly related to the difference between procedures with and without anesthesia, we chose Package 2 and added time as discussed below so as not to exceed the survey median time for each category.

FACILITY				
1	2	REC	3	4

CPT Code: 15851

	Total Pre-Service Time	20	25	33	51	63
	CATEGORY SUBTOTALS					
A	Pre-Service Evaluation (IWPUT =0.0224)	13	18	20	33	40
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	3	3	3
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	6	10	15	20
	DETAILS					
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	10		10	15
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2		2	4
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3		5	5
A	Communicate with other professionals	0	0	+2	5	5
A	Check/set-up room, supplies and equipment	1	1		5	5
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1		5	5
A	Prepare/ review/ confirm procedure	1	1		1	1
B	Perform/ supervise patient positioning	1	1	+2	3	3
C	Administer local/topical anesthesia	1	1		0	0
C	Observe (wait anesthesia care)	0	0	+4	10	15
C	Dress and scrub for procedure	5	5		5	5

Evaluation time: Package 2 time of 18 minutes has been increased to the median survey time of 20 minutes to account for discussion with the anesthesiologist and other members of the surgical team regarding length and type of anesthesia. This work is not included in package 2, but is typical of procedures requiring general anesthesia or moderate sedation.

Positioning time: Package 2 time of 1 minute has been increased to 3 minutes to account for additional positioning time related to moderate or deep sedation IV lines. Three minutes is consistent with the minimum amount of time for supine positioning for all procedures requiring moderate or deep sedation in an operating room (see Packages 3 and 4 supine positioning time).

Scrub, dress, wait time: Package 2 time of 6 minutes has been increased to the survey median time of 10 minutes. A scrub, dress, wait time of 10 minutes is consistent with extra time included in package 3 for " Observe (wait anesthesia care)" as it relates to moderate sedation or general anesthesia.

Total Pre-time: As a reality check, the total pre-time of 33 minutes is conservative because of the expected typical patient (child or those who are intellectually disabled).

Post-time

Package 8A is selected with a reduction in time from 25 minutes to 15 minutes to match the survey median time. There will likely not be postop orders and monitoring patient recovery will not be extensive.

Key Reference Codes

Code 11042 is typically performed in an office, nursing home, or assisted living facility and may include (not typical) topical anesthesia. Although the intra-time is the same for both codes, code 15851 requires more pre- and post-work related to a procedure under general anesthesia or moderate sedation and a procedure where all patient communications are second hand through a parent or caregiver. The slightly higher RVW reflects the additional time and work.

Code 36555 was valued based on the survey increment of 36556 (over 5 years of age) and 36555 after the value for 36556 was established. The pre-time package and service description indicate the procedure is performed using local anesthetic. The current survey respondents who chose 36555 indicated that 15851 was similar/somewhat less complex/intense than 36555 and therefore should be valued less. Similar to the discussion above, the intra-time is the same for both codes, however code 15851 requires more pre- and post-work related to a procedure under general anesthesia or moderate sedation and a procedure where all patient communications are second hand through a parent or caregiver.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	POSIT	SDW	INTRA	POST
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	**1.01**	**0.037**	**0.028**	**36**	**9**	**1**	**1**	**15**	**10**
15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	**1.20**	**0.018**	**0.019**	**63**	**20**	**3**	**10**	**15**	**15**
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	**1.93**	**0.084**	**0.040**	**48**	**15**	**3**	**5**	**15**	**10**

MPC Codes

Code 12002 is typically performed in conjunction with an EM service and therefore includes less pre- and post-time. Code 54150 is similar to 15851 as it is a minor procedure performed on an infant. Code 54150 requires less pre time because local anesthesia and a block is used instead of IV lines and moderate sedation or general anesthesia. Less post op time is associated with 54150 because monitoring of reversal from anesthesia is not necessary.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	POSIT	SDW	INTRA	POST
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	**1.14**	**0.059**	**0.042**	**27**	**5**	**1**	**1**	**15**	**5**
15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	**1.20**	**0.018**	**0.019**	**63**	**20**	**3**	**10**	**15**	**15**
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	**1.90**	**0.087**	**0.042**	**45**	**15**	**5**	**5**	**15**	**5**

Other Code Comparison

The table below presents every RUC reviewed 0-day global code with 15 minutes of intra-time that was reviewed since January 2016 (past 5 years). In the first column, an "X" indicates that CMS did not accept the RUC recommendations. The table also shows the typical place of service (Facility or Office) in the column labeled SOS and the pre-time package selected for the code. This table shows that a procedure with the same intraservice time can require variable pre and post time which is reflective of whether anesthesia is typical, what type of anesthesia is typical, whether an E/M is typically performed on the same day, and whether another procedure is performed on the same day. All of these pre, and post differences add to the difference in work RVU. We believe these codes support the survey median RVW of 1.20 for revised code 15851. [*CMS reject = CMS did not accept RUC recommendation]

*CMS reject	Year	CPT	Long Descriptor	IWPUT	RVW	SOS	Pre Pkg	Total Time	EVAL	POSIT	SDW	INTRA	POST
	2017	**36470**	Injection of sclerosant; single incompetent vein (other than telangiectasia)	**0.029**	**0.75**	OFF	5	**30**	9		1	**15**	5
yes	2017	**27369**	Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography	**0.034**	**0.77**	FAC	1	**28**	5	1	2	**15**	5
yes	2018	**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…first 20 sq cm or less	**0.031**	**0.77**	OFF	5	**29**	7	1	1	**15**	5
	2017	**57160**	Fitting and insertion of pessary or other intravaginal support device	**0.031**	**0.89**	OFF	5	**34**	7	3		**15**	9
	2019	**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	**0.033**	**0.90**	OFF	5	**35**	7	5	3	**15**	5
yes	2021	**21315**	Closed treatment of nasal bone fracture with manipulation; without stabilization	**(0.006)**	**0.96**	FAC	3	**68**	30	3	10	**15**	10

*CMS reject	Year	CPT	Long Descriptor	IWPUT	RVW	SOS	Pre Pkg	Total Time	EVAL	POSIT	SDW	INTRA	POST
	2017	**11106**	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion	**0.043**	**1.01**	OFF	6	**33**	6	3	3	**15**	6
		15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	**0.018**	**1.20**	FAC	2	**63**	20	3	10	**15**	15
yes	2019	**62270**	Spinal puncture, lumbar, diagnostic;	**0.059**	**1.22**	FAC	3	**32**	5	4	3	**15**	5
	2017	**11755**	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	**0.052**	**1.25**	OFF	6	**39**	10	3	5	**15**	6
yes	2018	**64446**	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)	**0.058**	**1.36**	FAC	1	**40**	13	1	5	**15**	6
	2016	**51703**	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	**0.058**	**1.47**	OFF	6A	**45**	10	5	5	**15**	10
yes	2020	**46030**	Removal of anal seton, other marker	**0.031**	**1.48**	OFF	6	**67**	17	10	10	**15**	15
	2017	**33286**	Removal, subcutaneous cardiac rhythm monitor	**0.061**	**1.50**	FAC	1	**45**	13	1	6	**15**	10
	2019	**64451**	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	**0.061**	**1.52**	OFF	5	**45**	17	1	5	**15**	7
	2016	**30903**	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	**0.072**	**1.54**	FAC	1a	**39**	8	1	5	**15**	10
	2017	**36516**	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	**0.052**	**1.56**	OFF	6	**50**	25			**15**	10
yes	2019	**62272**	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);	**0.055**	**1.58**	FAC	1	**52**	13	4	5	**15**	15
yes	2018	**36573**	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated RS&I required to perform the insertion; age 5 years or older	**0.082**	**1.70**	FAC	1	**40**	10	3	6	**15**	6
	2016	**36556**	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	**0.084**	**1.75**	FAC	1a	**40**	12	3	5	**15**	5
yes	2018	**11983**	Removal with reinsertion, non-biodegradable drug delivery implant	**0.094**	**1.91**	OFF	6	**40**	15	1	4	**15**	5
	2016	**36555**	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	**0.084**	**1.93**	FAC	1a	**48**	15	3	5	**15**	10
	2016	**93503**	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	**0.105**	**2.00**	FAC	1a	**37**	5	2	5	**15**	10
	2016	**55700**	Biopsy, prostate; needle or punch, single or multiple, any approach	**0.142**	**2.50**	OFF	6A	**35**	5	5	5	**15**	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) 15850, 15851

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty hand surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty Frequency Percentage %

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? 250 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The typical patient will not be Medicare-aged. Estimate is based on current Medicare utilization in facilities that can accommodate general anesthesia or moderate sedation (inpatient hospital, outpatient hospital, ACS).

Specialty general surgery Frequency 50 Percentage 20.00 %

Specialty colorectal surgery Frequency 10 Percentage 4.00 %

Specialty hand surgery Frequency 10 Percentage 4.00 %

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:
Skin

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. 15758 represents a code with the closest expected specialty mix for this revised facility only code.

ISSUE: Removal of Sutures or Staples

TAB: 4

SOURCE	Review Year	CPT	DESC	global	Resp	IWPUT	WPUT	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	POST P-SD	12 Month Svy Experience MIN	12 Month Svy Experience 25th	12 Month Svy Experience MED	12 Month Svy Experience 75th	12 Month Svy Experience MAX	TYP?
REF1	2010	11042	Debridement, subcutaneous tissue (incl	000	44	0.037	0.028			1.01			36	9	1	1			15			10						
REF2	2016	36555	Insertion of non-tunneled centrally insert	000	24	0.084	0.040			1.93			48	15	3	5			15			10						
deleted	1993	15850	Removal of sutures under anesthesia (c	000		0.012	0.020			0.78			40	15					18			10						
current	HVD	15851	Removal of sutures under anesthesia (c	000		0.020	0.022			0.86			40	11					18			11						
SVY	2022	15851	Removal of sutures or staples requiring	000	131	0.015	0.018	0.50	0.95	1.20	1.65	3.26	65	20	5	10	5	10	15	16	60	15	0	0	1	3	100	82%
REC		15851	Removal of sutures or staples requiring	000		0.026	0.021			1.10			53	10	3	10			15			15						
crosswalk	2015	50431	Injection procedure for antegrade nephr	000		0.019	0.020			1.10			55	18	1	6			15			15						

FACILITY DIRECT PE INPUTS

CPT CODE(S): 15850, 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01-2022

Please Note:
15850 – deleted – no facility inputs recommended
158X1, 158X2 - no facility inputs recommended

CPT Code	Long Descriptor	Global Period
~~15850~~	~~Removal of sutures under anesthesia (other than local), same surgeon~~	~~000~~
15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	000
158X1	Removal of sutures OR staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ
158X2	Removal of sutures AND staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
~~15850~~	~~The patient is a 3-month-old infant who has had repair of a cleft lip and a few days later needs to have the small skin sutures removed while under general anesthesia.~~
15851	A 3-year-old male who is status post repair of multiple lacerations, now undergoes suture removal while under general anesthesia.
158X1	During a separately reportable office or other outpatient evaluation and management service, a 60-year-old male status post hernia repair of a defect that was 3 to 10 cm undergoes removal of sutures. (Note: This is an add-on service. Consider only the work associated with the removal of sutures.)
158X2	During a separately reportable office or other outpatient evaluation and management service, a 60-year-old male status post hernia repair of a defect that was 3 to 10 cm undergoes removal of sutures and staples. (Note: This is an add-on service. Consider only the work associated with the removal of sutures and staples.)

The following information is only related to code 15851 in Facility

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:

   15851: The society advisors discussed the patients that would require a return to the operating room (eg, within a global period) and general anesthesia or moderate sedation for removal of sutures and/or staples and determined this would typically be a child that cannot be controlled (for example, an infant who had cleft lip repair or who had repair of multiple facial lacerations including near the eye). The specialties also agreed that this would not be a common procedure as the vast majority of suture/staple removal would not require moderate sedation or general anesthesia.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for

FACILITY DIRECT PE INPUTS

CPT CODE(S): 15850, 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
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the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Code 15851 is shown as the reference code, however, it is clear that "anesthesia other than local" and the intent of this code had not been understood since 80% of the Medicare claims are in an office setting, with current practice expense inputs for suturing a wound, not removing sutures. We believe the intent of this code was for instances where deep sedation is required to remove sutures/staples for patients such as children or those who are intellectually disabled who cannot be otherwise controlled for the procedure.

3. Is this code(s) typically reported with an E/M service?

No.

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

When code 15851 was reviewed by the PEAC in Feb 2005, it was an "unclaimed" code and the PEAC only considered the old Clinical Practice Expense Panel (CPEP) details for the office setting (ie, the facility details were not critically reviewed and updated). This is documented in the RUC database which shows "N" for "Out of Office CMS Profiled" as shown below.

CMS PROFILED	
IN OFFICE	OUT OF OFFICE
Y	N

Code 15851 was likely not claimed by any surgical group during the PEAC review because an "other surgeon" as included in the previous code descriptor would never return a patient to the OR for suture/staple removal and instead the same surgeon would perform the procedure.

We believe that compelling evidence has been met in that code 15851 was never reviewed for facility PE details and that the code descriptor has been extensively revised to clearly define an OR facility-only procedure.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 15850, 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

n/a

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

We are recommending preservice "Minimal Use of Clinical Staff". All patients requiring this procedure will be atypical - the patient will be an infant or child that cannot undergo the standard removal of sutures/staples in an office setting and all communications will be with parents or caregivers that add a layer to work to the service. Many codes at recent meetings have been allocated additional clinical staff time for a similar clinical scenario of managing preservice activities with a patient's parent/caregiver.

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. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

CA001	Complete pre-service diagnostic and referral forms	One or more phone calls to obtain prior authorization for OR take-back procedure
CA002	Coordinate pre-surgery services (including test results)	One or more phone calls with pediatrician/PCP and anesthesia to coordinate sedation clearance.
CA003	Schedule space and equipment in facility	One or more phone calls to arrange for pediatric procedure.
CA004	Provide pre-service education/obtain consent	One or more phone calls with anxious parent / caregiver about procedure.
CA005	Complete pre-procedure phone calls and prescription	One or more phone calls to confirm health of patient and NPO instructions.

   b. Service period (includes pre, intra and post):

n/a

   c. Post-service period:

n/a

9. 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*):

n/a

10. 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

FACILITY DIRECT PE INPUTS

CPT CODE(S): 15850, 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? n/a

12. ☐ 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

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

n/a

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

n/a

15. 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

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

n/a

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

n/a

18. 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

19. 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

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

FACILITY DIRECT PE INPUTS

CPT CODE(S): 15850, 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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): 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01-2022

Please Note
15850 - deleted
15851 - No nonfacility inputs recommended – this is now a facility-only code

CPT Code	Long Descriptor	Global Period
~~15850~~	~~Removal of sutures under anesthesia (other than local), same surgeon~~	~~000~~
15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	000
158X1	Removal of sutures OR staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ
158X2	Removal of sutures AND staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
~~15850~~	~~The patient is a 3-month-old infant who has had repair of a cleft lip and a few days later needs to have the small skin sutures removed while under general anesthesia.~~
15851	A 3-year-old male who is status post repair of multiple lacerations, now undergoes suture removal while under general anesthesia.
158X1	During a separately reportable office or other outpatient evaluation and management service, a 60-year-old male status post hernia repair of a defect that was 3 to 10 cm undergoes removal of sutures. (Note: This is an add-on service. Consider only the work associated with the removal of sutures.)
158X2	During a separately reportable office or other outpatient evaluation and management service, a 60-year-old male status post hernia repair of a defect that was 3 to 10 cm undergoes removal of sutures and staples. (Note: This is an add-on service. Consider only the work associated with the removal of sutures and staples.)

The following information is only related to codes 158X1, 158X2 in Nonfacility – PE only

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:

   Society advisors considered the incremental additional PE details that are not included in an E/M service that would be required for 158X1, 158X2.

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Codes 61800 and 33257 are ZZZ global codes that include suture removal pack and suture/staple

removal pack and are used as references.

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 the *Billed Together* tab in the RUC Database)

   Yes, service is add-on to specific EM codes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

   What specialty is the dominant provider in the nonfacility? The dominant provider will remove sutures after simple laceration repair or 0-day surgical procedures. Considering the utilization for 0-day procedures requiring suture/staple removal, this may include: family practice, nurse practitioner, general surgery, plastic surgery, orthopaedic surgery, and dermatology
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? For code 158X1, there will be many specialties that may report this service equally. Code 10080 specialty distributed may be similar to what is expected for 158X1.
   For code 158X2, it will more likely be a surgical specialty reporting this service for the few 0-day global major surgical procedure that include closure by staple and sutured drains. Code 11008 specialty distributed may be similar to what is expected for 158X2
   Is the dominant provider in the nonfacility different than for the global? N/A, these non-facility PE-only codes do not apply to facilities.

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

   N/A

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

8. 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

9. 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

10. 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):

- PRE: One minute to set up supplies related to suture / staple removal – this is clearly additional to any supply setup that would be attributed to an E/M (ie, table paper, pillow case cover, thermometer cover)
- INTRA: (6 minutes for 158X1 and 10 minutes for 158X2) The area surrounding the wound(s) is/are cleansed with normal saline or the area is soaked if crusting inhibits access to sutures/staples. The sutures/staples are removed. The wound line(s) is/are observed for separation during the procedure. Hemostasis is obtained with pressure as needed. Steri-strips are applied as needed. Sterile dressings are applied.
- POST: One minute for clinical staff to separate and dispose of contaminated (hazardous waste) supplies/ instruments and removed sutures/staples into red bag and sharps containers. [Note: the additional minute above the time allocated for cleaning a room after an E/M service is consistent with the additional minute recently approved for immunization codes at the April 2021 RUC meeting - "CA024: Disposal of vaccine specific medical waste." Keeping in mind that the amount and type of hazardous waste related to 158X1, 158X2 exceeds what is related to vaccinations]

    c. Post-service period:

N/A

11. 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 area surrounding the wound(s) is/are cleansed with normal saline or soaked if crusting inhibits access to sutures/staples. The sutures/staples are removed. The wound line(s) is/are observed for separation during the procedure. Hemostasis is obtained with pressure as needed. Steri-strips are applied as needed. Sterile dressings are applied.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. 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.

The "skin to skin" time for clinical staff is based on the results of a physician work survey using the vignettes on the cover of this SoR. The request was sent to a random selection of members from the ACS, ASCRS, and SAGES based on the LOI response for these codes.

There were 111 respondents representing the following surgical specialties: general surgery, colon and rectal surgery; pediatric surgery; plastic surgery; otolaryngology; trauma surgery; surgical oncology; vascular surgery; breast surgery; and cardiac surgery.

The expert panel reviewing the survey data believe that the survey median times (6 minutes for 158X1 and 10 minutes for 158X2) fairly represent the time for suture/staple removal for physicians who place sutures and staples and conservative for clinical staff time.

13. 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*):

n/a

14. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment? - n/a

16. ☐ 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

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

n/a

18. Are you recommending a PE supply pack for this recommendation? **Yes**
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

pack, post-op incision care (suture)	SA054	pack	
pack, post-op incision care (suture & staple)	SA053	pack	

19. 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, post-op incision care (suture)	SA054	pack	qty
kit, suture removal (sterile: 1 Littauer hook-tipped scissors, 1 posi-grip forceps, 1 gauze sponge)		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

pack, post-op incision care (suture & staple)	SA053	pack	qty
kit, staple removal (sterile: 1 skin staple remover, 1 gauze sponge)		kit	1
kit, suture removal (sterile: 1 Littauer hook-tipped scissors, 1 posi-grip forceps, 1 gauze sponge)		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

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

n/a

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

n/a

22. 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

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 15851, 158X1, 158X2
SPECIALTY SOCIETY(IES): ACS, ASCRS, ASSH (15851), SAGES (158X1, 158X2)
PRESENTER(S): Charles Mabry MD FACS, Steve Sentovich MD FACS, Guy Orangio MD FACS, Anne Miller MD, Ketan Sheth MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

23. 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:

EQ168	light, exam	Default
EF031	table, power	Default

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

158X1: 10080 specialty mix most closely approximates expected reporting specialties for suture OR staple.

158X2: 11008 specialty mix most closely approximates expected reporting specialties for suture AND staple.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, 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).

15851 ***CMS CPEP 2005 Data - Proposed Practice Expense Inputs*** ***RUC Survey Specialty-if any:*** ***Specialty Presenting:*** PEAC

Removal of sutures under anesthesia (other than local), other surgeon

Global Period 000 ***Total Physician Time*** 40.0 ***Intra-Service Time*** 18.0 *2002 Utilization: Non-Facility Total-Percent* 3,477 89%

Time Source Harvard 3,893 *Facility Total-Percent* 416 11%

Number and Level of Visits Data ***Source*** Harvard ***glob*** ***26***

99211 99212 99213 99214 99215 99231 99232 99233 99238 99239 99291 99292 ***Yr 2004 Non-Facility PERVU:*** 1.72

Yr 2004 Facility PERUV: 0.34

CLINICAL LABOR DIRECT INPUTS

					CLINICAL STAFF TIME					*CMS PROFILED AS*	
SOURCE	**STAFF TYPE**	**DESCRIPTION**	**Compensation Per Minute**	**PRE-SERV Non-Facility**	**SERV Non-Facility**	**POST-OPS Non-Facility**	**PRE-SERV Facility**	**SERV Facility**	**POST-OPS Facility**	**Non-Facility**	**Facility**
CPEP	C 1 L037D	RN/LPN/MTA	0.37	0	50	0	0	0	0	Y	Y

MEDICAL SUPPLY DIRECT INPUTS

SOURCE & CPEP	*SUPPLY CODE*	*DESCRIPTION*	*QUANTITY*	*QUANTITY IN OFFICE*	*QUANTITY OUT OFFICE*	*COST IN OFFICE*	*COST OUT OF OFFICE*
CPEP C 1	SA069	tray, suturing	tray 1	1.00		8.99	
CPEP C 1	SB007	drape, sterile barrier 16in x 29in	item 1	1.00		0.49	
CPEP C 1	SB011	drape, sterile, fenestrated 16in x 29in	item 1	1.00		0.56	
CPEP C 1	SB022	gloves, non-sterile	pair 1	2.00		0.17	
CPEP C 1	SB024	gloves, sterile	pair 1	1.00		0.84	
CPEP C 1	SB033	mask, surgical	item 1	1.00		0.20	
CPEP C 1	SB036	paper, exam table	foot 1	7.00		0.10	
CPEP C 1	SC064	syringe-needle 3ml 22-26g	item 1	1.00		0.16	
CPEP C 1	SF018	cautery, monopolar, electrode, needle	item 1	1.00		1.89	
CPEP C 1	SF033	scalpel with blade, surgical (#10-20)	item 1	1.00		0.69	
CPEP C 1	SF036	suture, nylon, 3-0 to 6-0, c	item 1	1.00		2.40	
CPEP C 1	SG017	bandage, Kling, non-sterile 2in	item 1	2.00		0.73	
CPEP C 1	SG054	gauze, sterile 3in x 3in	item 1	6.00		0.56	
CPEP C 1	SG056	gauze, sterile 4in x 4in (10 pack uou)	item 1	1.00		0.80	
CPEP C 1	SH047	lidocaine 1%-2% inj (Xylocaine)	ml 1	20.00		0.70	
CPEP C 1	SJ028	hydrogen peroxide	ml 1	10.00		0.03	
CPEP C 1	SJ041	povidone soln (Betadine)	ml 1	10.00		0.08	
CPEP C 1	SJ046	silver nitrate applicator	item 1	2.00		0.14	
CPEP C 1	SJ053	swab-pad, alcohol	item 1	2.00		0.03	

EQUIPMENT

SOURCE	*CPEP*	*EQUIPMENT CODE*	*DESCRIPTION*	*MINUTES EQUIP IN USE, IN-OFFICE*	*MINUTES EQUIP IN USE OUT-OFFICE*	*COST OUT OF OFFICE*	*COST IN OFFICE*	*PURCHASE PRICE*
CPEP	C 1	E11001	table, exam	50	0	0	0	1,338.17
CPEP	C 1	E30005	electrocautery-hyfrecator, up to 45 watts	50	0	0	0	975.08

Removal of sutures under anesthesia (other than local), other surgeon

CPEP	C 1	E30006	light, exam	50	0	0	0	1,630.12

RUC Vignette if

Pre Service Work if

Intra Service Work if available:

Post Service Work if

	A	B	D	E	F	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1	RUC Practice Expense Spreadsheet					CURRENT Feb-05 CPEP DATA		CURRENT Feb-05 CPEP DATA		RECOMMENDED		REFERENCE CODE		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2						15850 deleted		15851		15851		61800		158X1		33257		158X2	
3	Clinical Activity Code	Meeting Date: 01/2022 Revision Date (if applicable): 01-09-2022 Tab: 4 Specialty: ACS, ASCRS, ASSH (18581), SAGES (158X1-X2)	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Removal of sutures under anesthesia (other than local), same surgeon		Removal of sutures under anesthesia (other than local), other surgeon		Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)		Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition		Removal of sutures **OR** staples not requiring anesthesia (List separately in addition to E/M code)		Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s)		Removal of sutures **AND** staples not requiring anesthesia (List separately in addition to E/M code)	
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**	**000**	**000**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	N/A	$ -	$ -	$ -	$ -	N/A	$ -	$ -	$ -	N/A
7		**TOTAL CLINICAL STAFF TIME**	L037D			**50**	**0**	**50**	**0**	**0**	**15**	**0**	**0**	**8**	**0**	**0**	**102**	**12**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**60**	**0**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**50**	**0**	**50**	**0**	**0**	**0**	**0**	**0**	**8**	**0**	**0**	**6**	**12**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**0**	**0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12		**PRE-SERVICE PERIOD**																	
13		**Start: Following visit when decision for surgery/procedure made**																	
14	CA001		L037D								3						5		
15	CA002		L037D								3						20		
16	CA003		L037D								3						8		
17	CA004		L037D								3						20		
18	CA005		L037D								3						7		
21		**End: When patient enters office/facility for surgery/procedure**																	
22		**SERVICE PERIOD**																	
23		**Start: When patient enters office/facility for surgery/procedure:**																	
24		**Pre-Service (of service period)**																	
29	CA013		L037D											1				1	
40		**Intra-service (of service period)**																	
42	CA021		L037D			50		50						6				10	
44		**Post-Service (of service period)**																	
47	CA024		L037D											1				1	
59	CA036		L037D			**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	**6**	**n/a**	
66		**End: Patient leaves office/facility**																	
67		**POST-SERVICE PERIOD**																	
68		**Start: Patient leaves office/facility**																	
71		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
72		99211 16 minutes	16																
73		99212 27 minutes	27																
74		99213 36 minutes	36														1		
75		99214 53 minutes	53																
76		99215 63 minutes	63																
77	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**36.0**	**0.0**	**0.0**
84		**End: with last office visit before end of global period**																	
85	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**															
86		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
87	SA048																1		
88	SA054												1	1					
89	SA053																1	1	
90	SA069					1		1											
91	SB036					7		7											
92	SF033					1		1											
93	SG056					1		1											
94	SB007					1		1											
95	SB011					1		1											
96	SB022					2		2											
97	SB024					1		1											
98	SB033					1		1											
99	SF036					1		1											
100	SG017					2		2											
101	SG054					6		6											
102	SH047					20		20											
103	SJ028					10		10											
104	SJ041					10		10											
105	SJ046					2		2											
106	SJ053					2		2											
107	SF018					1		1											
108	SC064					1		1											
109																			
111	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**														
112		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
113	EQ110			Other Formula		50		50											
114	EF023			Default		50		50									36		
115	EF031			Default										8				12	
116	EQ168			Default		50		50						8			36	12	

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Total Disc Arthroplasty – Tab 5

In September 2021, the CPT Editorial Panel created Category I code 228XX to describe *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)* and replace Category III code 0163T, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure).* CPT codes 228XX and 22857, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar* were surveyed for the January 2022 RUC meeting.

The specialty societies surveyed codes 228XX and 22857 for the January 2022 RUC meeting. The survey was sent to a random sample of members from five specialty societies with a total of 48 respondents. In reviewing the survey responses for code 22857, the specialties noted, and the RUC concurred that the collected data was inaccurate for several suspected reasons. The survey results indicated a median intra-service (i.e., skin-to-skin) time of 120 minutes which immediately suggested to the specialty societies, and RUC members familiar with this service, that the survey results were inaccurate. It is likely that survey respondents were unfamiliar with the procedure as it is very low volume and generally takes much longer than 120 minutes to perform the intra-service work. The RUC concludes that the survey respondents only accounted for the work of the orthopaedic or neurosurgeon and did not account for the additional co-surgeon that routinely performs part of the intra-service work for this procedure. Those familiar with this procedure further indicated that respondents likely did not account for the time spent performing the approach and closure, which is typically performed by a second surgeon. Furthermore, the standard survey tool used for this survey did not include specific instructions regarding the skin-to-skin related work by each surgeon, and this likely contributed to respondents inaccurate reporting of skin-to-skin time. Therefore, after thorough review, the specialty societies indicated, and the RUC agreed, that the survey results for both CPT codes 22857 and 228XX were erroneous and that the codes should be resurveyed for the April 2022 RUC meeting with a targeted survey tool that has been reviewed and approved by the Research Subcommittee. **The RUC recommends an interim work RVU of 27.13 for CPT code 22857 and contractor pricing for CPT code 228XX. The specialty society will resurvey for the April 2022 RUC meeting and work with the RUC's Research Subcommittee to draft a targeted survey.**

Practice Expense
The RUC recommends the current direct practice expense inputs for CPT codes 22857 and 228XX. The specialty society will resurvey for the April 2022 RUC meeting.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Musculoskeletal System
Spine (Vertebral Column)
Spinal Instrumentation

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲22857	T1	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression)~~,~~; single interspace, lumbar *(Do not report 22857 in conjunction with 22558, 22845, 22853, 22854, 22859, 49010 when performed at the same level)* ~~(For additional interspace, use Category III code 0163T)~~	090	Resurvey for April 2022 (Interim Recommendation = 27.13) (No Change)
+ ●228XX	T2	second interspace, lumbar (List separately in addition to code for primary procedure) (Use 228XX in conjunction with 22857) (For total disc arthroplasty, anterior approach, lumbar, more than two interspaces, use 22899)	ZZZ	Resurvey for April 2022 (Interim Recommendation = Contractor Price)

Category III Codes

~~+ 0163T~~ ~~Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)~~

~~(Use 0163T in conjunction with 22857)~~

(0163T has been deleted)

(To report total disc arthroplasty [artificial disc], anterior approach, lumbar, see 22857, 228XX)

0165T *Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)*

(Use 0165T in conjunction with 22862)

(Do not report ~~0163T,~~ 0164T, 0165T in conjunction with 22853, 22854, 22859, 49010, when performed at the same level)

(For decompression, see 63001-63048)

December 14, 2021

Ezequiel Silva, III, MD
Chair, AMA/Specialty Society RVS Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 39300
Chicago, IL 60611-5885

Dear Dr. Silva,

Our societies are writing in regards to Tab 5-Total Disc Arthroplasty, CPT code, 22857, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar,* that was flagged for survey for the January 2022 RUC meeting as part of the family with code 228XX, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)*. Code 228XX was approved at the 2021 September/October CPT Editorial Panel meeting as a conversion from Category III code 0163T, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)*

Codes 22857 and 228XX were surveyed together as an array survey by AAOS, AANS, CNS, ISASS, and NASS using random samples of membership. This procedure is mature and has been performed for over 15 years. Codes 22857 and 0163T were approved as new codes for CPT 2007.

In reviewing the survey data, the Advisors determined that the survey respondents did not understand that the skin-to-skin time was for all work and not just the work of the orthopedic or neurosurgeon. Our group of surgical advisors believe this procedure is typically performed by two surgeons acting as co-surgeons using modifier 62. We believe the standard RUC survey led to erroneous estimates for total intra-time by the respondents because they did not account for the time spent doing the approach and closure, typically performed by a second surgeon. The standard RUC survey does not include instructions specifically asking surgeons to account for the total skin-to-skin time spent by Co-Surgeons, even if it does specify "skin-to-skin."

The surveying societies recommend that the existing value and times for code 22857 be maintained for CY 2023 and that code 228XX be contractor-priced for CY 2023. The societies will resurvey both codes with a revised survey tool noting that the co-surgeon's approach and closure time and work should be included in the intra-service time estimates. The societies would then present recommendations based on this modified survey instrument. We note that maintaining the current times and work RVUs for 22857 and contractor-pricing code 228XX for CY 2023 will have little impact for Medicare payment since Medicare rarely pays for this procedure because it is not indicated for Medicare-aged patients. Medicare has a National Coverage Determination (NCD) that lists lumbar total disc arthroplasty as non-covered, which is appropriate based on the clinical data indicating the procedure is for non-Medicare-aged patients.

In summary, we recommend maintaining current work, time, and visits for 22857and contractor-pricing for 228XX for CY 2023, and a resurvey with a revised survey tool that requests the total skin-to-skin time and work of all surgeons.

We appreciate that the RUC is reluctant to resurvey procedures. However, we believe for this specific tab, with the unique circumstances of being non-covered by Medicare and typically requiring co-surgeons, this approach will allow the most accurate review of 22857 and 228XX.

Thank you for considering our recommendations.

Sincerely,

William R. Creevy, MD
AAOS RUC Advisor

Clemens Schirmer, MD
CNS RUC Advisor

Karin Swartz, MD
NASS RUC Advisor

Morgan Lorio, MD
ISASS RUC Advisor

John Ratliff, MD
AANS RUC Advisor

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Percutaneous Arteriovenous Fistula Creation – Tab 6

In October 2021, the CPT Editorial Panel created two new Category I CPT codes (368X1 and 368X2) to describe the creation of an arteriovenous fistula in an upper extremity via a percutaneous approach. Previously, CPT coding did not account for percutaneous arteriovenous access creation, as current CPT codes 36818, 36819, 36820, and 36821 only describe an open surgical approach. Given that new technologies have been developed that allow for less invasive approaches that utilize percutaneous image-guided methods to approximate a target artery and vein using magnets or mechanical capture, CMS had created two temporary HCPCS G-codes (G2170 and G2171) in July 2020 that describe two approaches to percutaneous arteriovenous access creation. The most significant material difference between these procedures is that G2170 requires two catheters from two different percutaneous access sites, one in the vein and one in the artery that are then approximated using magnets, while G2171 requires a single percutaneous access that then connects the artery and the vein under ultrasound guidance and then uses mechanical capture for approximation. Both procedures may require flow directing techniques and intra-procedural guidance, including arteriography or venography, depending on the vascular anatomy and the choice of the physician or operator.

CPT codes 368X1 and 368X2, which represent two percutaneous approaches to creating arteriovenous access for End-Stage Renal Disease (ERSD) patients during hemodialysis, are intended to replace HCPCS codes G2170 and G2171, both of which the RUC have submitted for deletion by CMS. Both 368X1 and 368X2 were surveyed by a random sample of diagnostic and interventional radiologists, as well as nephrologists and vascular surgeons for the January 2022 RUC meeting.

368X1 ***Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation***

The RUC reviewed the survey results from 37 physicians and recommends the survey 25th percentile work RVU of 7.50 for CPT code 368X1. The RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time, 6 minutes scrub/dress/wait time, 60 minutes of intra-service time, and 18 minutes of immediate post-service time. The specialties noted that the 26 minutes of pre-service time accounts for diagnostic imaging retrieval and review, in addition to preoperative preparation and positioning. The recommended 15 minutes of pre-service time is 3 minutes less than the 18 minutes of pre-service time in the pre-service package and median time, and the RUC found that to be appropriate. Additionally, the RUC agreed with the recommended increase from 1 to 5 minutes of positioning time given the importance of proper positioning and demarcation of the venous access site in this procedure and other similar upper extremity procedures utilizing ultrasound guidance. The RUC determined that the physician work and time maintain relativity to open arteriovenous anastomosis codes (36818-36821).

The RUC compared the surveyed code to the top key reference service and Multi-Specialty Points of Comparison (MPC) code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes of intra-service time, and 141 minutes total time) and noted that the survey code typically involves less intra-service and total time, and even though it is slightly more intense to perform, it involves less physician work overall. The RUC noted that 75 percent of those that selected the top key reference code had indicated that the surveyed code is more intense and complex to perform and the RUC recommendation appropriately accounts for this difference in intensity. The RUC also compared the surveyed code to the second top key reference service and MPC code 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* (work RVU = 9.00, 75 minutes of intra-service time, and 126 minutes total time) and again determined that CPT code 368X1 requires less physician work and time to perform, thus appropriately valued lower. The RUC concluded that CPT code 368X1 should be valued at the 25th percentile work RVU as supported by the survey.

For additional support, the RUC referenced the MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, 60 minutes of intra-service time and 133 minutes of total time) and noted that it is a reasonable comparator code to 368X1. MPC code 52353 exactly matches the intra-service time of the survey code and closely aligns in terms of total time and intensity of physician work. **The RUC recommends a work RVU of 7.50 for CPT code 368X1.**

368X2 ***Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation***

The RUC reviewed the survey results from 39 physicians and recommends the survey 25th percentile work RVU of 9.60 for CPT code 368X2. The RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time, 6 minutes scrub/dress/wait time, 75 minutes of intra-service time, and 18 minutes of immediate post-service time. The RUC determined that the pre-service time for 368X2 should be the same as CPT code 368X1. This is because the need for diagnostic imaging retrieval and review, as well as preoperative preparation and positioning, is identical to the work associated with the procedure in code 368X1. The specialties noted that the 26 minutes of pre-service time accounts for diagnostic imaging retrieval and review, in addition to preoperative preparation and positioning. The recommended 15 minutes of pre-service time is 3 minutes less than the 18 minutes of pre-service time in the pre-service package and median time, and the RUC found that to be appropriate. Additionally, the RUC agreed with the recommended increase from 1 to 5 minutes of positioning time given the importance of proper positioning and demarcation of the venous access site in this procedure and other similar upper extremity procedures utilizing ultrasound guidance. The RUC again determined that the physician work and time maintain relativity to open arteriovenous anastomosis codes (36818-36821).

The RUC compared the surveyed code to the top key reference service and MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes of intra-service time, and 141 minutes total time) and noted that the survey code typically involves less intra-service and total time, and even though it is more intense to perform, it involves less physician work overall. The RUC noted that 90 percent of that selected the top key reference code had indicated that the survey is more intense and complex to perform and the RUC recommendation appropriately accounts for this difference in intensity. The RUC compared the surveyed code to the second top key reference service and MPC code 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* (work RVU = 9.00, 75 minutes of intra-service time, and 126 minutes total time) and recognized that the intra-service time of KRS 36905 is an exact match to the survey code. The RUC further determined that the recommendation for 368X2 accounts for the increased level of intensity in the physician work and concluded that 25th percentile work RVU was appropriate and supported by the survey. Futhermore, the survey code RVU is properly bracketed by the top two key reference services in terms of their work RVU. **The RUC recommends a work RVU of 9.60 for CPT code 368X2.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed the new supply and equipment items recommended for these services. The two new supply inputs are the procedure specific catheters for the individual codes, the Ellipsys catheter/device (386X1) and the Wavelinq catheters/device (386X2). These items are required to create the arteriovenous anastomosis during the procedures. Two new equipment inputs are recommended that correspond to the industry specific/procedure specific RF generators for these catheters, the Ellipsys Generator, and the Wavelinq Generator. These generators can only be used for this specific service. The PE Subcommittee noted the high cost of the two new supply inputs and reiterates its previous request to CMS:

> The RUC calls on CMS to separately identify and pay for high-cost disposable supplies. The RUC makes this recommendation to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies, but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty. If high costs supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool. **The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced in excess of $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

In addition, it was clarified that EF019 *stretcher chair* is needed on hand in the ultrasound room for preoperative and postoperative sedation and recovery. The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Service
The RUC recommends that CPT codes 368X1 and 368X2 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Recommendation to Delete G2170 and G2171
The RUC recommends that CMS delete both G2170 *Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed* and G2171 *Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, wen performed) and fistulogram(s), angiography, enography, and/or ultrasound, with radiologic supervision and interpretation, when performed.*

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cardiovascular System **Arteries and Veins** **Hemodialysis Access, Intervascular Cannulation for Extracorporeal Circulation, or Shunt Insertion**				
36832		*Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)*		
36833		*with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)*		
		(For percutaneous thrombectomy within the dialysis circuit, see 36904, 36905, 36906)		
		(For central dialysis segment angioplasty in conjunction with 36818-36833, use 36907)		
		(For central dialysis segment stent placement in conjunction with 36818-36833, use 36908)		
		(Do not report 36832, 36833 in conjunction with 36901, 36902, 36903, 36904, 36905, 36906 for revision of the dialysis circuit)		

Codes 368X1, 368X2 describe percutaneous arteriovenous fistula creation in the upper extremity for hemodialysis access, including image-guided percutaneous access into a peripheral artery and peripheral vein via single access (368X1) or two separate access sites (368X2). The artery and vein are approximated and then energy (eg, thermal) is applied to establish the fistulous communication between the two vessels. Fistula maturation procedures promote blood flow through the newly created fistula by augmentation (eg, angioplasty) or redirection (eg, coil embolization of collateral pathways) of blood flow. Codes 368X1, 368X2 include all vascular access, angiography, imaging guidance, and blood flow redirection or maturation techniques (eg, transluminal balloon angioplasty, coil embolization) performed for fistula creation. These procedures may not be reported separately with 368X1, 368X2 when performed at the same operative session.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●368X1	V1	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation (For arteriovenous fistula creation via an open approach, see 36800, 36810, 36815, 36818, 36819, 36820, 36821) (For percutaneous arteriovenous fistula creation in any location other than the upper extremity, use 37799) (Do not report 368X1 in conjunction with 368X2) (Do not report 368X1 in conjunction with 36005, 36140, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37236, 37238, 37241, 37242, 37246, 37248, 37252, 37253, 75710, 75716, 75820, 75822, 75894, 75898, 76937, 77001)	000	7.50
●368X2	V2	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation (For arteriovenous fistula creation via an open approach, see 36800, 36810, 36815, 36818, 36919, 36820, 36821)	000	9.60

		(For percutaneous arteriovenous fistula creation in any location other than the upper extremity, use 37799) (Do not report 368X2 in conjunction with 368X1) (Do not report 368X2 in conjunction with 36005, 36140, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37236, 37238, 37241, 37242, 37246, 37248, 37252, 37253, 75710, 75716, 75820, 75822, 75894, 75898, 76937, 77001)		
G2170	-	Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed	YYY	Request for CMS to Delete
G2171	-	Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, enography, and/or ultrasound, with radiologic supervision and interpretation, when performed	YYY	Request for CMS to Delete

Vascular Injection Procedures

Intravenous

36005 *Injection procedure for extremity venography (including introduction of needle or intracatheter)*

(Do not report 36005 in conjunction with 368X1, 368X2)

(For radiological supervision and interpretation, see 75820, 75822)

Intra-Arterial—Intra-Aortic

36140 *Introduction of needle or intracatheter, upper or lower extremity artery*

(Do not report 36140 in conjunction with 368X1, 368X2)

(For insertion of arteriovenous cannula, see 36810-36821)

...

36215 *Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family*

36216 *initial second order thoracic or brachiocephalic branch, within a vascular family*

36217 *initial third order or more selective 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)*

(Do not report 36215, 36216, 36217, 36218 in conjunction with 368X1, 368X2)

...

36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family*

36246 *initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family*

36247 *initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family*

+36248 *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)*

(Do not report 36245, 36246, 36247, 36248 in conjunction with 368X1, 368X2)

(Use 36248 in conjunction with 36246, 36247)

Dialysis Circuit

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;*

(Do not report 36901 in conjunction with 36833, 368X1, 368X2, 36902, 36903, 36904, 36905, 36906)

36902 *with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*

(Do not report 36902 in conjunction with 368X1, 368X2, 36903)

36903	*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*
	(Do not report 36902, 36903 in conjunction with 36833, 368X1, 368X2, 36904, 36905, 36906)
	(Do not report 36901, 36902, 36903 more than once per operative session)
	(For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907)
	(For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)
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);*
	(Do not report 36904 in conjunction with 368X1, 368X2)
	(For open thrombectomy within the dialysis circuit, see 36831, 36833)
36905	*with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*
	(Do not report 36905 in conjunction with 368X1, 368X2, 36904)
36906	*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*
	(Do not report 36906 in conjunction with 368X1, 368X2, 36901, 36902, 36903, 36904, 36905)
	(Do not report 36904, 36905, 36906 more than once per operative session)
	(For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907)
	(For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)
✚*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)*
	(Use 36907 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906)

	(Do not report 36907 in conjunction with 368X1, 368X2, 36908)
	(Report 36907 once for all angioplasty performed within the central dialysis segment)
✚*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)*
	(Use 36908 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906)
	(Do not report 36908 in conjunction with 368X1, 368X2, 36907)
	(Report 36908 once for all stenting performed within the central dialysis segment)
✚*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)*
	(Report 36909 in conjunction with 36901, 36902, 36903, 36904, 36905, 36906)
	(36909 includes all permanent vascular occlusions within the dialysis circuit and may only be reported once per encounter per day)
	(Do not report 36909 in conjunction with 368X1, 368X2)
	(For open ligation/occlusion in dialysis access, use 37607)
	(For percutaneous procedure, use 37182)
Endovascular Revascularization (Open or Percutaneous, Transcatheter)	
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*
✚*37237*	*each additional artery (List separately in addition to* code for primary procedure)
	(Use 37237 in conjunction with 37236)
	(Do not report 37236, 37237 in conjunction with 368X1, 368X2)
	(Do not report 37236, 37237 in conjunction with 34841-34848 for bare metal or covered stents placed into the visceral branches within the endoprosthesis target zone)

	(For stent placement(s) in iliac, femoral, popliteal, or tibial/peroneal artery(s) for occlusive disease, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)
	(For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216)
	(For transcatheter placement of intracranial stent(s), use 61635)
	(For transcatheter placement of intracoronary stent(s), see 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944)
	(For stenting of visceral arteries in conjunction with fenestrated endovascular repair, see 34841-34848)
	(For open or percutaneous antegrade transcatheter placement of intrathoracic carotid/innominate artery stent(s), use 37218)
	(For open or percutaneous transcatheter placement of extracranial vertebral artery stent(s), see Category III codes 0075T, 0076T)
	(For open retrograde transcatheter placement of intrathoracic common carotid/innominate artery stent(s), use 37217)
	(For placement of a stent at the arterial anastomosis of a dialysis circuit with or without transluminal mechanical thrombectomy and/or infusion for thrombolysis, see 36903, 36906)
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*
+37239	*each additional vein (List separately in addition to code for primary procedure)*
	(Use 37239 in conjunction with 37238)
	(Do not report 37238, 37239 in conjunction with 368X1, 368X2)
	(Do not report 37238, 37239 in conjunction with 0505T, within the femoral-popliteal segment)
	(Do not report 37238, 37239 in conjunction with 0620T within the tibial-peroneal segment)
	(For placement of a stent[s] within the peripheral segment of the dialysis circuit, see 36903, 36906)
	(For transcatheter placement of an intravascular stent[s] within central dialysis segment when performed through the dialysis circuit, use 36908)
#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*
#+37247	*each additional artery (List separately in addition to code for primary procedure)*
	(Use 37247 in conjunction with 37246)

(Do not report 37246, 37248 in conjunction with 368X1, 368X2)

(Do not report 37246, 37247 in conjunction with 37215, 37216, 37217, 37218, 37220-37237 when performed in the same artery during the same operative session)

(Do not report 37246, 37247 in conjunction with 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848 for angioplasty[ies] performed, when placing bare metal or covered stents into the visceral branches within the endoprosthesis target zone)

Intravascular Ultrasound Services

✚*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)*

✚*37253* *each additional noncoronary vessel (List separately in addition to code for primary procedure)*

(Use 37253 in conjunction with 37252)

(Report 37252, 37253 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 33477, 33880, 33881, 33883, 33884, 33886, 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34718, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 36010, 36011, 36012, 36013, 36014, 36015, 36100, 36140, 36160, 36200, 36215, 36216, 36217, 36218, 36221, 36222, 36223, 36224, 36225, 36226, 36227, 36228, 36245, 36246, 36247, 36248, 36251, 36252, 36253, 36254, 36481, 36555-36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 36595, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37184, 37185, 37186, 37187, 37188, 37200, 37211, 37212, 37213, 37214, 37215, 37216, 37218, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, 37235, 37236, 37237, 37238, 37239, 37241, 37242, 37243, 37244, 37246, 37247, 37248, 37249, 61623, 75600, 75605, 75625, 75630, 75635, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75805, 75807, 75810, 75820, 75822, 75825, 75827, 75831, 75833, 75860, 75870, 75872, 75885, 75887, 75889, 75891, 75893, 75894, 75898, 75901, 75902, 75956, 75957, 75958, 75959, 75970, 76000, 77001, 0075T, 0076T, 0234T, 0235T, 0236T, 0237T, 0238T, 0338T)

(Do not report 37252, 37253 in conjunction with 368X1, 368X2, 37191, 37192, 37193, 37197)

Vascular Embolization and Occlusion

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)*

37242 *arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)*

(Do not report 37241, 37242 in conjunction with 368X1, 368X2)

(Do not report 37241 in conjunction with 36468, 36470, 36471, 36473, 36474, 36475-36479, 75894, 75898 in the same surgical field)

(For sclerosis of veins or endovenous ablation of incompetent extremity veins, see 36468-36479)

(For dialysis circuit permanent endovascular embolization or occlusion, use 36909)

Radiology
Diagnostic Radiology (Diagnostic Imaging)
Vascular Procedures
Aorta and Arteries

75710 *Angiography, extremity, unilateral, radiological supervision and interpretation*

(Do not report 75710 in conjunction with 368X1, 368X2)

75716 *Angiography, extremity, bilateral, radiological supervision and interpretation*

(Do not report 75716 in conjunction with 368X1, 368X2)

Veins and Lymphatics

75820 *Venography, extremity, unilateral, radiological supervision and interpretation*

(Do not report 75820 in conjunction with 368X1, 368X2)

75822 *Venography, extremity, bilateral, radiological supervision and interpretation*

(Do not report 75822 in conjunction with 368X1, 368X2)

Transcatheter Procedures

75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*

(Do not report 75894 in conjunction with 36475, 36476, 36478, 36479, 368X1, 368X2, 37241-37244)

75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis*

(For thrombolysis infusion management other than coronary, see 37211-37214, 61645)

(For non-thrombolysis infusion management other than coronary, see 61650, 61651)

(Do not report 75898 in conjunction with 368X1, 368X2, 37211-37214, 37241-37244, 61645, 61650, 61651)

Ultrasonic Guidance Procedures

✚*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)*

(Do not report 76937 in conjunction with 33274, 33275, 36568, 36569, 36572, 36573, 36584, 368X1, 368X2, 37191, 37192, 37193, 37760, 37761, 76942)

(Do not report 76937 in conjunction with 0505T, 0620T for ultrasound guidance for vascular access)

(If extremity venous non-invasive vascular diagnostic study is performed separate from venous access guidance, see 93970, 93971)

Radiologic Guidance
Fluoroscopic Guidance

✚*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)*

(Do not report 77001 in conjunction with 33957, 33958, 33959, 33962, 33963, 33964, 36568, 36569, 36572, 36573, 36584, 368X1, 368X2, 77002)

(If formal extremity venography is performed from separate venous access and separately interpreted, use 36005 and 75820, 75822, 75825, or 75827)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:368X1 Tracking Number V1 Original Specialty Recommended RVU: **7.50**
Presented Recommended RVU: **7.50**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **7.50**

CPT Descriptor: Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial artery and perforating vein with a distance between the respective vessels of <1.5 mm, suitable for percutaneous arteriovenous fistula creation in the upper extremity.

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: The patient's medical history, physical exam, and laboratory studies, are reviewed and consent is obtained. Relevant preoperative diagnostic imaging studies are retrieved and reviewed for the chosen upper extremity, with site marking. The patient is positioned supine on the procedure table with extremity extended and secured. Ultrasound guidance is used to mark the target venous access site prior to prepping and draping in order to include all necessary anatomy within the field. A time out is performed. The skin over the upper extremity of the intended percutaneous arteriovenous fistula site is prepared and draped in sterile fashion and local anesthetic is administered subcutaneously over the intended access site under ultrasound guidance.

Description of Intra-Service Work: Using ultrasound guidance the target vein is accessed with a micropuncture needle. Next, using continuous ultrasound guidance, the same needle is carefully navigated within the perforator vein and advanced to the level of the adjacent artery. After confirming location of the needle on orthogonal views by ultrasound, the artery is then punctured using the needle. A guidewire is advanced through the artery. The needle is exchanged over the wire for a sheath until the distal end just enters the artery. A catheter is advanced into the artery. The catheter is then carefully retracted to grasp the arterial wall allowing approximation of the artery and vein, which must be confirmed with ultrasound. Energy is applied to create the anastomosis. The catheter is then removed and the anastomosis and perforating vein are dilated with a balloon to ensure adequate flow under imaging guidance. The balloon, guidewire and sheath are removed. Hemostasis is achieved at the percutaneous venous access site using manual pressure.

Description of Post-Service Work: Sterile dressings are applied. The patient is transported to the recovery room for hemodynamic monitoring and pain control. The procedure is documented in the permanent record. Imaging results and patient status are communicated to the patient's family. Permanent reports are created for the medical record and copies of the reports are sent to the patient's referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Curtis Anderson, MD, Minhaj Khaja, MD, Matthew Sideman, MD, Wayne Causey, MD, Lauren Golding, MD, and Stephen Clyne, MD					
Specialty Society(ies):	SIR, SVS, ACR, RPA					
CPT Code:	368X1					
Sample Size:	4604	**Resp N:**	37			
Description of Sample:	4104 were random SIR SIR - 500 randomly selected US/MD members RPA - 2030 randomly selected US/MD members ACR - 500 randomly selecetd US/MD members an additional 500 targeted members who specialize in interventional radiology for 1000 total SVS - 1074 randomly selected US/MD members					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	60.00
Survey RVW:	1.00	7.50	**10.00**	12.00	22.00
Pre-Service Evaluation Time:			**18.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	45.00	**60.00**	70.00	122.00

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)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	368X1	**Recommended Physician Work RVU: 7.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**18.00**	**-3.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**18.00**	**18.00**	**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
36906	000	10.42	**RUC Time**

CPT Descriptor 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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36905	000	9.00	**RUC Time**

CPT Descriptor 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

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
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

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
		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: 16 **% of respondents:** 43.2 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 10.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 368X1	Top Key Reference CPT Code: 36906	2nd Key Reference CPT Code: **36905**
Median Pre-Service Time	26.00	31.00	31.00
Median Intra-Service Time	60.00	90.00	75.00
Median Immediate Post-service Time	18.00	20.00	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	**104.00**	**141.00**	**126.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	44%	31%

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%	12%	88%
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%	25%	75%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	60%	20%

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%	0%	100%
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	20%	20%	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.

Background

In July of 2020 CMS created two HCPCS G codes to capture two percutaneous approaches to creating an arteriovenous anastomosis.

G2170 *Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed.*

G2171 *Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed.*

The most significant material difference between the procedures is that one approach requires two catheters from two different percutaneous access sites, one in the vein and one in the artery that are then approximated using magnets and radiofrequency energy, while the other technique requires a single percutaneous access that then connects the artery and the vein under ultrasound guidance and then uses mechanical capture and thermal energy for approximation. Flow directing techniques and intra-procedural guidance including arteriography or venography can also be needed depending on the vascular anatomy and the choice of the physician.

There was no CPT code that captured a percutaneous approach to creating an arteriovenous anastomosis. CPT codes 36818, 36819, 36820 and 36821 describe an open surgical approach only. New technologies have been developed that allow for less invasive approaches utilizing percutaneous image-guided methods to approximate a target artery and vein using magnets or mechanical capture. Thermal energy is applied to fuse the artery and vein together and to cut an elliptical anastomosis, permanently connecting the artery and vein. These techniques may also use balloons or coils to direct blood flow as well as different imaging methods (e.g., ultrasound and/or fluoroscopy) to guide the percutaneous procedure.

Two new CPT codes (368X1 and 368X2) were approved by CPT Editorial Panel for percutaneous arteriovenous access creation at the September 2021 meeting.

Methodology

A multi-disciplinary survey including SIR, SVS, ACR, and RPA was distributed randomly to the members of the representative societies. For code 368X1 37 surveys were completed. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved.

Work RVU Recommendation for 368X1

We are recommending the 25th percentile survey value of 7.50 RVW for 368X1.

Pre- and Post-Service Time Packages

The specialties have selected pre-package 2 (difficult patient/straightforward procedure), with standard package times of 18 minutes pre-evaluation time, 1 minute of pre-positioning time, and 6 minutes of pre-scrub, dress, and wait time.

The specialties recommend the following times

1. Evaluation: We recommend a pre-service evaluation time of 15 minutes. This is 3 minutes less than the pre-service package and median time, but still appropriate for the evaluation needed and similar to the time also recommended for code 368X2.

2. Positioning: We recommend time of 5 minutes, which is 4 minutes more than the package time. We feel this additional time is justified given the importance of positioning in these procedures and other similar upper extremity procedures utilizing ultrasound guidance. This is critical as the added time needed to ensure proper positioning and demarcation of the venous access site with ultrasound may result in more efficient and safe procedural success.

3. Scrub, dress, and wait: We recommend the pre-service package time of 6 minutes for pre-service scrub, dress, and wait time.

4. Post: We recommend the post-service package 7A (local anesthesia/straightforward patient) time of 18 minutes.

Comparison with Key Reference Services

The key reference codes chosen by the majority of the survey respondents were 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* (43%) and 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* (11%). These key references are similar to 368X1 and the following data and established values supports this.

CPT	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36906 Key Ref	10.42	0.104	141	22	4	5	90	20
368X1 Survey	7.50	0.110	104	15	5	6	60	18
36905 Key Ref	9.00	0.106	126	22	4	5	75	20

This comparison thus favorably supports our recommendation for the 25th percentile survey value of 7.50 RVW for CPT 368X1.

Comparison to MPC codes

The highest value 000 day global MPC code is 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* with 10.42 wRVUs is also our top reference code. See values above.

Conclusion

A multi-disciplinary survey of CPT 368X1 was performed with strong survey results and concordance between specialties. When comparing the survey results to the key reference services, which are also two MPC codes, we believe that the 25th percentile survey RVW of 7.50 appropriately ranks CPT 368X1 relative to other services.

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) G2170

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 Interventional Radiology How often? Sometimes

Specialty Nephrology How often? Sometimes

Specialty Vascular Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2200
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Due to lack of claims data, the estimate is based on vendor sales monthly data to determine potential frequency of service. Estimate is based on 2020 sales data (1,461) plus 50%

Specialty Interventional Radiology Frequency 733 Percentage 33.31 %

Specialty Nephrology Frequency 733 Percentage 33.31 %

Specialty Vascular Surgery Frequency 733 Percentage 33.31 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,760
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 specialty estimate in consideration of vendor sales data

Specialty Interventional Radiology Frequency 586 Percentage 33.29 %

Specialty Nephrology Frequency 586 Percentage 33.29 %

Specialty Vascular Surgery Frequency 586 Percentage 33.29 %

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

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. 36901

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:368X2 Tracking Number V2 Original Specialty Recommended RVU: **9.60**
Presented Recommended RVU: **9.60**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **9.60**

CPT Descriptor: Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial and ulnar artery, presence of a perforating vein, and radial and ulnar vein within < 1mm of the respective corresponding arteries, suitable for percutaneous arteriovenous fistula creation in the upper extremity.

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: The patient's medical history, physical exam, and laboratory studies are reviewed, and consent is obtained. Relevant preoperative diagnostic imaging studies are retrieved and reviewed for the chosen upper extremity, with site marking. The patient is positioned supine on the angiography table with the upper extremity extended and secured. Ultrasound guidance is used to mark the target arterial and venous access sites prior to prepping and draping in order to include all necessary anatomy within the field. A time out is performed. The skin over the upper extremity of the intended percutaneous arteriovenous fistula site is prepared and draped in a sterile fashion. Local anesthetic is administered subcutaneously over each intended access site under ultrasound guidance.

Description of Intra-Service Work: Ultrasound-guided access is obtained in a vein in the extremity, and a guidewire is inserted. Next, a dilator and vascular sheath is introduced, and a venogram of the central veins is performed. Next, under ultrasound guidance, the target artery is then accessed separately. An arteriogram of the entire extremity is then performed. A guidewire is advanced to the target creation site. Using the arterial guidewire as a roadmap, the venous guidewire is advanced into the vein and navigated under fluoroscopy to the intended fistula site. Then a venogram is performed at the intended fistula site to confirm superficial communication via the presence of a perforator vein. Under fluoroscopic guidance, the arterial catheter is carefully advanced over the guidewire to the target fistula creation site making sure proper orientation to the venous guide catheter is maintained. The venous catheter is then inserted into the sheath and advanced over the guidewire to the target fistula creation. The catheters and magnetic components are optimally positioned and brought into alignment. Correct orientation and alignment are confirmed via fluoroscopy in multiple orthogonal projections. Radiofrequency energy is delivered to the electrode for 0.7 seconds creating the arteriovenous fistula. After the arteriovenous fistula has been created, catheters are removed. An angiogram of the newly created fistula is then obtained through the arterial sheath or an arterial catheter that has been advanced central to the percutaneous arteriovenous fistula to verify successful arteriovenous fistula creation with outflow in cephalic and/or basilic veins. From the venous access site, a catheter is navigated to the brachial vein. The brachial vein in the mid-upper extremity is then occluded by coil embolization to direct more flow to the cephalic and/or basilic veins, which is confirmed by repeat arteriography to evaluate the percutaneous arteriovenous fistula and outflow veins. Then the venous and arterial sheaths are removed.

Finally, hemostasis is obtained at the arterial and venous access sites using manual compression for a minimum of 20 minutes.

Description of Post-Service Work: Sterile dressings are applied. The patient is transported to the recovery room for hemodynamic monitoring and pain control. The procedure is documented in the permanent record. Fluoroscopic and ultrasound results and patient status are communicated to the patient's family. Permanent reports are created for the medical record, and copies of the reports are sent to the patient's referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Curtis Anderson, MD, Minhaj Khaja, MD, Matthew Sideman, MD, Wayne Causey, MD, Lauren Golding, MD, and Stephen Clyne, MD					
Specialty Society(ies):	SIR, SVS, ACR, RPA					
CPT Code:	368X2					
Sample Size:	4604	**Resp N:**	39			
Description of Sample:	SIR - 500 randomly selected US/MD members RPA - 2030 randomly selected US/MD members ACR - 500 randomly selecetd US/MD members an additional 500 targeted members who specialize in interventional radiology for 1000 total SVS - 1074 randomly selected US/MD members					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**3.00**	7.00	65.00
Survey RVW:	1.00	9.60	**11.00**	13.75	38.80
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	60.00	**75.00**	90.00	150.00

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)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	368X2	**Recommended Physician Work RVU: 9.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**18.00**	**-3.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**75.00**		

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:	**18.00**	**18.00**	**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
36906	000	10.48	**RUC Time**

CPT Descriptor 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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36905	000	9.00	**RUC Time**

CPT Descriptor 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

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
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

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
		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: 21 **% of respondents:** 53.8 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 368X2	**Top Key Reference CPT Code:** 36906	**2nd Key Reference CPT Code:** **36905**
Median Pre-Service Time	26.00	31.00	31.00
Median Intra-Service Time	75.00	90.00	75.00
Median Immediate Post-service Time	18.00	20.00	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	**119.00**	**141.00**	**126.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	10%	38%	52%

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%	9%	86%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	19%	76%
Physical effort required	0%	29%	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	0%	24%	76%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	50%	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	0%	17%	83%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	17%	66%
Physical effort required	17%	66%	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%	33%	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

In July of 2020 CMS created two HCPCS G codes to capture two percutaneous approaches to creating an arteriovenous anastomosis.

G2170 *Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed.*

G2171 *Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed.*

The most significant material difference between the procedures is that one approach requires two catheters from two different percutaneous access sites, one in the vein and one in the artery that are then approximated using magnets, while the other technique requires a single percutaneous access that then connects the artery and the vein under ultrasound guidance and then uses mechanical capture for approximation. Flow directing techniques and intra-procedural guidance including arteriography or venography can also be needed depending on the vascular anatomy and the choice of the physician.

There was no CPT code that captured a percutaneous approach to creating an arteriovenous anastomosis. CPT codes 36818, 36819, 36820 and 36821 describe an open surgical approach only. New technologies have been developed that allow for less invasive approaches utilizing percutaneous image-guided methods to approximate a target artery and vein using magnets or mechanical capture. Thermal energy is applied to fuse the artery and vein together and to cut an elliptical anastomosis, permanently connecting the artery and vein. These techniques may also use balloons or coils to direct blood flow as well as different imaging methods (e.g., ultrasound and/or fluoroscopy) to guide the percutaneous procedure.

Two new CPT codes (368X1 and 368X2) were approved by CPT Editorial Panel for percutaneous arteriovenous access creation at the September 2021 meeting.

Methodology

A multi-disciplinary survey including SIR, SVS, ACR, and RPA was distributed randomly to the members of the representative societies. For code 368X2 39 surveys were completed. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved.

Work RVU Recommendation for 368X2

We are recommending the 25th percentile survey value of 9.60 RVW for 368X2.

Pre- and Post-Service Time Packages

The specialties have selected pre-package 2 (difficult patient/straightforward procedure), with standard package times of 18 minutes pre-evaluation time, 1 minute of pre-positioning time, and 6 minutes of pre-scrub, dress, and wait time.

The specialties recommend the following times

1. Evaluation: We recommend the median time of 15 minutes of evaluation time based on median survey data. This is 3 minutes less than package time, but still appropriate for the evaluation needed and similar to the time also recommended for code 368X1.

2. Positioning: We recommend time of 5 minutes, which is 4 minutes more than the package time. We feel this additional time is justified given the importance of positioning in these procedures and other similar upper extremity procedures utilizing ultrasound guidance. This is critical as the added time needed to ensure proper positioning and demarcation of the venous access site with ultrasound may result in more efficient and safe procedural success.

3. Scrub, dress, and wait: We recommend the pre-service package time of 6 minutes for pre-service scrub, dress, and wait time.

4. Post: We recommend the post-service package 7A (local anesthesia/straightforward patient) time of 18 minutes.

Comparison with Key Reference Services

The key reference codes chosen by the majority of the survey respondents were 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* (54%) and 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* (13%). These key references are similar to 368X2 and the following data and established values supports this.

CPT	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
36906 Key Ref	10.42	0.104	141	22	4	5	90	20
368X2 Survey	9.60	0.116	119	15	5	6	75	18
36905 Key Ref	9.00	0.106	126	22	4	5	75	20

This comparison thus favorably supports our recommendation for the 25th percentile survey value of 9.60 RVW for CPT 368X2.

Comparison to MPC codes

The highest value 000 day global MPC code is 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* with 10.42 wRVUs is also our top reference code. See values above.

Conclusion

A multi-disciplinary survey of CPT 368X2 was performed with strong survey results and concordance between specialties. When comparing the survey results to the key reference services, which are also two MPC codes, we believe that the 25th percentile survey RVW of 9.60 appropriately ranks CPT 368X2 relative to other services.

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) G2171

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 Invertentional Radiology How often? Sometimes

Specialty Nephrology How often? Sometimes

Specialty Vascular Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2222
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Due to lack of claims data, an estimate based on vendor sales data since inception in 2018 to determine potential frequency of service. Estimate is based on 1/3 of sales from April 2018 -April 2021 (total 4,443 or 1,481/year) plus 50%

Specialty Interventional Radiology Frequency 740 Percentage 33.30 %

Specialty Nephrology Frequency 740 Percentage 33.30 %

Specialty Vascular Surgery Frequency 740 Percentage 33.30 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,777
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 specialty estimate in consideration of vendor sales data

Specialty Interventional Radiology Frequency 592 Percentage 33.31 %

Specialty Nephrology Frequency 592 Percentage 33.31 %

Specialty Vascular Surgery Frequency 592 Percentage 33.31 %

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

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. 36901

ISSUE: Percutaneous Arteriovenous Fistula Creation
TAB: 6

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	36906	000	Percutaneous transluminal	2016	16	0.104	0.074			10.42			141	22	4	5			90			20	0	5	22	33	100
2nd REF	36905	000	Percutaneous transluminal	2016	4	0.106	0.071			9.00			126	22	4	5			75			20	3	12	15	40	200
CURRENT	G2170	YYY	Percutaneous arteriovenous fistula			-	-						0														
SVY	368X1	000	Percutaneous arteriovenous fistula		37	0.147	0.085	1.00	7.50	10.00	12.00	22.00	118	18	10	10	15	45	60	70	122	20	0	0	2	5	60
REC	368X1	000	Percutaneous arteriovenous fistula			0.110	0.072			7.50			104	15	5	6			60			18					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	36906	000	Percutaneous transluminal		21	0.104	0.074			10.42			141	22	4	5			90			20	0	10	20	50	411
2nd REF	36905	000	Percutaneous transluminal		5	0.106	0.071			9.00			126	22	4	5			75			20	3	10	33	48	100
CURRENT	G2171	YYY	Percutaneous arteriovenous fistula			-	-						0														
SVY	368X2	000	Percutaneous arteriovenous fistula		39	0.132	0.085	1.00	9.60	11.00	13.75	38.80	130	15	10	10	15	60	75	90	150	20	0	0	3	7	65
REC	368X2	000	Percutaneous arteriovenous fistula			0.116	0.081			9.60			119	15	5	6			75			18					

FACILITY DIRECT PE INPUTS **CPT CODE(S):386X1-2**

SPECIALTY SOCIETY(IES):SIR, ACR, SVS, RPA

PRESENTER(S):Khaja, Anderson, Et. Al PRESENTER(S): Curtis Anderson, MD, Minhaj Khaja, MD, Matthew Sideman, MD, Wayne Causey, MD, Lauren Golding, MD, and Stephen Clyne, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 1/2022

CPT Code	Long Descriptor	Global Period
368X1	*Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*	000
368X2	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
368X1	A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial artery and perforating vein with a distance between the respective vessels of <1.5 mm, suitable for percutaneous arteriovenous fistula creation in the upper extremity.
368X2	A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial and ulnar artery, presence of a perforating vein, and radial and ulnar vein within < 1mm of the respective corresponding arteries, suitable for percutaneous arteriovenous fistula creation in the upper extremity.

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:

   SIR, ACR, RPA, and SVS convened a panel of experts familiar with these services to evaluate the direct practice expense inputs for two new Endovascular Creation of Arteriovenous Fistula codes.

2.

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

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The Endovascular Arteriovenous Fistula Creation tab includes two new bundled procedures. We have included the code 36905 as the comparison code for the practice expense as it is a commonly performed dialysis access procedure. This code also happens to be one of the most frequently selected Key Reference Services and is an MPC. The clinical staff times for scheduling the Facility site of service should be the similar based on the similar patient type and demands of procedure.

3.

3. Is this code(s) typically reported with an E/M service?

No

4.

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

5.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

6.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

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We believe there is extensive use of clinical staff time for these codes.

386X1-386X2
Pre Service Time

- *CA002 Coordinate pre-surgery services (3)*
- *CA003 Schedule space and equipment in facility (3)*

Intra Service Time (post service of service period)

- *CA035 Follow-up phone calls & prescriptions (3)*

Post-Service Period

- *CA039 Coordinate post-procedure services (3)*

We are recommending 12 minutes of clinical staff time total. This staff time is necessary to coordinate multiple services to schedule a complicated patient, in a clinical Facility remote from the office and with very specific equipment, supply and room requirements that need to be coordinated and scheduled.

7.

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.

8. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

- *Coordinate pre-surgery services (3) - During this time the staff is collecting and coordinating the request from referring physician and ensuring all appropriate preoperative imaging has been performed. In addition, the staff is arranging an preoperative medical clearances and coordinating with dialysis centers and primary care staff the medical fitness for procedure.*
- *Schedule space and equipment in facility (3) - Staff must schedule availability in the OR (386X1) or Hybrid OR/Angiography Suite (386X2) as well as confirm availability of the procedure specific Equipment and supplies.*

   b.
   c. Service period (includes pre, intra and post):

- *Follow-up phone calls & prescriptions (3) - During this period staff calls patient and monitors for postoperative pain control and assures patients is taking prescribed anti-platelet medications.*

   d.
   e. Post-service period:

- *Coordinate post-procedure services (3) - During this period Post-operative calls to dialysis centers regarding access monitoring during dialysis visits.*

   f.

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9. 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*):

N/A

10.

10. 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

11.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/a

14.

14. Are you recommending a PE supply pack for this recommendation? No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/a

15. 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

16.

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/a

17.

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17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18.

18. 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

    d.

19. 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

20.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/a

21.

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

22.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition to those revisions, please also provide an

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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):386X1-2**
SPECIALTY SOCIETY(IES):SIR, ACR, SVS, RPA
PRESENTER(S): Curtis Anderson, MD, Minhaj Khaja, MD, Matthew Sideman, MD, Wayne Causey, MD, Lauren Golding, MD, and Stephen Clyne, MD

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368X2	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
368X1	A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial artery and perforating vein with a distance between the respective vessels of <1.5 mm, suitable for percutaneous arteriovenous fistula creation in the upper extremity.
368X2	A 65-year-old male with advanced chronic kidney disease will require hemodialysis. Preoperative vascular imaging shows appropriate size and patency of the radial and ulnar artery, presence of a perforating vein, and radial and ulnar vein within < 1mm of the respective corresponding arteries, suitable for percutaneous arteriovenous fistula creation in the upper extremity.

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:

   SIR, ACR, RPA, and SVS convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for two new Endovascular Creation of Arteriovenous Fistula 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 (NOTE: *For services reviewed prior to the implementation of*

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clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes):

The Endovascular Arteriovenous Fistula Creation tab includes two new bundled procedures. We have included the code 36905 as the comparison code for the practice expense as it is a commonly performed dialysis access procedure. This code also happens to be one of the most frequently selected Key Reference Services and is an MPC.

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 the *Billed Together* tab in the RUC Database)

   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 the *Billed Together* tab in the RUC Database)

   The dominant provider of this service is not known as this is a new service. It is believed that this procedure will be performed 80% in the non facility setting.

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

   No, new CPT codes.

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7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

We believe there is extensive use of clinical staff time for this tab. However, we are recommending 13 minutes of pre service staff time instead of the standard 18 minutes.

Pre Service Time

- *Complete pre-service diagnostic & referral forms (3)*
- *Coordinate pre-surgery services (3)*
- *Complete pre-procedure phone calls & prescriptions (3)*
- *Confirm availability of prior images/studies (2)*
- *Patient Clinical Information and Questionnaire reviewed by technologist (2) - The standard for this input is 1 minute however additional minute is used to discuss risks of fluoroscopy and contrast, particularly as it pertains to residual renal function and possible pregnancy.*

Prepare and Position Patient
We are requesting three additional minutes of positioning over the standard of two minutes. This extra time is needed to prepare the arm for the procedure in relation to the imaging equipment and other procedural equipment.

Review home care instructions
We are requesting three minutes instead of the standard 2 minutes as monitoring of the newly created access by the patient is necessary.

8. 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

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We are requesting 5 minutes for vital signs because this patient population has a very high incidence of cardiovascular comorbidities. We measure weight and obtain heart rate, O2 saturation, respiratory rate, temperature and blood pressure before these procedures.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

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- *Complete pre-service diagnostic & referral forms (3) - During this time the staff is collecting and cooordinating the request from referring physician and ensuring all appropriate preoperative imaging has been performed.*
- *Coordinate pre-surgery services (3) - During this portion the staff is arranging an preoperative medical clearances and coordinating with dialysis centers and primary care staff the medical fitness for procedure.*
- *Complete pre-procedure phone calls & prescriptions (3)* -Coordinate with patient any information related to scheduling of procedure. Prescribe preoperative lab work if any are missing. Ensure procedure and recovery do not conflict with dialysis schedule.
- *Confirm availability of prior images/studies (2) - Staff must ensure that imaging studies are available for review prior to the procedure.*
- *Patient Clinical Information and Questionnaire reviewed by technologist (2) - Staff discuss with the patient the procedure, confirms patient information and planned side of procedure and patient handedness. If contrast or fluoroscopy is to be used, associated risks determined such as pregnancy or damage to residual kidney function.*

b. Service period (includes pre, intra and post):

- Assist Physician - Angio Tech L041A 100% Physician time - This is a hip-to-hip clinical staff who is scrubbed into the procedure and assists the physician throughout the procedure from puncture to close.
- Nurse /Tech blend - Circulating staff in the room that acquires images, opens supplies, adjusts and connects equipment. This by convention has been a 75% Angio Tech (L041A) 25% Nurse/LPN/MTA (L037D) role for interventional procedures.

c. Post-service period:

- Monitor patient following procedure (CA022) - Nurse monitors patients vital signs and and pain post procedure as well as monitors for signs of bleeding, vascular complications or neurologic complications.
- Clean room (CA024) - This is typically done by the Angio technician (L041A) including cleaning the US equipment, table and fluoroscopy machine (if used). This was listed as the Nurse blend staff (L037D) on the comparator code but this does not represent the typical scenario in the non facility setting.
- Check dressings, catheters and wounds (CA029) - The nurse blend staff (L037D) check on the operative site(s) and confirm hemostasis prior to discharge.
- Technologist QC's images in PACS (CA030) - The Angio technologist QCs all images and makes sure the images transfer to PACS. Both procedures require numerous images to be obtained that will be need to be stored for future review as the access matures.
- Review examination with interpreting MD/DOs - Angio Tech (L041A) reviews the images to confirm accuracy and completeness of imaging record of procedure, particularly intraprocedural doppler imaging to access flow of fistula post creation.
- Scan exam documents into PACS - Angio Tech (L041A) scans all documentation into PACS including any drawings/diagrams which may have been created for communication of new access anatomy.

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11. 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 Physician - Angio Tech L041A 100% Physician time - This is a hip-to-hip clinical staff who is scrubbed into the procedure and assists the physician throughout the procedure from puncture to close. This staff person directly works with physician to complete procedure including handing equipment/supplies off the sterile table, maintaining sterility of wires, catheters and devices. Often the technologist will hold the ultrasound probe while the physician manipulates the needles or wires.
- Nurse /Tech blend - Circulating staff in the room that acquires images, opens supplies, adjusts and connects equipment. This by convention has been a 75% Angio Tech (L041A) 25% Nurse/LPN/MTA (L037D) role for interventional procedures. This staff member operates both the fluoroscopy machine and the ultrasound machine, obtaining images, adjusting imaging parameters, opening sterile and nonsterile supplies and otherwise assists in a mobile capacity while not scrubbed in.

12. 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.

For CPT Codes 368X1 and 368X2 we have included a tech at 75% of the physician work time to perform the image acquisition portion of the procedure and a nurse blend at 25% of the physician time as the circulator.

13. 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*):

14. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. **X** Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

N/A

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16. **X** Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

> We have introduced two new supply inputs. The supply inputs are the procedure specific catheters for the individual codes. These catheters are the Ellipsys catheter/device (386X1) and the Wavelinq catheters/device (386X2). These items are required to create the arteriovenous anastomosis during the procedures.

18. Are you recommending a PE supply pack for this recommendation? Yes.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

> SA048

19. 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**		**5.02**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

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We have requested two new equipment inputs for this tab. The equipment inputs correspond to the industry specific/procedure specific RF generators for these catheters. These generators can only be used for this specific service. These are the Ellipsys Generator and the Wavelinq Generator.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

The specialty societies and manufacturers suggest a 5 year usable life and the equipment cost per minute should be based on this lifespan.

22. 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

23. 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:

EL011 room, angiography – Highly technical formula
ED050 Technologist PACS workstation – PACS formula
EF027 table, instrument, mobile – Default formula
EF019 stretcher chair – Default formula - This chair is used for the 1 hour recovery and monitoring period. The patient is not recovered in the Ultrasound room.
EQ011 ECG, 3-channel (with SpO2, NIBP, temp, resp) – Default formula
EQ032 IV infusion pump – Default formula
EL016 room, ultrasound, vascular – Highly technical formula
New Equipment Wavelinq EndoAVF generator – Default formula
New Equipment. Ellipsys EndoAVF generator – Default formula

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PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

In order to provide a more detailed explanation for the supply item choices, below is a table detaining the rationale for the inclusion and item number for each item and for each different code.

Code	Description	386X1	386x2	Explanation
SA048	pack, minimum multi-specialty visit	1	1	Basic patient encounter supplies
SA016	kit, guidewire introducer (Micro-Stick)	1	2	Initial access to blood vessels
SA019	kit, iv starter	1	1	For IV access for the patient
SA067	tray, shave prep	1	1	Arm typically needs to be shaved for sterile preparation.
SB001	cap, surgical	3	3	One for MD, Angio Tech (hip to hip), and Tech/nurse blend
SB008	drape, sterile, c-arm, fluoro	1	1	To cover the image intensifier/flat panel during procedure
SB009	drape, sterile, femoral	1	1	Drapes sterile field. This is the most commonly used drape for these procedures to protect a large area from wire/catheter contamination.
SB014	drape, sterile, three-quarter sheet	1	1	To cover back table as a workspace
SB019	drape-towel, sterile 18in x 26in	2	2	To frame operate site.
SB022	gloves, non-sterile	1	1	For placing IV, prepping patient, and cleanup (one staff at each activity, two pairs are in SA048)
SB024	gloves, sterile	2	2	For MD and Angio Tech (hip to hip)
SB028	gown, surgical, sterile	2	2	For MD and Angio Tech (hip to hip)
SB033	mask, surgical	2	2	For AngioTech/circulator

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SB034	mask, surgical, with face shield	2	2	For MD and Angio Tech (hip to hip)
SB039	shoe covers, surgical	3	3	One for MD, Angio Tech (hip to hip), Tech/nurse blend
SB044	underpad 2ft x 3ft (Chux)	1	1	To place under the arm during procedure.
SC010	closed flush system, angiography	1	1	Flush system for fluid administration and waste management
SC051	syringe 10-12ml		2	For Contrast administration during 386X2
SC053	syringe 20ml	2	2	For Heparinized Saline Flushes
SC058	syringe w-needle, OSHA compliant (SafetyGlide)	1	1	For lidocaine administration
SD089	guidewire, hydrophilic		1	For catheterization of fistula creation site at artery and vein.
SD136	vascular sheath	1	2	One access site for 386x1 and two for 386X2
SD147	catheter, (Glide)		1	For catheterization of fistula creation site at artery and vein.
SD149	catheter, balloon inflation device	1	1	Both procedures require gentle angioplasty of new anastomosis.
SD152	catheter, balloon, PTA	1	1	Both procedures require gentle angioplasty of new anastomosis.
SD171	guidewire bowl w-lid, sterile	1	1	For wire management and saline soak.
SD172	guidewire, cerebral (Bentson)		1	Primary access wire for sheath
SD173	guidewire, low profile (SpartaCore)	1	2	Wire needed for catheter and balloon delivery. Two for 386x2 since requires two treatment catheters (artery/vein)
SD176	guidewire, torque		1	For hydrophilic wire used in catheterization (386x2)
SD211	tubing, pressure injection line (angiography)		1	For power injector used in arteriography (386X2)
SF007	blade, surgical (Bard-Parker)	1	1	Skin knick to introduce sheath.
SF056	Detachable coil		1	Coil embolization is typical. Dialysis embolization typically is high flow, requiring a detachable coil first to secure location.
SF057	Non-detachable embolization coil		2	Two additional non-detachable coils are utilized once a secure coil is placed.

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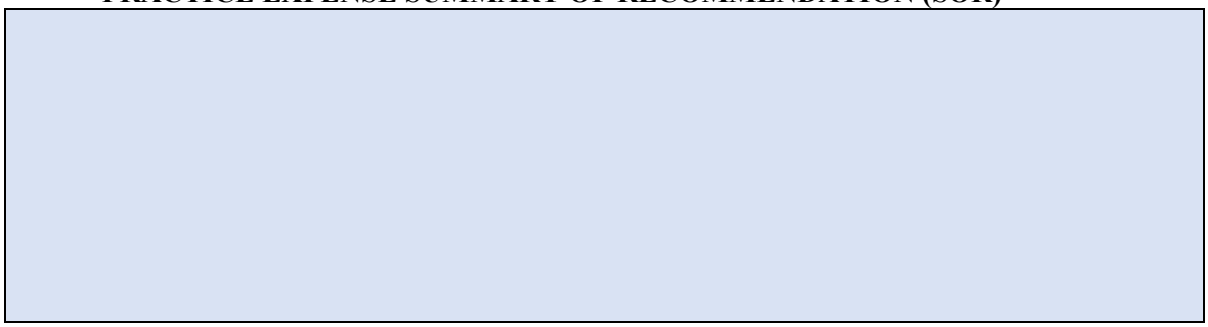
SG009	applicator, sponge-tipped	4	4	For sterile preparation with Betadine
SG035	dressing, 3in x 4in (Telfa, Release)		1	For wiping hydrophilic wire during procedure.
SG037	dressing, 4in x 4.75in (Tegaderm)	1	2	For operative site(s).
SG055	gauze, sterile 4in x 4in	6	12	For wiping Bentson and Spartacore wires and operative field during procedure. Two access sites for X2 code.
SG095	Hemostatic patch	1	2	For operative site(s).
SH039	heparin 1,000 units-ml inj	5	5	Intraoperative anticoagulation is recommended for both procedures.
SH047	lidocaine 1%-2% inj (Xylocaine)	10	20	Local anesthesia. Two access sites for X2 code.
SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	1	1	Saline Flush for the table
SJ088	swab, patient prep, 3.0 ml (chloraprep)	1	2	Sterile preparation
SM013	disinfectant, surface (Envirocide, Sanizide)	2	3	For cleaning of operative table, patient table, and US (386X1) as well as C-arm components (386X2)
SM021	sanitizing cloth-wipe (patient)	1	1	To clean arm of remaining Betadine.
	Wavelinq EndoAVF catheters		1	Procedure specific catheter kit for creating fistula
	Ellipsys Vascular Access Catheter	1		Procedure specific catheter kit for creating fistula

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, 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)



	A	B	C	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**						**REFERENCE CODE**		**RECOMMENDED**		**RECOMMENDED**	
2							**36905**		**368X1**		**368X2**	
3		***RUC Collaboration Website***							Percutaneous		Percutaneous	
4	**Clinical Activity Code**	**Meeting Date: 1/2022 Revision Date (if applicable): Tab: 06 Specialty: SIR, SVS, RPA, ACR**	**Standards/ Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Percutaneous transluminal mechanical thrombectomy and/or		arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and		arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and	
5		**LOCATION**					**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**					**$ -**	**$ -**	**$ 6,001.00**	**$ -**	**$ 7,007.29**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**		L037D			**70.0**	**9.0**	**66.0**	**12.0**	**70.0**	**12.0**
9				L041A			**140.0**	**0.0**	**117.0**	**0.0**	**143.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D			**9.0**	**6.0**	**9.0**	**6.0**	**9.0**	**6.0**
11				L041A			**4.0**	**0.0**	**4.0**	**0.0**	**4.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D			**58.0**	**0.0**	**54.0**	**3.0**	**58.0**	**3.0**
13				L041A			**136.0**	**0.0**	**113.0**	**0.0**	**139.0**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
15		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**					**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
16		**PRE-SERVICE PERIOD**										
17		**Start: Following visit when decision for surgery/procedure made**										
18	CA001			L037D			3		3		3	
19	CA002			L037D			3	3	3	3	3	3
20	CA003			L037D				3		3		3
21	CA004											
22	CA005			L037D			3		3		3	
23	CA006			L041A			2		2		2	
24	CA007			L041A			2		2		2	
25	CA008											
26												
29		*Other activity: please include short*										
32		**End: When patient enters office/facility for surgery/procedure**										
33		**SERVICE PERIOD**										
34		**Start: When patient enters office/facility for surgery/procedure:**										
35		**Pre-Service (of service period)**										
36	CA009			L037D			3		3		3	
37	CA010			L037D			5		5		5	
38	CA011			L037D			5		5		5	
39	CA012											
40	CA013			L037D			2		2		2	
41	CA014											
42	CA015											
43	CA016			L037D			3		3		3	
44	CA017											
45												
48		*Other activity: please include short*										
51		**Intra-service (of service period)**										
52	CA018			L041A			75		60		75	
53	CA019											
54	CA020			L041A			56		45		56	
55	CA020			L037D			19		15		19	
56												
57		*Other activity: please include short*										
60		**Post-Service (of service period)**										
61	CA022			L037D			15		15		15	
62	CA023											
63	CA024			L037D			3					
64	CA024			L041A					3		3	
65	CA025											
66	CA026											
67	CA027											
68	CA028											
69	CA029			L037D			3		3		3	
70	CA030			L041A			2		2		2	
71	CA031			L041A			2		2		2	
72	CA032			L041A			1		1		1	
73	CA033											
74	CA034											
75	CA035			L037D					3	3	3	3
76	CA036						**n/a**		**n/a**		**n/a**	
77												
80		*Other activity: please include short*										
83		**End: Patient leaves office/facility**										
84		**POST-SERVICE PERIOD**										
85		**Start: Patient leaves office/facility**										
86	CA037			L037D			3	3	3	3	3	3
87	CA038											
88		***Office visits: List Number and***		**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes		16								
90		99212 27 minutes		27								
91		99213 36 minutes		36								
92		99214 53 minutes		53								
93		99215 63 minutes		63								
94	CA039			L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95				L037D								
98		*Other activity: please include short*		L037D								
99		*Other activity: please include short*		L037D								
100		*Other activity: please include short*		L037D								
101		**End: with last office visit before**										
102	**Supply Code**	**MEDICAL SUPPLIES**		**PRICE**	**UNIT**							
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**					**$ -**	**$ -**	**$ 6,000.00**	**$ -**	**$ 7,000.00**	**$ -**
104	SA048						1		1		1	
105	SA015						1					
106	SA016						1		1		2	
107	SA019						1		1		1	
108	SA067								1		1	
109	SB001						3		3		3	
110	SB008						1		1		1	
111	SB009								1		1	
112	SB014						1		1		1	
113	SB019						2		2		2	
114	SB022						1		1		1	
115	SB024						2		2		2	
116	SB028						2		2		2	
117	SB033						1		2		2	
118	SB034						2		2		2	
119	SB039						3		3		3	
120	SB044						1		1		1	
121	SC010						1		1		1	

	A	B	C	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**						**REFERENCE CODE**		**RECOMMENDED**		**RECOMMENDED**	
2							**36905**		**368X1**		**368X2**	
3		***RUC Collaboration Website***					Percutaneous transluminal mechanical thrombectomy and/or		Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and		Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and	
4	**Clinical Activity Code**	**Meeting Date: 1/2022 Revision Date (if applicable): Tab: 06 Specialty: SIR, SVS, RPA, ACR**	**Standards/ Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**					**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**					**$ -**	**$ -**	**$ 6,001.00**	**$ -**	**$ 7,007.29**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**		L037D			**70.0**	**9.0**	**66.0**	**12.0**	**70.0**	**12.0**
9				L041A			**140.0**	**0.0**	**117.0**	**0.0**	**143.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D			**9.0**	**6.0**	**9.0**	**6.0**	**9.0**	**6.0**
11				L041A			**4.0**	**0.0**	**4.0**	**0.0**	**4.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D			**58.0**	**0.0**	**54.0**	**3.0**	**58.0**	**3.0**
13				L041A			**136.0**	**0.0**	**113.0**	**0.0**	**139.0**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
122	SC051						2				2	
123	SC053						2		2		2	
124	SC057						1					
125	SC058						2		1		1	
126	SD089						1				1	
127	SD136						1		1		2	
128	SD147						1				1	
129	SD149						1		1		1	
130	SD152						1		1		1	
131	SD171						1		1		1	
132	SD172						1				1	
133	SD252						1					
134	SD173								1		2	
135	SD176										1	
136	SD211										1	
137	SF007						1		1		1	
138	SF036						1					
139	SF056										1	
140	SF057										2	
141	SG009						4		4		4	
142	SG035										1	
143	SG037								1		2	
144	SG055						6		6		12	
145	SG079						12					
146	SG095						2		1		2	
147	SH039						5		5		5	
148	SH047						10		10		20	
149	SH065						2					
150	SH069						1		1		1	
151	SJ088						2		1		2	
152	SM013						1		2		3	
153	SM021						1		1		1	
154	**NEW**	Wavelinq EndoAVF catheters		7000							1	
155	**NEW**	Ellipsys Vascular Access Catheter		6000					1			
156		*Other supply item: to add a new supply item please include the*	*Other supply*									
157												
158	**Equipment Code**	**EQUIPMENT**		**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
159		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**					**$ -**	**$ -**	**$ 1.00**	**$ -**	**$ 7.29**	**$ -**
160	EL011				Highly Technical		85				83	
161	ED050				PACS		104		89		104	
162	EF027				Default		60		84		99	
163	EF019				Default		60		84		99	
164	EQ011				Default		60		84		99	
165	EQ032				Default		60		84		99	
166	EL016				Highly Technical				68			
167	**NEW**	Wavelinq EndoAVF generator		18580	Default	0.073617606					99	
168	**NEW**	Ellipsys EndoAVF generator		3000	Default	0.011886589			84			
169		*Other equipment item: to add a new equipment item please include the name of the item consistent with the*	*Other equipment item: to*									
170												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2022

Energy Based Repair of Nasal Valve Collapse – Tab 7

In September 2021, the CPT Editorial Panel created Category I code 37X01 to report *Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling* which is currently reported with an unlisted code. For the January 2022 RUC meeting, both CPT code 37X01 and family code 30468 *Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)* were reviewed.

30468 *Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)*
The RUC reviewed the specialty society request to affirm the recent RUC valuations for CPT code 30468. Although this code was identified with the new code to be surveyed, the specialty society elected not to survey because the code was recently surveyed and valued by the RUC in January 2020. Additionally, there are no changes to the code descriptor or related work to perform this service. **The RUC recommends affirming a work RVU of 2.80 for CPT code 30468.**

37X01 *Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling*
The RUC reviewed the survey results from 82 otolaryngologists and recommends a work RVU of 2.70 based on a direct work RVU crosswalk to CPT code 31295 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa* (work RVU = 2.70, 20 minutes intra-service time, and 56 minutes total time). This valuation maintains relativity in comparison to family code 30468 as well as other 000-day global otolaryngology codes within the Medicare Physician Payment Schedule (MFS). The RUC recommends 17 minutes of pre-service evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, and 10 minutes immediate post-service time. The post service package was reduced to as to not exceed survey median data.

The original CPT coding change application (CCA) brought forth by industry stated this service was primarily performed in the hospital outpatient setting. After discussion, the RUC determined that this service is typically performed in an office setting under local anesthesia, which differs from the CCA, but was the consensus of those who routinely perform the service. Based on this determination, and to maintain relativity, the RUC determined that the survey 25th percentile work RVU of 2.80 was not appropriate because it is the same value as CPT code 30468, which requires 20 minutes more total time. In addition, CPT code 30468 is typically performed in the operating room, and CPT code 37X01 is typically performed in an office setting. While the intra-service time is the same for both procedures, there is a noticeable difference in intensity between these two services. The RUC noted that the work required for 30468 is less intense and more straightforward, albeit being performed in the operating room and requiring more total time. Though 37X01 requires less total time, the intra-service time requires more meticulous care to perform the procedure using the radiofrequency handpiece to determine the appropriate amount of tissue ablation. For this reason, the RUC determined that the survey 25th percentile for code 37X01 did not maintain relativity, and a direct crosswalk to CPT code 31295 with 2.70 work RVUs, was more appropriate given the similarities in site of service, total time, and intensity within 20 minutes of intra-service work.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 30140 *Submucous resection inferior turbinate, partial or complete, any method* (work RVU = 3.00, 20 minutes intra-service time and 78 minutes total time) and 31238 *Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage* (work RVU = 2.74, 25 minutes intra-service time and 53 minutes total time) which demonstrate appropriate comparisons to determine relativity. Most of the survey respondents that selected these key reference codes identified the surveyed code as having either identical or somewhat more intensity and complexity. It is important to note that 30140 is typically performed in the hospital outpatient setting and notably requires more total time. The second key reference service, code 31238, is typically performed in the physician office and has identical total time to the survey code suggesting that the codes should be valued similarly. For additional support, the RUC did a database search of 000-day global codes with intra-service time between 20 and 25 minutes, intensity between 0.08 and 0.12, total time between 40 and 80 minutes, and work RVU between 2.40 and 2.80 and found that the survey code falls appropriately within the middle to upper range of the list. The RUC concluded that the value of CPT code 37X01 should be 2.70, which is below the survey 25th percentile and maintains relativity within the family and MFS. **The RUC recommends a work RVU of 2.70 for CPT code 37X01.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made modifications to the pre-service clinical staff time to both CPT codes 30468 and 37X01 in accordance with current standards. Specifically, the Subcommittee discussed whether the requested inputs were sufficient or whether there was an oversight in valuing the PE for CPT code 30468 previously and whether all time for "extensive use of clinical staff" standards when applied to 000-day global periods, should be included for both codes. The specialty recommended that the standard time for phone calls be included in CA005 *Complete pre-procedure phone calls and prescription*, but not the standard time for CA002 *Coordinate pre-surgery services (including test results)*, as there was not clinical rationale to include it. The PE subcommittee agreed and voted to approve compelling evidence based on a prior error in valuation. Thus, three additional minutes were included for CA005 for both codes in the office and facility settings.

The PE Subcommittee also discussed the new supply and equipment inputs recommended for CPT code 37X01. The new supply item, the *VivAer Stylus*, is the radio frequency wand needed to deliver the radio frequency to the nasal valve. It is used for only one patient at a time and disposed of after use. The new equipment item, *Console Set*, is the console required to generate the radiofrequency that is delivered, via the wand, to the nasal valve. The PE Subcommittee noted the high cost of the new supply input and reiterates its previous request to CMS:

> The RUC calls on CMS to separately identify and pay for high-cost disposable supplies. The RUC makes this recommendation to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies, but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty. If high costs supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool. **The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Respiratory System **Nose** **Repair**				
30465		*Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)* *(30465 excludes obtaining graft. For graft procedure, see 15769, 20900, 20902, 20910, 20912, 20920, 20922, 20924, 21210, 21235)* *(30465 is used to report a bilateral procedure. For unilateral procedure, use modifier 52)* (Do not report 30465 in conjunction with 30468, 37X01, when performed on the ipsilateral side) *(For repair of nasal vestibular lateral wall collapse with subcutaneous/submucosal lateral wall implant[s], use 30468)* (For repair of nasal valve collapse with low energy, temperature-controlled [ie radiofrequency] subcutaneous/submucosal remodeling, use 37X01)		
(f)30468	X1	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) (30468 is used to report a bilateral procedure. For unilateral procedure, use modifier 52) (Do not report 30468 in conjunction with 30465, 37X01, when performed on the ipsilateral side) (For repair of nasal vestibular stenosis [eg, spreader grafting, lateral nasal wall reconstruction], use 30465) (For repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant [eg, ~~radiofrequency remodeling,~~ lateral wall suspension, or stenting without graft or subcutaneous/submucosal implant], use 30999)	000	2.80 (Affirm January 2020 RUC Recommendation)

●37X01	X2	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling (37X01 is used to report a bilateral procedure. For unilateral procedure, use modifier 52) (Do not report 37X01 in conjunction with 30465, 30468, when performed on the ipsilateral side) (For repair of nasal vestibular stenosis [eg, spreader grafting, lateral nasal wall reconstruction], use 30465) (For repair of nasal vestibular lateral wall collapse with subcutaneous/submucosal lateral wall implant[s], use 30468) (For repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant [eg, lateral wall suspension, or stenting without graft or subcutaneous/submucosal implant], use 30999)	000	2.70

AMERICAN ACADEMY OF
OTOLARYNGOLOGY-
HEAD AND NECK SURGERY®

December 11, 2021

Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

RE: Request for Reaffirmation of Values for CPT 30468

Dear Dr. Silva,

On behalf of the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), we would like to respectfully request that the RUC reaffirm the existing values for CPT 30468 *Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)* as part of its review of Tab 7 – Energy Based Repair of Nasal Valve.

As you may be aware, the other code in this tab, 30XX1 *Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling*, was approved by the CPT Editorial Panel at the October 2021. CPT 30468 is also a newer code, valued in January of 2020. When the RUC LOI for the January 2022 meeting was issued, both CPT codes were indicated. However, due to the recent review of 30468 by the RUC, we are respectfully requesting that the RUC reaffirm the January 2020 values recommended for this code, which were approved by CMS through rulemaking.

The values we are requesting be reaffirmed for 30468 are captured in both our PE and work recommendations for Tab 7. For ease of review, we are also listing them here: CPT 30468 *Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s);* 2.80 work RVUs, 38 minutes pre time, 20 minutes intra time, and 15 minutes post time, for a total time of 73 minutes and an IWPUT of 0.0878.

Thank you in advance for your consideration of this request. If you have any questions, please contact Jenna Minton, AAO-HNS RUC staff, at jenna@proactivestrategies.net or 517.927.8696.

Sincerely,

T: 1-703-836-4444
F: 1-703-683-5100
W: www.entnet.org
A: 1650 Diagonal Road, Alexandria, VA 22314

R. Peter Manes, MD
AAO-HNS RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37X01 Tracking Number X2 Original Specialty Recommended RVU: **2.70**
Presented Recommended RVU: **2.70**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **2.70**

CPT Descriptor: Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with chronic bilateral nasal airway obstruction that affects breathing and disturbs sleep. The patient is unresponsive to medical therapy and has nasal valve collapse on examination. The patient is referred for nasal valve collapse repair with low energy, temperature controlled subcutaneous remodeling with a radiofrequency device.

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: Meet with the patient and family to describe and discuss in detail the planned procedure. Review and update the patient's medical history. Perform a current physical examination. Reconcile medications and allergies. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Review and obtain informed consent. Confirm planned site to apply radiofrequency technology. Provide a detailed description of the postoperative changes to the treated site and the expected dynamic changes in cosmesis as the wound matures. Examine and mark the nasal anatomy as well as the area of maximum lateral wall collapse during inspiration to identify the target treatment site. Evaluate the area of maximum collapse using the modified Cottle maneuver. Verify availability of all required instruments and supplies. Perform a time-out with the entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. Position the patient. Wash hands and don proper gloves, gown, and personal protective equipment. Drape the patient. Apply topical decongestant and anesthetic sprays to the nostrils, followed by a wait-time for them to take effect. Inject the ablation sites with local anesthetic very slowly, taking care not to expand the lateral nasal sidewall tissue, inject intravascularly, or create a hematoma from the angular artery in this location.

Description of Intra-Service Work: The radiofrequency handpiece is introduced into the caudal border of the upper lateral cartilage, and radiofrequency treatment is applied in three adjacent non-overlapping areas. The treatments are performed in both an active period and a cool-down period. Meticulous care is taken to perform this in a non-overlapping fashion. Hemostasis is carefully monitored and maintained during the procedure. The same procedure is then repeated on the opposite side.

Description of Post-Service Work: Monitor the patient for adequate hemostasis. Clean the prepared areas of the surgical sites. Dictate a procedure report. Reconcile discharge medications. Review the prescription drug monitoring database. Write postoperative orders, medications, and instructions. Talk with the family and patient regarding the procedure and findings. Reiterate convalescence instructions, precautions, follow-up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD; Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	37X01					
Sample Size:	4089	**Resp N:**	82			
Description of Sample:	Targeted Random - Survey sent to AAO-HNS members with specialty designatons of general, rhinology, or facial plastics in membership database.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**6.00**	15.00	100.00
Survey RVW:	1.15	2.80	**3.00**	3.50	17.00
Pre-Service Evaluation Time:			**21.00**		
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	100.00

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)

6-NF Proc w local/topical anes care req wait time

CPT Code:	37X01	**Recommended Physician Work RVU: 2.70**		
		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:		**1.00**	**1.00**	**0.00**
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)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**21.00**	**-11.00**

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
30140	000	3.00	**RUC Time**

CPT Descriptor Submucous resection inferior turbinate, partial or complete, any method

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31238	000	2.74	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage

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
15002	000	3.65	**RUC Time**	24,066

CPT Descriptor 1 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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.53	**RUC Time**	52,315

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
31295	000	2.70	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa

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: 37 **% of respondents:** 45.1 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 17.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 37X01	Top Key Reference CPT Code: 30140	2nd Key Reference CPT Code: **31238**
Median Pre-Service Time	23.00	43.00	18.00
Median Intra-Service Time	20.00	20.00	25.00
Median Immediate Post-service Time	10.00	15.00	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	**53.00**	**78.00**	**53.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	46%	46%	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	0%	46%	54%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	54%	38%

Physical effort required	8%	72%	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	8%	46%	46%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	21%	36%	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	7%	21%	72%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	36%	43%	21%
Physical effort required	28%	43%	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	28%	36%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, Aerin Medical brought forward a Code Change Application requesting a new CPT code to report repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal

remodeling. The panel approved this request and created CPT code 37X01. This code is now being presented to the RUC for physician work and practice expense valuation. We are also presenting the related code 30468 Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) which was initially valued in January of 2020 by the RUC, for reaffirmation. Please see the submitted letter requesting the RUC reaffirm the RUC / CMS approved values for that code.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 4089 members from the AAO-HNS of those with sub-specialty designations of general otolaryngology, rhinology or facial plastics.

Key Reference Codes

The first KRS selected was CPT 30140 Submucous resection inferior turbinate, partial or complete, any method valued at 3.00 RVUs with a pre time of 43 / intra time of 20 / post time of 15, totaling 78 minutes. 37 respondents selected this as their primary KRS.

The second KRS selected was CPT 31238 Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage valued at 2.74 RVUs with a pre time of 18 / intra time of 25 / post time of 10, totaling 53 minutes. 14 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU **2.70 and 20 minutes of intra service time**, based on a crosswalk to CPT 31295. Our expert panel felt this value which was close to our survey's 25th percentile, maintains relativity with 30468 and fits well related to other 000 otolaryngology codes within the fee schedule.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 6 Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect

This service is typically performed in the physician office setting. We acknowledge that the CCA indicated the typical site of services was hospital outpatient, however, the CCA (as referenced above) was submitted by Aerin medical and not our specialty. Our expert panel, therefore, disagrees with the CCAs assignment of hospital outpatient as the typical site of service and is correcting that with this recommendation for pre and post packages utilized in the physician office setting under local/topical anesthesia care.

Evaluation Time – We are recommending 17 minutes of evaluation time which less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 1 minutes of positioning time which is less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 5 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 23 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 7B Local Anesthesia/ Complex Procedure

Recommended time has been reduced to 10 minutes which is a decrease of 20 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 10 minutes, taking the lesser of surveyed time or the pre-service package time.***

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	Work RVU	IWPUT	Pre Pkg	Pre Eval	Pre Posit	Pre SDW	Intra	Post	Total Time	Most Recent RUC Review	Top_Specialty
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	000	2.60	0.1022	6	17	1.0	5.0	20	5	48	2017-01	OTOLARYNGOLOGY
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	000	2.61	0.0783	3	25	3.0	10.0	20	15	73	2017-01	OTOLARYNGOLOGY
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	000	2.67	0.0956	1b	14	3.0	5.0	20	15	57	2013-01	GASTROENTEROLOGY
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	000	2.70	0.0983	6	15	1.0	5.0	20	15	56	2017-01	OTOLARYNGOLOGY
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)	000	2.81	0.1071	2b	15	3.0	5.0	20	10	53	2013-10	GASTROENTEROLOGY
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	000	2.91	0.1076	1b	14	3.0	5.0	20	15	57	2013-01	GASTROENTEROLOGY
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	000	2.97	0.1151	1b	11	3.0	5.0	20	14	53	2013-01	GASTROENTEROLOGY
30140	Submucous resection inferior turbinate, partial or complete, any method	000	3.00	0.0922	3	30	3.0	10.0	20	15	78	2016-10	OTOLARYNGOLOGY
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral	000	3.01	0.1121	6A	20	1.0	9.0	20	10	60	2015-10	OTOLARYNGOLOGY
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	000	3.47	0.1401	2b	15	3.0	5.0	20	10	53	2013-04	GASTROENTEROLOGY

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	000	3.50	0.0925	4	40	10.0	10.0	20	20	100	2011-04	GENERAL SURGERY
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	000	3.50	0.0982	4	40	5.0	10.0	20	20	95	2015-04	OTOLARYNGOLOGY
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	000	3.65	0.0868		45	15.0	15.0	20	20	115	2006-04	PLASTIC AND RECONSTRUCTIVE SURGERY

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) 30999

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 Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on utilization data provided by Aerin medical for years 2018-2021 and assumes an increase in 2022 commensurate with the prior four years.

Specialty Otolaryngology Frequency 15000 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? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the information provided above to estimate national volume and attributes 1/3 of the national volume for this service to Medicare aged patients.

Specialty Otolaryngology Frequency 5000 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:
Minor procedure

BETOS Sub-classification Level II:
Skin

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. 30140

SS Rec Summary

ISSUE: Energy Based Repair of Nasal Valve Collapse (30468, 37X01)

TAB: 7

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	30140	000	Submucous resection inferior turbinate, partial or complete, any method	2016	37	0.092	0.038			3.00			78	30	3	10			20			15					
2nd REF	31238	000	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	2013	14	0.087	0.052			2.74			53	12	1	5			25			10					
CURRENT	NEW	000											0														
SVY	37X01	000	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling		82	0.108	0.049	1.15	2.80	3.00	3.50	17.00	61	21	5	5	1	15	20	30	100	10	0	2	6	15	100
SVY w/ exp	37X01	000			65	0.109	0.047	1.15	3.00	3.05	3.50	17.00	65	20	5	10	3	15	20	30	100	10	1	5	10	20	100
SVY w/out exp	37X01	000			17	0.108	0.049	1.15	2.25	3.00	3.24	5.00	61	25	4	5	1	15	20	30	60	7	0	0	0	0	0
CROSSWALK	31295	000	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa			0.098	0.048			2.70			56	15	1	5			20			15					
REC	37X01	000	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling			0.102	0.051			2.70			53	17	1	5			20			10					

Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	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
CURRENT	30468	000	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	2019		0.088	0.038			2.80			73	25	3	10			20			15					
AFFIRM	30468	000	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	2019		0.088	0.038			2.80			73	25	3	10			20			15					

FACILITY DIRECT PE INPUTS

CPT CODE(S): 30468, 37X01
SPECIALTY SOCIETY(IES): AAO-HNS
PRESENTER(S): R. Peter Manes, MD & Ari Wirtschafter, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	000
37X01	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	000

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
30468	A 50-year-old male presents with chronic nasal obstruction affecting his activity level and sleep despite medical management. Examination reveals nasal valve collapse on normal inspiration relieved by Cottle maneuver. Patient undergoes bilateral absorbable nasal implants to support the upper and lower lateral nasal cartilages.
37X01	A 50-year-old male presents with chronic bilateral nasal airway obstruction that affects breathing and disturbs sleep. The patient is unresponsive to medical therapy and has nasal valve collapse on examination. The patient is referred for nasal valve collapse repair with low energy, temperature controlled subcutaneous remodeling with a radiofrequency device.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, rhinology and facial plastics. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current inputs for 30468 were utilized for reaffirming those inputs at this meeting. Code 30140 was used as well as for the reference code for new code 37X01

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 the *Billed Together* tab in the RUC Database)

   No.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are recommending clinical staff pre-time above the standard for 000 globals of 0 minutes. This is consistent with the PE approved in the January 2017 for the FESS family of codes and October 2016 meeting for CPT 30140 Resection of Inferior Turbinate. The rationale for this time is that non-facility staff are essential to completing diagnostic and referral forms and providing education and consent to the patient prior to the procedure. During the presentation of PE for these codes, the PE subcommittee discussed whether the requested inputs were sufficient or whether there was an oversight in valuing the PE for 30468 previously. Specifically, they questioned whether all time for "extensive use of clinical staff" standards when applied to 000 globals should be included for both of these codes. AAO-HNS recommended that the standard time for phone calls be included, but not the standard time for coordinating pre surgery services, as there was not clinical rationale to include it. The PE subcommittee agreed, and voted to approve compelling evidence based on prior error in valuation. Thus, three additional minutes were include for pre-surgery phone calls for both codes in the office and facility settings.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A Facility	

   b. Service period (includes pre, intra and post):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A Facility

c. Post-service period:

N/A Facility

9. 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*):

N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

15. 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

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

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

19. 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:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, 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): 30468, 37X01**

SPECIALTY SOCIETY(IES): AAO-HNS

PRESENTER(S): R. Peter Manes, MD & Ari Wirtschafter, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	000
37X01	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
30468	A 50-year-old male presents with chronic nasal obstruction affecting his activity level and sleep despite medical management. Examination reveals nasal valve collapse on normal inspiration relieved by Cottle maneuver. Patient undergoes bilateral absorbable nasal implants to support the upper and lower lateral nasal cartilages.
37X01	A 50-year-old male presents with chronic bilateral nasal airway obstruction that affects breathing and disturbs sleep. The patient is unresponsive to medical therapy and has nasal valve collapse on examination. The patient is referred for nasal valve collapse repair with low energy, temperature controlled subcutaneous remodeling with a radiofrequency device.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, rhinology and facial plastics. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current inputs for 30468 were utilized for reaffirming those inputs at this meeting. Reference code 30140 was used as well as for the reference code for new code 37X01

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 the *Billed Together* tab in the RUC Database)

   No.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

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 the *Billed Together* tab in the RUC Database)

Otolaryngology is the dominant specialty for all sites of service. There is no data in the database at present due to these being new codes.

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are recommending clinical staff pre-time above the standard for 000 globals of 0 minutes. This is consistent with the PE approved in the January 2017 for the FESS family of codes and October 2016 meeting for CPT 30140 Resection of Inferior Turbinate. The rationale for this time is that non-facility staff are essential to completing diagnostic and referral forms and providing education and consent to the patient prior to the procedure. During the presentation of PE for these codes, the PE subcommittee discussed whether the requested inputs were sufficient or whether there was an oversight in valuing the PE for 30468 previously. Specifically, they questioned whether all time for "extensive use of clinical staff" standards when applied to 000 globals should be included for both of these codes. AAO-HNS recommended that the standard time for phone calls be included, but not the standard time for coordinating pre surgery services, as there was not clinical rationale to include it. The PE subcommittee agreed, and voted to approve compelling evidence based on prior error in valuation. Thus, three additional minutes were included for pre-surgery phone calls for both codes in the office and facility settings.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

7. 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)

8. 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

9. 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:

Obtain vital signs (3-5) - *heart rate, blood pressure, temperature, oxygen saturation*

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Complete pre-service diagnostic and referral forms Provide pre-service education/obtain consent Conduct pre surgery phone calls

    b. Service period (includes pre, intra and post):

Greet patient, provide gowning, ensure appropriate medical records are available Obtain vital signs (3-5) - *heart rate, blood pressure, temperature, oxygen saturation* Prepare room, equipment and supplies Prepare, set-up and start IV, initial positioning and monitoring of patient Sedate/apply anesthesia Assist physician or other qualified healthcare professional---directly related to physician work time (100%) Monitor patient following procedure/service, multitasking 1:4 Clean room/equipment by clinical staff Clean surgical instrument package - Check dressings, catheters, wounds Review home care instructions, coordinate visits/prescriptions - *educate on what patient needs to do at home - activity, meds / confirm pharmacy, set up f/u appt.*

    c. Post-service period:

Conduct patient communications - *check in to see how the patient is doing.*

11. 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:*

Staff is there during the entirety of the procedure. They are directly involved in assisting throughout the procedure, handing off instruments to the physician, dabbing the treated area to avoid any collection of blood and acting to ease any anxiety the patient is experiencing through conversation and distraction techniques.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. 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

13. 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*):
    N/A

14. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    The radio frequency wand is needed to deliver the radio frequency to the nasal valve. It is used for only one patient at a time and disposed of after use.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    Yes, these are established packs SA045 and SA048

19. 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.

SA043	pack, cleaning, surgical instruments	12.61	pack
SA048	pack, minimum multi-specialty visit	5.02	pack

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:
    The console generates the radiofrequency that is delivered, via the wand, to the nasal valve.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

Estimated useful life is five years on this device.

22. 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

23. 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:

We selected "other formula" for line 134, Chair with headrest, reclining, exam. The reason for this is that it is the default formula with the monitoring time added to it. The patient is in this chair for the entire procedure (pre/intra/post) as well as the one hour of monitoring time. ENT offices do not have waiting rooms or stretchers for monitoring, so the patient remains in the exam chair during this time.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

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
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 30468**		**CPT Code 30468**		**30140**		**CPT Code 37X01**	
3		***RUC Collaboration Website***				Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)		Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)		Submucous resection inferior turbinate, partial or complete, any method		Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	
4	**Clinical Activity Code**	**Meeting Date: January 2022 Revision Date (if applicable): Tab: 7 Specialty: AAO-HNS**	**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**				**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,950.79**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**82.0**	**30.0**	**85.0**	**33.0**	**80.0**	**30.0**	**85.0**	**33.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**12.0**	**27.0**	**15.0**	**30.0**	**12.0**	**27.0**	**15.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**67.0**	**0.0**	**67.0**	**0.0**	**65.0**	**0.0**	**67.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
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		L037D			5	5	5	5	5	5	5	5
16	CA002		L037D				10	0	10		10	0	10
17	CA003		L037D				5		5		5		5
18	CA004		L037D			7	7	7	7	7	7	7	7
19	CA005		L037D					3	3			3	3
20	CA006		L037D										
21	CA007		L037D										
22	CA008		L037D										
23			L037D										
26		*Other activity: please include short clinical description here and type new*	L037D										
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		L037D			3		3		3		3	
34	CA010		L037D			5		5		5		5	
35	CA011		L037D										
36	CA012		L037D										
37	CA013		L037D			2		2		2		2	
38	CA014		L037D										
39	CA015		L037D										
40	CA016		L037D			2		2		2		2	
41	CA017		L037D			2		2		2		2	
42			L037D										
45		*Other activity: please include short clinical description here and type new*	L037D										
48		**Intra-service (of service period)**											
49	CA018		L037D			20		20		20		20	
50	CA019		L037D										
51	CA020		L037D										
52	CA021		L037D										
55			L037D										
56		*Other activity: please include short clinical description here and type new*	L037D										
59		**Post-Service (of service period)**											
60	CA022		L037D			15		15		15		15	
61	CA023		L037D										
62	CA024		L037D			3		3		3		3	
63	CA025		L037D										
64	CA026		L037D			10		10		10		10	
65	CA027		L037D										
66	CA028		L037D										
67	CA029		L037D			3		3		3		3	
68	CA030		L037D										
69	CA031		L037D										
70	CA032		L037D										
71	CA033		L037D										
72	CA034		L037D										
73	CA035		L037D			2		2				2	
74	CA036		L037D			n/a		n/a		n/a		n/a	
75			L037D										
78		*Other activity: please include short clinical description here and type new*	L037D										
81		**End: Patient leaves office/facility**											
82		**POST-SERVICE PERIOD**											
83		**Start: Patient leaves office/facility**											
84	CA037		L037D			3	3	3	3	3	3	3	3
85	CA038		L037D										
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**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,950.00**	**$ -**
102	SA043					1		1		1		1	
103	SA048					1		1				1	
104	SA133					1		1					
105	SB012					1		1				1	
106	SB019					4		4		4		4	
107	SB024					2		2		2		2	
108	SB027					2		2		2		2	
109	SB034					2		2		2		2	
110	SB046					1		1		1		1	

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 30468**		**CPT Code 30468**		**30140**		**CPT Code 37X01**	
3		***RUC Collaboration Website***				Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)		Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)		Submucous resection inferior turbinate, partial or complete, any method		Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	
4	**Clinical Activity Code**	**Meeting Date: January 2022 Revision Date (if applicable): Tab: 7 Specialty: AAO-HNS**	**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**				**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,950.79**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**82.0**	**30.0**	**85.0**	**33.0**	**80.0**	**30.0**	**85.0**	**33.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**12.0**	**27.0**	**15.0**	**30.0**	**12.0**	**27.0**	**15.0**	**30.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**67.0**	**0.0**	**67.0**	**0.0**	**65.0**	**0.0**	**67.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
111	SC029					2		2		2		2	
112	SC051					1		1		1		1	
113	SD009					1		1		1		1	
114	SD132					1		1		1		1	
115	SD214					1		1		1		1	
116	SF033									1			
117	SG031									2			
118	SG055					3		3		3		3	
119	SH047					5		5		5		5	
120	SH050					5		5		5		5	
121	SJ010									1			
122	SJ037					1		1		1		1	
123	SJ043					1		1				1	
124	SL464					1		1		1		1	
125	SM001					1		1		1		1	
126	NEW	VivAer Stylus	1950	unit								1	
127		*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.*											
129	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
130		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 0.79**	**$ -**
131	EQ234			Default		40		40		100		40	
132	EQ170			Default		40		40		100		40	
133	EF015			Default		40		40				40	
134	EQ137			Instrument Packs		44		44		104		44	
135	EF008			Other Formula		100		100		100		100	
136	EQ385			Default						100			
137	EQ384			Default						100			
138	EQ383			Instrument Packs						104			
139	NEW	Console Set	4995	Default	0.01979117							40	
140													
141		*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
Screen: Site of Service Anomaly – 2019

January 2022

Percutaneous Nephrolithotomy – Tab 8

In October 2019, CPT code 50081 was identified via the site of service anomaly screen because it is performed less than 50% of the time in the inpatient setting but includes inpatient hospital E/M services within the global period based on 2016-2018 Medicare claims data. The RUC recommended to survey for the January 2020 RUC meeting. 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 dilation", to describe the work more clearly in current practice. In September 2021, the CPT Editorial Panel revised CPT codes 50080 and 50081 to describe percutaneous nephrostolithotomy by removing "with or without dilation" nomenclature, to differentiate simple and complex services more clearly and to bundle the work of nephrostomy tube placement and image guidance, when performed. In January 2022, CPT codes 50080 and 50081 were surveyed for the RUC meeting. It is important to note that both codes 50080 and 50081 are currently Harvard-valued.

50080 ***Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones)***
The RUC reviewed the survey results from 276 urologists and recommends a work RVU of 13.50 based on a direct work RVU crosswalk to MPC code 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.50- and 90-minutes intra-service time, 255.5 minutes total time), which maintains relativity within the family and has identical intra-service time and similar intensity and total time. The RUC recommends 36 minutes of pre-service evaluation time, 3 minute positioning time, 10 minutes scrub/dress/wait time, 90 minutes intra-service time, and 40 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 office visits, and 244 minutes total time. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The RUC also noted that CPT Editorial Panel revised this code to newly bundle in the additional work of nephrostomy tube placement and image-guidance, when performed. Under the previous coding structure, these services were separately reported. In addition, the RUC noted that this code was last reviewed as part of the Harvard study, nearly 30 years ago, and this is the first time it is being valued by the RUC. The RUC recommendation accurately accounts for the site of service, decrease in post-service work, and subsequent decrease in total time from the current value and is appropriately lower than the survey 25th percentile given these changes. Additionally, the RUC discussed the time packages and designation as a difficult patient. It was the consensus that the patient is generally considered difficult due to multiple comorbidities (e.g., obesity, chronic kidney disease, hypertension, diabetes, etc.) which increases the complexity and the level of medical decision making. A patient can have a smaller stone but as the stone increases in size, it becomes an emergent issue that requires immediate intervention. There may be a current or developing infection of the renal collecting system due to the stone or surrounding peri-nephric tissues in addition to the increased possibility of infection, including urosepsis, post-procedure due to stone manipulation. Moreover, the intra-service intensity is quite high as the physician is

handling the scope the entire time and there is potential to perforate the surrounding arteries and blood vessels. It is also important to differentiate this procedure from a transurethral approach which is typically reserved for less complex cases with smaller stones. As the stone size increases, the complexity increases, and the patient becomes a candidate for this procedure.

For further support, the RUC compared CPT code 50080 to MPC code 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36, 90 minutes intra-service time and 248 minutes total time) and noted that this MPC code appropriately supports the survey code recommendation with identical intra-service time and similar value, total time, intensity, and post-service work. **Therefore, the RUC recommends a work RVU of 13.50 for CPT code 50080.**

50081 Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)
The RUC reviewed the survey results from 277 urologists and recommends a work RVU of 22.00 based on the survey 25th percentile which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3-minute positioning time, 10 minutes scrub/dress/wait time, 140 minutes intra-service time, and 44 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 office visits, and 302 minutes total time. Survey respondents indicated, and the RUC concurred, that an overnight stay and a same-day post-operative hospital visit are typical.

The RUC also noted that CPT Editorial Panel revised this code to newly bundle in the additional work of nephrostomy tube placement and image-guidance, when performed. Under the previous coding structure, these services were separately reported. In addition, the RUC noted that this code was last reviewed as part of the Harvard study, nearly 30 years ago, and this is the first time being valued by the RUC. Over the years, the physician work to perform this service has evolved and become more efficient, although much more intense given new approaches and technology. Therefore, any comparison to the intensity of the current valuation is unreliable, as the work is significantly different from the Harvard-valuation. Throughout the discussion of the code family, the RUC agreed that this procedure is performed on a difficult patient population. The urologists familiar with performing this procedure would describe a difficult patient as one with multiple comorbidities that have the potential to lead to complications. As discussed in the previous recommendation for CPT code 50080, there is considerable complexity that is added as the size of the stone increases. For this procedure, the patient becomes a candidate when the stone or stone(s) are greater than 2 cm, therefore adding a significant opportunity for possible complications such as infections and/or perforations of surrounding anatomy. The additional intensity and medical decision making far exceeds that of CPT code 50080 as there could be multiple stones in multiple locations and/or branching stones making the removal more anatomically difficult.

For additional support, the RUC compared CPT code 50081 to codes 58573 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU = 20.79, 130 minutes intra-service time and 281 minutes total time) and 92987 *Percutaneous balloon valvuloplasty; mitral* valve (work RVU = 23.38, 150 minutes intra-service time and 329 minutes total time) which appropriately bracket the survey code recommendation. The RUC concluded the survey was robust and the 25th percentile appropriately accounts for the physician work required to perform this service. **The RUC recommends a work RVU of 22.00 for CPT code 50081.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs.
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Urinary System **Kidney**				
~~Nephrolithotomy is the surgical removal of stones from the kidney, and pyelolithotomy is the surgical removal of stones from the renal pelvis. This section refers to the removal of stones from the kidney or renal pelvis from using a percutaneous antegrade approach. The work of b~~Breaking and removing stones is separate from the work of accessing the kidney (ie, 50040, 50432, 50433, 52334), accessing the kidney with dilation of the tract to a size large enough to accommodate an endoscope for used in an endourologic procedure (ie, 50437), or dilation of a previously established tract to a size large enough to accommodate an endoscope for used in an endourologic procedure (ie, 50436). These procedures include work for the antegrade removal of stones in the calyces, renal pelvis, and/or ureter along with the antegrade placement of catheters, stents, and tubes, but does not include work retrograde placement of catheters, stents, and tubes, performed in a retrograde manner.			
Incision				
Nephrolithotomy is the surgical removal of stones from the kidney, and pyelolithotomy is the surgical removal of stones from the renal pelvis. This section refers to the removal of stones from the kidney or renal pelvis ~~from~~ using a percutaneous antegrade approach. ~~The work of b~~Breaking and removing stones is separate from ~~the work of~~ accessing the kidney (ie, 50040, 50432, 50433, 52334), accessing the kidney with dilation of the tract ~~to a size large enough~~ to accommodate an endoscope ~~for~~ used in an endourologic procedure (ie, 50437), or dilation~~g~~ of a previously established tract to ~~a size large enough to~~ accommodate an endoscope ~~for~~ used in an endourologic procedure (ie, 50436). These procedures include ~~work for~~ the antegrade removal of stones in the calyces, renal pelvis, and/or ureter along with the antegrade placement of catheters, stents, and tubes, but do~~es~~ not include ~~work~~ retrograde placement of catheters, stents, and tubes~~, performed in a retrograde manner~~.			
Code 50080 describes nephrolithotomy or pyelolithotomy using a percutaneous antegrade approach using endoscopic instruments to break and remove kidney stones 2 cm or smaller.				
Code 50081 includes the elements of 50080, but is reported for stones larger than 2 cm, branching, stones in multiple locations, ureteral stones, or in patients with complicated anatomy.				
~~Codes 50080, 50081 do not include c~~Creation of percutaneous access or dilation~~ng~~ of the tract to ~~a large enough size to~~ accommodate ~~the~~ large endoscopic instruments used in ~~the~~ stone removal (50436, 50437) ~~procedure~~ are not included in 50080, 50081~~, as the work for performing those procedures should~~ and may be reported separately, if performed. Codes 50080, 50081 include placement of any stents or drainage catheters that remain indwelling after the procedure.				
Report ~~O~~one unit of 50080 or 50081 per side (ie, per kidney) regardless of the number of stones broken and/or removed or locations of the stones. ~~If 50080 is performed~~ For bilateral~~ly~~ procedure, report 50080 or 50081 ~~is performed bilaterally then append~~ with modifier 50.~~; if~~ When				

50080 is performed on one side and 50081 is performed on the ~~other~~ contralateral side, modifier ~~-~~50 is not applicable. ~~The additional work of p~~Placement~~ing~~ of additional accesses into the kidney, if needed, and ~~the work of removing~~ removal~~ing~~ of stones through other approach~~(es)~~ (eg, ~~such as~~ open or retrograde)~~, can~~ may be reported separately, if performed.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲50080	U1	Percutaneous nephrolithotomy~~nephrostolithotomy~~ or pyelolithotomy~~pyelostolithotomy~~, ~~with or without dilation, endoscopy,~~ lithotripsy~~, stenting, or~~ stone~~basket~~ extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones)	090	13.50
▲50081	U2	complex (eg, stone[s] > 2 cm, ~~or~~ branching stones, stones in multiple locations, ureter stones, complicated anatomy) ~~over 2 cm~~ (Report 50080, 50081 only once per side. For bilateral procedure, report 50080, 50081 with modifier 50) (Do not report 50080, 50081 in conjunction with 50430, 50431, 50433, 50434, 50435 if performed on the same side) ~~(For fluoroscopic guidance, use 76000)~~ ~~(Do not report 50080, 50081 in conjunction with 50436, 50437, when performed by the same physician or other qualified health care professional)~~ (For establishment of nephrostomy without nephrolithotomy ~~nephrostolithotomy~~, see 50040, 50432, 50433, 52334) (For dilation of an existing percutaneous access for endourologic procedure, use 50436) (For dilation of an existing percutaneous access for endourologic procedure with new access into the collecting system, use 50437; for	090	22.00

		additional new access into the kidney, use 50437 for each new access that is then dilated for endourologic procedure) (For removal of stone without lithotripsy, use 50561) (For cystoscopy with insertion of ureteral guidewire through kidney to establish a percutaneous nephrostomy, retrograde, use 52334)		

Introduction
Renal Pelvis Catheter Procedures
Other Introduction (Injection/Change/Removal) Procedures

#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;*

 # 50437 *including new access into the renal collecting system*

(For dilation of an existing percutaneous access for endourologic procedure with a new access into the collecting system, use 50437; for additional new access into the kidney, use 50437 for each new access that is then dilated for endourologic procedure)

(For nephrolithotomy ~~nephrostolithotomy~~, see 50080, 50081)

(For retrograde percutaneous nephrostomy, use 52334)

(For endoscopic surgery, see 50551-50561)

(Do not report 50436, 50437 in conjunction with ~~50080, 50081,~~ 50382, 50384, 50430, 50431, 50432, 50433, 52334, 74485)

Bladder
Transurethral Surgery
Ureter and Pelvis

52334 *Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde*

(For percutaneous nephrolithotomy ~~nephrostolithotomy~~, see 50080, 50081; for establishment of percutaneous nephrostomy, see 50432, 50433)

(For cystourethroscopy, with ureteroscopy and/or pyeloscopy, see 52351-52356)

(For cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves or obstructive hypertrophic mucosal folds, use 52400)

(Do not report 52334 in conjunction with 50437, 52000, 52351)

Diagnostic Radiology (Diagnostic Imaging)
Vascular Procedures
Transcatheter Procedures

75984 *Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation*

(For percutaneous replacement of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy [or other colonic] tube including fluoroscopic imaging guidance, see 49450-49452)

(To report exchange of a percutaneous nephrostomy catheter, use 50435)

(For percutaneous cholecystostomy, use 47490)

(For percutaneous biliary procedures, including radiological supervision and interpretation, see 47531- 47544)

(For percutaneous nephrolithotomy ~~nephrostolithotomy~~ or pyelolithotomy ~~pyelostolithotomy~~, see 50080, 50081)

(For removal and/or replacement of an internally dwelling ureteral stent via a transurethral approach, see 50385- 50386)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50080 Tracking Number U1 Original Specialty Recommended RVU: **16.00**
Presented Recommended RVU: **16.00**
Global Period: 090 Current Work RVU: **15.74** RUC Recommended RVU: **13.50**

CPT Descriptor: Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male with a 1.8 cm calculus in the lower pole of the kidney undergoes a percutaneous nephrolithotomy (initial access and dilation are reported separately).

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 96% , In the ASC 4%, 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 8% , Overnight stay-less than 24 hours 70% , Overnight stay-more than 24 hours 22%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 90%

Description of Pre-Service Work: The surgeon will review results of preadmission testing including laboratory tests and urologic imaging; review and update H&P; write orders for preoperative medications including antibiotics and prophylactic DVT medication, and meet with anesthesiologist, radiology technician and other qualified health care professionals to review planned procedure. The surgeon will also meet with patient and family to review the procedure and postoperative management, explain operative risks and benefits, and obtain informed consent. Required equipment, instruments and supplies are confirmed as available and operational. After induction of anesthesia in the supine position, the surgeon assists with repositioning the patient prone for the procedure; including padding of bony prominences, adjusting the head and extremities as needed, and positioning the equipment and instruments. The patient will be marked for incision and prepped and draped. The surgeon will scrub and gown and perform a surgical time out with operating surgical team.

Description of Intra-Service Work: A rigid nephroscope is inserted in through the previously placed Amplatz sheath and the stone is identified. The hand-held lithotripter is inserted through the nephroscope and the stone is fragmented as much as possible. Fragments are extracted with grasping forceps and/or suction. Once the limits of rigid nephroscopy have been reached (due to angulation) a flexible nephroscope is inserted to access calyces inaccessible with the rigid nephroscope. Calyceal stones are removed with a stone basket or fragmented with a laser and then the fragments are removed with a stone basket. Antegrade ureteroscopy is performed to ascertain there are no fragments is the ureter. The flexible ureteroscope is passed through the access sheath into the calyx and into the renal pelvis. The ureteropelvic junction is identified and the ureteroscope is passed through it into the ureter. The entire length of the ureter is assessed for injury from passage of guide wires/catheters. The ureteroscope is subsequently withdrawn. At the completion of the nephrolithotomy the nephroscope is removed. During the entire procedure the operating surgeon tracks the use of fluids and pressures in real time to ensure no fluid mismatch. The Amplatz sheath is removed. Fluoroscopic images are obtained over the ipsilateral lung to ascertain that there is no evidence of a pneumothorax or hydrothorax. A nephrostomy tube is place. A nephrostogram is performed to ascertain proper positioning of the nephrostomy tube.

Description of Post-Service Work: Immediate Postop work: Surgical drapes are removed, and the patient is returned to supine position. The surgeon waits for the anesthesiologist to awaken the patient. The patient is transferred from the operating table to a stretcher. The patient is accompanied to the recovery area, and assistance is provided in moving the

patient to the recovery area bed. The procedure and expected care are reviewed with the recovery room nursing staff. The procedure is discussed with the patient in the recovery room when awake. Procedure and outcome are discussed with family in waiting area. A brief operative note is written. A postoperative note is written in recovery room. An operative report is dictated, and a copy is sent to the referring physician(s). The patient is discharged from the recovery room. Patient-care orders are written for care of the nephrostomy tube, pain management, dietary restrictions, lab tests, and imaging. Floor care is discussed with nursing staff. The patient is seen the day of surgery. Their nephrostomy tube drainage is assessed for the degree of gross hematuria. The patient is assessed for bleeding for the incision around the nephrostomy tube. Pain control is assessed and appropriate orders to adjust pain medications and antispasmodics are written. Post-operative chest X-Ray as well as post-operative labs are reviewed. The operation is reviewed with the patient and expected course of recovery reviewed.

Postop Day 1 Facility: Interval chart notes are reviewed. Interval labs and imaging is reviewed. The surgeon examines the patient and nephrostomy tube. The need for DVT prophylaxis and beta blocker is assessed and ordered as required. The need for antibiotics and pain medication is assessed and ordered as required. Orders for patient activity and diet are written. Patient progress notes are charted. Patient and family questions are answered. Nursing and/or other staff questions are answered.
Postop Day 2 Facility Discharge Management: Interval chart notes are reviewed. The patient is examined. Patient and family questions are answered. Pain score is assessed. Home restrictions (e.g., diet, activity, bathing) are discussed with patient and family members. Education on nephrostomy tube care is reviewed... Medications are reconciled, and orders for discharge medications are written. All appropriate medical records are completed, including day-of-discharge progress notes, discharge summary, discharge instructions, and insurance forms.
Postop Office Visit 1: The patient is questioned about postoperative course, including query of fever, nausea, vomiting, pain, bleeding, and bladder function, and bowel function, shortness of breath, lower extremity edema, and neurologic dysfunction. The patient is examined. The nephrostomy tube is removed if appropriate. Lab results are reviewed and discussed with the patient. Voiding activity is thoroughly reviewed, with emphasis on completion of micturition, frequency, urgency, hematuria, nocturia, and dysuria. Defecatory function is reviewed. The patient is counseled regarding progression of activities and diet.

Postop Office Visit 2: The patient is questioned about postoperative course, including query of fever, nausea, vomiting, pain, bleeding, and bladder function, and bowel function, shortness of breath, lower extremity edema, and neurologic dysfunction. The patient is examined including nephrostomy tube site. Voiding activity is thoroughly reviewed, with emphasis on completion of micturition, frequency, urgency, hematuria, nocturia, and dysuria. Defecatory function is reviewed. The patient is counseled regarding progression of activities and diet. Pathology and lab results are reviewed and discussed with the patient. Stone prevention strategies are viewed in detail. Laboratory orders for metabolic evaluation are ordered. Imaging studies for future visit are ordered.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richards, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	50080					
Sample Size:	5000	**Resp N:**	276			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	200.00
Survey RVW:	1.00	16.00	**20.50**	23.00	42.30
Pre-Service Evaluation Time:			**36.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	70.00	**90.00**	120.00	240.00

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):	**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:	**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:	50080	**Recommended Physician Work RVU: 13.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**36.00**	**40.00**	**-4.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**20.00**	**-10.00**
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:	**40.00**	**33.00**	**7.00**

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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50250	090	22.22	**RUC Time**

CPT Descriptor Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55840	090	21.36	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing;

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
63047	090	15.37	**RUC Time**	101,838

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; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	10,340

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	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: 70 **% of respondents:** 25.3 **%**

Number of respondents who choose 2nd Key Reference Code: 54 **% of respondents:** 19.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 50080	Top Key Reference CPT Code: 50250	2nd Key Reference CPT Code: **55840**
Median Pre-Service Time	49.00	55.50	51.00
Median Intra-Service Time	90.00	145.00	180.00
Median Immediate Post-service Time	40.00	30.00	33.00
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	38.00	38.00
Median Office Visit Time	46.0	78.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	195.00	60.00
Median Total Time	**244.00**	**541.50**	**448.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	36%	53%	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	12%	42%	46%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	32%	62%
Physical effort required	5%	23%	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	12%	33%	55%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	59%	24%	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	17%	65%	19%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	19%	61%	20%
Physical effort required	13%	53%	24%

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%	57%	28%

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 AUA reviewed the survey results from 276 urologists and determined that the survey 25th percentile work RVU of 16.00 was appropriate given the physician work associated with the procedure. AUA's RUC advisors determined that the survey intra-service time of 90 minutes is appropriate for this procedure.

CPT code 50080 has never been valued by the RUC and is currently Harvard valued. Therefore, the AUA's advisors determined that it is appropriate to recommend a work RVU value slightly higher than the current work RVU value of 15.74 despite a reduction in total time and intra-service time given the previous flawed valuation methodology which likely also did not take into account factors such as a complex patient population and the intensity of the procedure. The society added 20 minutes of intra-service time associated with a 99232 subsequent hospital visit to the immediate post-service time per CMS' 23-hour stay outpatient surgical services with subsequent hospital visits policy. This procedure is typically performed in the outpatient setting but generally requires an overnight stay and subsequent hospital visit.

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) 50080

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 Urology 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? 9800
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization data extrapolated using National Health Expenditures breakdown of payer breakdown for hospital care.

Specialty Urology Frequency 9800 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? 2,750
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.

Specialty Urology Frequency 2750 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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 50080

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:50081 Tracking Number U2 Original Specialty Recommended RVU: **22.00**
Presented Recommended RVU: **22.00**
Global Period: 090 Current Work RVU: **23.50** RUC Recommended RVU: **22.00**

CPT Descriptor: Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male with a staghorn (branched) calculus filling the entire renal pelvis and most calyces undergoes a percutaneous nephrolithotomy (Initial access and dilation are reported separately).

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 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Overnight stay-less than 24 hours 52% , Overnight stay-more than 24 hours 46%

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 90%

Description of Pre-Service Work: The surgeon will review results of preadmission testing including laboratory tests and urologic imaging; review and update H&P; write orders for preoperative medications including antibiotics and prophylactic DVT medication, and meet with anesthesiologist, radiology technician and other qualified health care professionals to review planned procedure. The surgeon will also meet with patient and family to review the procedure and postoperative management, explain operative risks and benefits, and obtain informed consent. Required equipment, instruments and supplies are confirmed as available and operational. After induction of anesthesia in the supine position, the surgeon assists with repositioning the patient prone for the procedure; including padding of bony prominences, adjusting the head and extremities as needed, and positioning the equipment and instruments. The patient will be marked for incision and prepped and draped. The surgeon will scrub and gown and perform a surgical time out with operating surgical team.

Description of Intra-Service Work: A rigid nephroscope is inserted in through the previously placed sheath and the large stone is identified. The hand-held lithotripter is inserted through the nephroscope and the stone is fragmented as much as possible. Fragments are extracted with grasping forceps and/or suction. Once the limits of rigid nephroscopy have been reached (due to angulation) the additional nephrostomy access into the kidney is utilized in a similar fashion. Rigid nephroscopy of calyceal and remaining renal pelvis stone is again carried out. Once this is complete a flexible a nephroscope is inserted to access calyces inaccessible with the rigid nephroscope. Calyceal stones are removed with a stone basket or fragmented with a laser and then the fragments are removed with a stone basket. Antegrade ureteroscopy is performed to ascertain there are no fragments is the ureter. The flexible ureteroscope is passed through the access sheath into the calyx and into the renal pelvis. The ureteropelvic junction is identified and the ureteroscope is passed through it into the ureter. The entire length of the ureter is assessed for injury from passage of guide wires/catheters. The ureter is assessed for primary stones or stone fragments. Small fragments are removed with a stone basket. For larger stones a laser fiber is passed and the stone(s) are fragmented. Small fragments are irrigated down the length of the ureter or removed with a stone basket. Once the ureter is deemed to be free of stone fragments the ureteroscope is withdrawn. The ureteroscope is subsequently withdrawn. At the completion of the nephrolithotomy the nephroscope is removed. During the entire procedure the operating surgeon tracks the use of fluids and pressures a real time to ensure no fluid mismatch. The Amplatz sheath is removed. Fluoroscopic images are obtained over the ipsilateral lung to ascertain that there is no evidence of a

pneumothorax or hydrothorax. A nephrostomy tube is placed in each access. A nephrostogram is performed to ascertain proper positioning of the nephrostomy tube(s).

Description of Post-Service Work: Immediate Postop work: Surgical drapes are removed, and the patient is returned to supine position. The surgeon waits for the anesthesiologist to awaken the patient. The patient is transferred from the operating table to a stretcher. The patient is accompanied to the recovery area, and assistance is provided in moving the patient to the recovery area bed. The procedure and expected care are reviewed with the recovery room nursing staff. The procedure is discussed with the patient in the recovery room when awake. Procedure and outcome are discussed with family in waiting area. A brief operative note is written. A postoperative note is written in recovery room. An operative report is dictated, and a copy is sent to the referring physician(s). The patient is discharged from the recovery room. Patient-care orders are written for care of the nephrostomy tube, pain management, dietary restrictions, lab tests, and imaging. Floor care is discussed with nursing staff. The patient is the seen the day of surgery. Their nephrostomy tube drainage is assessed for the degree of gross hematuria. The patient is assessed for bleeding for the incision around the nephrostomy tube. Pain control is assessed and appropriate orders to adjust pain medications and antispasmodics are written. Post-operative chest X-Ray as well as post-operative labs are reviewed. The operation is reviewed with the patient and expected course of recovery reviewed.

Postop Day 1 Facility: Interval chart notes are reviewed. Interval labs and imaging is reviewed. The surgeon examines the patient and nephrostomy tube. The need for DVT prophylaxis and beta blocker is assessed and ordered as required. The need for antibiotics and pain medication is assessed and ordered as required. Orders for patient activity and diet are written. Patient progress notes are charted. Patient and family questions are answered. Nursing and/or other staff questions are answered.
Postop Day 2 Facility Discharge Management: Interval chart notes are reviewed. The patient is examined. Patient and family questions are answered. Pain score is assessed. Home restrictions (eg, diet, activity, bathing) are discussed with patient and family members. Education on nephrostomy tube care is reviewed. Medications are reconciled, and orders for discharge medications are written. All appropriate medical records are completed, including day-of-discharge progress notes, discharge summary, discharge instructions, and insurance forms.
Postop Office Visit 1: The patient is questioned about postoperative course, including query of fever, nausea, vomiting, pain, bleeding, bladder function, bowel function, shortness of breath, lower extremity edema, and neurologic dysfunction. The patient is examined. The nephrostomy tube is removed if appropriate. Lab results are reviewed and discussed with the patient. Voiding activity is thoroughly reviewed, with emphasis on completion of micturition, frequency, urgency, hematuria, nocturia, and dysuria. Defecatory function is reviewed. The patient is counseled regarding progression of activities and diet.

Postop Office Visit 2: The patient is questioned about postoperative course, including query of fever, nausea, vomiting, pain, bleeding, bladder function, bowel function, shortness of breath, lower extremity edema, and neurologic dysfunction. The patient is examined including nephrostomy tube site. Voiding activity is thoroughly reviewed, with emphasis on completion of micturition, frequency, urgency, hematuria, nocturia, and dysuria. Defecatory function is reviewed. The patient is counseled regarding progression of activities and diet. Pathology and lab results are reviewed and discussed with the patient. Stone prevention strategies are viewed in detail. Laboratory orders for metabolic evaluation are ordered. Imaging studies for future visit are ordered.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richards, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	50081					
Sample Size:	5000	**Resp N:**	277			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**6.00**	18.00	300.00
Survey RVW:	1.00	22.00	**25.00**	27.00	45.71
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**16.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	120.00	**140.00**	180.00	360.00

Immediate Post Service-Time:	**24.00**	
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)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	50081	**Recommended Physician Work RVU: 22.00**		
		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:		**10.00**	**20.00**	**-10.00**
Intra-Service Time:		**140.00**		

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:	**44.00**	**33.00**	**11.00**

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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50543	090	27.41	**RUC Time**

CPT Descriptor Laparoscopy, surgical; partial nephrectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50250	090	22.22	**RUC Time**

CPT Descriptor Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if 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
35301	090	21.16	**RUC Time**	35,904

CPT Descriptor 1 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34705	090	29.58	**RUC Time**	13,089

CPT Descriptor 2 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)

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: 78 **% of respondents:** 28.1 **%**

Number of respondents who choose 2nd Key Reference Code: 62 **% of respondents:** 22.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 50081	Top Key Reference CPT Code: 50543	2nd Key Reference CPT Code: **50250**
Median Pre-Service Time	53.00	60.00	55.50
Median Intra-Service Time	140.00	240.00	145.00
Median Immediate Post-service Time	44.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	80.00	195.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	46.0	109.00	78.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**302.00**	**557.00**	**541.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	1%	6%	38%	37%	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	14%	45%	41%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	48%	35%
Physical effort required	4%	31%	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	12%	45%	43%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	35%	44%	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%	51%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	28%	64%
Physical effort required	7%	23%	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	2%	45%	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.

The AUA reviewed the survey results from 277 urologists and determined that the survey 25th percentile work RVU of 22.00 is appropriate given the physician work associated with the procedure. The AUA's advisors noted that CPT code 50081 is Harvard valued and that this flawed methodology likely does not take into account variables such as a complex patient population or the intensity of the procedure. The society added 20 minutes of intra-service time associated with a 99232 subsequent hospital visit to the immediate post-service time per CMS' 23-hour stay outpatient surgical services with subsequent hospital visits policy. This procedure is typically performed in the outpatient setting but generally requires an overnight stay and subsequent hospital visit.

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) 50081

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 Urology 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? 22000
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 2019 Medicare utilization data extrapolated using National Health Expenditures breakdown of payer breakdown for hospital care.

Specialty Urology Frequency 22000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data

Specialty Urology Frequency 6000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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 50081

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: Percutaneous Nephrolithotomy
TAB: 8

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	50250	090	Ablation, open, 1 or more renal mass lesion(s), cryosurgical,	2005	33	0.064	0.041			22.22			541.5	17.5	20	18			145			30			1	2	3	1.0							2	2							
2nd REF	55840	090	Prostatectomy, retropubic radical, with or without nerve	2014	38	0.071	0.048			21.36			448	33	3	15			180			33				1	1	1.0						1	2							
CURRENT	50080	090	Percutaneous nephrostolithotomy or	N/A		0.072	0.044			15.74			359.5	41	0	25			117			41					2	1.0						2.5							
SVY	50080	090	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy,		276	0.152	0.065	1.00	16.00	20.50	23.00	42.30	315	36	15	10	2	70	90	120	240	20			1			1.0				1			2			0	2	5	10	200
CROSSWALK	15730	090	Midface flap (ie, zygomaticofacial flap) with	2017		0.100	0.053			13.50			255.5	40	3	15			90			17.5						0.5						1	3							
REC	50080	090	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy,			0.101	0.055			13.50			244	36	3	10			90			40						0.5						2								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	50543	090	Laparoscopy, surgical; partial nephrectomy	2002	44	0.070	0.049			27.41			557	60					240			30				1	2	1.0						1	3							
2nd REF	50250	090	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative	2005	33	0.064	0.041			22.22			541.5	17.5	20	18			145			30			1	2	3	1.0							2	2							
CURRENT	50081	090	Percutaneous nephrostolithotomy or pyelostolithotomy, with or	N/A		0.068	0.046			23.50			507.5	42		25			195			27					5	1.0						3.5							
SVY	50081	090	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade		277	0.125	0.063	1.00	22.00	25.00	27.00	45.71	399	45	16	10	2	120	140	180	360	24			1			1.0				1			2			0	3	6	18	300
REC	50081	090	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade			0.124	0.073			22.00			302	40	3	10			140			44						0.5						2								

FACILITY DIRECT PE INPUTS

CPT CODE(S): 50080____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
50080	A 68-year-old male with a 1.8 cm calculus in the lower pole of the kidney undergoes a percutaneous nephrolithotomy (Initial access and dilation are reported separately).

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:

   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 50080 and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   50080

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):

   c. Post-service period:

9. 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*):

N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA048 and SA054

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

SA054 – Pack, Post-op Incision Care (Unit price $4.62): Kit, suture removal (1 kit); Betadine (10 ml); gauze, sterile, 4in X 4in (2 items); gloves, sterile (1 pair); steri-strip (6 strip uou) (2 items); swab-pad, alcohol (2 items); tape, surgical paper 1in (Micropore) (12 inches); tincture of benzoin, swab (1 item).

SA031 – Kit, suture removal (Purchase price $1.64)

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

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)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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): 50081____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	090

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
50081	A 66-year-old male with a staghorn (branched) calculus filling the entire renal pelvis and most calyces undergoes a percutaneous nephrolithotomy (Initial access and dilation are reported separately).

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:
   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 50081 and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):
   50081

3. Is this code(s) typically reported with an E/M service?
   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.
   No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):
   c. Post-service period:

9. 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*):
   N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA048 and SA054

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

SA054 – Pack, Post-op Incision Care (Unit price $4.62): Kit, suture removal (1 kit); Betadine (10 ml); gauze, sterile, 4in X 4in (2 items); gloves, sterile (1 pair); steri-strip (6 strip uou) (2 items); swab-pad, alcohol (2 items); tape, surgical paper 1in (Micropore) (12 inches); tincture of benzoin, swab (1 item).

SA031 – Kit, suture removal (Purchase price $1.64)

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

FACILITY DIRECT PE INPUTS

CPT CODE(S): 50081____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**50080**		**50080**		**50081**		**50081**	
3		***RUC Collaboration Website***				Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy,		Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade		Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy,		Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade	
4	**Clinical Activity Code**	**Meeting Date: January 2022 Revision Date (if applicable): Tab: 8 Specialty: American Urological Association**	**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**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**162.0**	**0.0**	**138.0**	**0.0**	**198.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**90.0**	**0.0**	**72.0**	**0.0**	**126.0**	**0.0**	**72.0**
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		L037D						5				5
16	CA002		L037D						20				20
17	CA003		L037D						8				8
18	CA004		L037D						20				20
19	CA005		L037D						7				7
20	CA006		L037D										
21	CA007		L037D										
22	CA008		L037D				60				60		
23			L037D										
26		*Other activity: please include short clinical description here and type new*	L037D										
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		L037D										
34	CA010		L037D										
35	CA011		L037D										
36	CA012		L037D										
37	CA013		L037D										
38	CA014		L037D										
39	CA015		L037D										
40	CA016		L037D										
41	CA017		L037D										
42			L037D										
45		*Other activity: please include short clinical description here and type new*	L037D										
48		**Intra-service (of service period)**											
49	CA018		L037D										
50	CA019		L037D										
51	CA020		L037D										
52	CA021		L037D				12				12		
55			L037D										
56		*Other activity: please include short clinical description here and type new*	L037D										
59		**Post-Service (of service period)**											
60	CA022		L037D										
61	CA023		L037D										
62	CA024		L037D										
63	CA025		L037D										
64	CA026		L037D										
65	CA027		L037D										
66	CA028		L037D										
67	CA029		L037D										
68	CA030		L037D										
69	CA031		L037D										
70	CA032		L037D										
71	CA033		L037D										
72	CA034		L037D										
73	CA035		L037D										
74	CA036		L037D			**n/a**		**n/a**	**6**	**n/a**		**n/a**	**6**
75			L037D										
78		*Other activity: please include short clinical description here and type new*	L037D										
81		**End: Patient leaves office/facility**											
82		**POST-SERVICE PERIOD**											
83		**Start: Patient leaves office/facility**											
84	CA037		L037D										
85	CA038		L037D										
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16										
88		99212 27 minutes	27										
89		99213 36 minutes	36				2.5		2		3.5		2
90		99214 53 minutes	53										
91		99215 63 minutes	63										
92	CA039		L037D			**0.0**	**90.0**	**0.0**	**72.0**	**0.0**	**126.0**	**0.0**	**72.0**
93			L037D										
96		*Other activity: please include short clinical description here and type new*	L037D										
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**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102	SA048						3		3		4		4
103	SA054						1		1		1		1
104	SA031								1				1
105	SG055								3				3
106	SG077								12				12
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**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112	EQ168	light, exam					90		72		126		72
113	EF023						90		72		126		72
114													
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

January 2022

Laparoscopic Simple Prostatectomy – Tab 9

In October 2021, the CPT Editorial Panel added CPT code 558XX *Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed,* to describe laparoscopic simple prostatectomy. The family of four codes pertaining to surgical prostatectomy and laparoscopy were surveyed for the January 2022 RUC meeting.

55821 ***Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages***
The RUC reviewed the survey results from 144 urologists and recommends a work RVU of 15.18 for CPT code 55821. The specialty society indicated that the survey 25th percentile work RVU of 20.00 overestimated the typical physician work for this procedure and, therefore, recommends a direct crosswalk to 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* (work RVU = 15.18, 120 minutes of intra-service time, and 329 minutes of total time). These servivces have the same intra-service time, as well as similar total time and intensity of physician work. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232, 1-99238, and 2-99213 post-operative visits. This major surgery, which involves an open approach, is typically performed in the inpatient setting (70% inpatient for 2020 Medicare claims).

For additional support, the RUC referenced MPC codes 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56, 120 minutes intra-service time, and 279 minutes total time) which requires slightly less total time than the surveyed code and 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60, 120 minutes of intra-service time, and 313 minutes of total time) which is somewhat more intense to perfrom. The RUC concluded that these codes accurately bracket the surveyed code and support the recommended work RVU of 15.18. **The RUC recommends a work RVU of 15.18 for CPT code 55821.**

55831 ***Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal***
The RUC reviewed the survey results from 139 urologists and recommends a work RVU of 15.60 for CPT code 55831. The specialty society indicated that the survey 25th percentile work RVU of 20.00 overestimated the typical physician work for this procedure, and therefore recommends a direct crosswalk to MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60, 120 minutes of intra-service time, and 313 minutes of total time). These services have the same intra-service time, with similar total time and intensity.

The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232, 1-99238, and 2-99213 post-operative visits. Differences in operative approach and technique add to the complexity and intensity of the procedure for CPT code 55831. This procedure involves a retropubic approach (behind the pubis) where an incision is made on top of the prostate and the enlarged center portion of the prostate is removed without opening the bladder, which is anatomically more difficult to perform than the suprapubic approach (over the pubis) used in CPT code 55821. The retropubic approach in CPT code 55831 requires primary ligation of a major complex of blood vessels near the prostate, including the dorsal vascular complex (DVC); the blood vessels are controlled in a more technically difficult manner, and thus an increased work RVU for the retropubic approach is appropriate. This major surgery, which involves an open approach, is typically performed in the inpatient setting (80% inpatient for 2020 Medicare claims).

For additional support, the RUC referenced MPC code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* (work RVU = 15.18, 120 minutes of intra-service time, and 329 minutes of total time) and CPT code 49653 *Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)* (work RVU = 15.68, 120 minutes of intra-sevice time, and 305 minutes total time). The RUC recognized that these two codes have an identical amount of intra-service time when compared to the surveyed code and appropriately bracket the RVU recommendation of 15.60, further supporting the relativity among similar services in the MFS. **The RUC recommends a work RVU of 15.60 for CPT code 55831.**

55866 ***Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed***
The RUC reviewed the survey results from 190 urologists and recommends a work RVU of 22.46 for CPT code 55866. The RUC determined that the survey 25th percentile work RVU of 25.18 somewhat overestimated the typical physician work for this procedure, and therefore, recommends a direct crosswalk to CPT code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU = 22.46, 145 minutes of intra-service time, and 414 minutes of total time). The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes positioning time, 12 minutes scrub/dress/wait time, 180 minutes of intra-service time, 50 minutes of immediate post-service time, 1/2-99238 and 2-99213 post-operative visits. This service is typically provided in the outpatient hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The typical patient for this service is a 48-year-old male diagnosed with prostate cancer who elects robotic-assisted laparoscopic radical prostatectomy. CPT code 55866 requires more time and physician work than CPT codes 55821 and 55831 due to more complex preoperative positioning for a retropubic radical prostatectomy, set-up for laparoscopic robotic assistance, and increased intra-service work related to nerve sparing and urethral reconstruction to prevent long-term complications for cancer patients (such as incontinence and erectile dysfunction). During the procedure, the nonautonomous robotic assistance requires constant surgical input at the hand of the surgeon, which increases technical difficulty. Given the enlarged prostate, it is imperative for the surgeon to carefully spare the surrounding nerves and urethral sphincter muscles when removing the entire prostate and related tissue. Moreover, the significant reconstructive component associated with this service is the reconnection of the bladder neck to the urethra, which needs to be conducted carefully and completely to ensure proper healing and long-term function. Removing the entire prostate with robotic assistance, and the complexity of nerve sparing when operating with a cancerous prostate, increases the medical complexity and intensity of this procedure compared to the other surgical prostatectomy codes in this family.

The RUC compared the surveyed code to CPT code 35304 *Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery* (work RVU = 24.60, intra-service time of 180 minutes, total time of 422 minutes) and noted that both services have an identical amount of intra-service time, whereas the reference code typically involves more total time. The RUC also compared the surveyed code to the second top key reference service 50543 *Laparoscopy, surgical; partial nephrectomy* (work RVU = 27.41, 240 minutes of intra-service time, and 557 minutes total time) which requires much more phyisican work and time to perform.

For additional support, the RUC referenced CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU = 22.10, intra-service time of 150 minutes, total time of 404 minutes) and noted that the survey code typically involves 30 more minutes of intra-service time, whereas the reference code involves more total time. The RUC determined that CPT code 55866 is appropriately bracketed by these codes and maintains relativity within the code family and MFS. **The RUC recommends a work RVU of 22.46 for CPT code 55866.**

558XX *Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed*

The RUC reviewed the survey results from 166 urologists and recommends a work RVU of 19.53 for CPT code 558XX. The RUC determined that the survey 25th percentile work RVU of 22.00 was too high compared to the radical laparoscopic prostatectomy, CPT code 55866. The RUC recommends a direct crosswalk to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU = 19.53, 180 minutes of intra-service time, and 383 minutes of total time). The RUC recommends 40 minutes of pre-service evaluation time, 8 minutes positioning time, 11 minutes scrub/dress/wait time, 180 minutes of intra-service time, 50 minutes of immediate post-service time, 1/2-99238 and 2-99213 post-operative visits. This service is typically provided in the outpatient hospital. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The typical patient for this service is a 65-year-old male who is symptomatic due to obstruction enlargement and elects to undergo laparoscopic simple suprapubic prostatectomy. Like CPT code 55866, additional pre-service, intra-service, and post-service time is required for CPT code 558XX when compared to family codes 55821 and 55831. For this procedure, the increased pre-service time is attributable to more complex preoperative work wherein the arms are tucked (identical to CPT codes 55821 and 55831), which requires careful padding to avoid compression injuries or neuropathies); additionally, the legs are placed in stirrups for dorsal lithotomy positioning. More intra-service time, along with a longer postoperative recovery time, is required for the set-up and utilization of laparoscopic robotic assistance. However, when compared to CPT code 55866, the surveyed procedure requires slightly less pre-service time, as it is a simple subtotal laparoscopic prostatectomy as opposed to a retropubic radical approach. The RUC determined that the physician work and time maintain relativity within the surgical prostatectomy code family.

For additional support, the RUC referenced MPC code 55880 *Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance* (work RVU = 17.73, 180 minutes of intra-service time, and 373 minutes total time) and CPT code 60650 *Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal* (work RVU = 20.73, 180 minutes of intra-service time, and 384 minutes of total time). The RUC determined that CPT code 558XX is appropriately bracketed by these codes and maintains relativiety within the code family and MFS. **The RUC recommends a work RVU of 19.53 for CPT code 558XX.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made minor modifications as presented by the specialty. **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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Prostate Excision				
(f)55821	Y1	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	090	15.18
(f)55831	Y2	retropubic, subtotal (For laparoscopy, surgical prostatectomy, simple subtotal, use 558XX)	090	15.60
Laparoscopy				
(f)55866	Y3	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed (For open procedure, use 55840) (For laparoscopy, surgical prostatectomy, simple subtotal, use 558XX)	090	22.46
●558XX	Y4	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed (For open subtotal prostatectomy, see 55821, 55831)	090	19.53

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:55821 Tracking Number Y1 Original Specialty Recommended RVU: **15.18**
Presented Recommended RVU: **15.18**
Global Period: 090 Current Work RVU: **15.76** RUC Recommended RVU: **15.18**

CPT Descriptor: Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement undergoes subtotal suprapubic prostatectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 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 2% , Overnight stay-less than 24 hours 27% , Overnight stay-more than 24 hours 71%

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 93%

Description of Pre-Service Work: On the day before the surgery, the patient's medical record, preoperative lab results, prostate imaging and urodynamic reports are reviewed. Preoperative orders are written and sent electronically to the hospital. A preoperative H&P is dictated. On the day of surgery, the surgeon scrubs and gowns. The surgical procedure and postoperative recovery in and out of the hospital are reviewed with the patient and/or the patient's family. Questions from the patient and/or the patient's family are answered, and informed consent is obtained. The expected length of the procedure and any special concerns about this particular patient (eg, teeth, positioning, unusual medical problems) are discussed with the anesthesiologist. The availability of all necessary instruments is verified. The anesthesiologist places the endotracheal tube followed by the orogastric tube and general anesthesia is induced. The patient's wrists, elbows, shoulders, and legs are padded, and sequential compression devices are placed and tested. The patient is then placed in the moderate Trendelenburg position, and all pressure points are padded and adjusted as needed. The abdomen, genitalia, and perineum are prepared and draped in standard fashion. A urinary catheter is placed into the bladder and the balloon is inflated.

Description of Intra-Service Work: A low midline incision is made and the fascia is opened in the midline. The space of Retzius is developed and a self retaining retractor is placed to allow exposure of the bladder and prostate. An incision is made in the anterior bladder wall. Several stay sutures are placed in the bladder wall to expose the base of the bladder. The ureteral orifices are identified and the prostate anatomy is surveyed to assess for median lobe location and relational anatomy to the bladder. An incision is made at the junction of the prostate and the bladder neck. The incision is carried cirumferentially along the capsule of the prostate out laterally and distally. The prostate is rocked back and forth and dissection is continued along the lateral pedicle plane to define the apex of the prostate posteriorly. The final attachments are unfastened, and the specimen is released completely and passed off the field for pathologic processing. Bleeding may be significant at this time and various measures are utilized to control the bleeding including packing for 10 minutes, cautery, and suture ligation of bleeders. Once hemostasis is assured, the bladder neck is advanced to the urethral mucosa using fine monofilament suture. The anterior bladder wall is closed with suture. A catheter is passed into the bladder, and the closure is tested by placing 200 ml of saline into the bladder to distend it. A drain is placed through a separate counterincision in the abdomen. The rectus fascia is closed using suture, local anesthetic is injected, and the incision is closed with staples. Sterile dressings are placed over the incision, and the catheter is secured to the thigh with a catheter strap.

Description of Post-Service Work: The patient is transferred from the operating table to the postoperative stretcher. The patient is accompanied to the recovery area and transferred to the recovery area bed. Postoperative orders are written, and recovery area care and medications are reviewed with the recovery staff. The results of the procedure, expected outcome, and planned postoperative care in the hospital and out of the hospital are discussed with the patient's family. After the patient is awake, the outcome of the surgery is discussed with the patient. The referring physician is notified of the outcome of the procedure and of any unusual aspects of postoperative care (eg, cardiac disease, diabetes management). A detailed operative report is dictated for the patient's medical record. After discharge from recovery, the patient is examined and the wound and patient's progress are checked. Hospital notes (ie, nursing, pharmacy, dietary, discharge planner) are reviewed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. A progress note is written for the patient's medical record. During the patient's stay in the hospital, laboratory results and vital signs are checked. The patient is examined. Urine output and output from the drain are checked and the drain is removed if appropriate. Wounds and dressings are checked, and the patient's progress is discussed with the patient and/or the patient's family. The patient's hospital medical records are reviewed. Postoperative care of the wound at home is discussed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. Progress notes are written for the patient's medical record. On day of discharge, the patient is examined. The wounds and the patient's progress are checked. All patient hospital medical records are reviewed, and questions from the patient and/or the patient's family are answered. Orders for postdischarge care and prescriptions for postoperative medications are written. Postoperative care of the wound is discussed with the patient and/or the patient's family. A detailed hospital discharge summary is dictated. During office visits, the patient is examined. Vital signs are checked and all surgical incisions are inspected. The final pathology report, implications, follow-up plan, and the possible need for additional treatments are reviewed in detail. Expectations for the return of bladder control following the removal of the catheter and proper performance of Kegel exercises are discussed. The urinary catheter and staples are removed during the first office visit. Prior to removal of the Foley catheter, the bladder is filled with 250 mL of sterile saline with a Toomey syringe. Penile rehabilitation therapy, including timing, options of oral therapies, injections, and vacuum pump, is discussed and prescriptions of chosen medications are written. Bladder control exercises are reviewed after the catheter is removed. Questions from the patient and/or the patient's family are answered. The next office visit is scheduled. The second office visit is to ensure the patient's voiding has improved, check their post-void residual, and wean any medications they were on pre-operatively for their BPH. The appropriate diagnosis and Current Procedural Terminology (CPT) code are marked on the encounter form (superbill). Patient progress notes for the office medical record and a letter to the referring physician are dictated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richards, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	55821					
Sample Size:	5000	**Resp N:**	144			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	3.00	50.00
Survey RVW:	12.00	20.00	**21.36**	24.85	35.23
Pre-Service Evaluation Time:			**33.00**		
Pre-Service Positioning Time:			**12.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	0.00	120.00	**120.00**	180.00	305.00

Immediate Post Service-Time:	**25.00**	
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:	**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:	55821	**Recommended Physician Work RVU: 15.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**40.00**	**-7.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**20.00**	**-10.00**
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)

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:	**25.00**	**33.00**	**-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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 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
55840	090	21.36	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing;

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55845	090	25.18	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

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
52601	090	13.16	**RUC Time**	44,942

CPT Descriptor 1 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	10,340

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	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: 97 **% of respondents:** 66.8 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 14.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 55821	**Top Key Reference CPT Code:** 55840	**2nd Key Reference CPT Code:** **55845**
Median Pre-Service Time	51.00	51.00	51.00
Median Intra-Service Time	120.00	180.00	198.00
Median Immediate Post-service Time	28.00	33.00	33.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	60.00	60.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	46.0	86.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**323.00**	**448.00**	**466.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	34%	46%	19%	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	43%	45%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	42%	40%	18%
Physical effort required	20%	56%	24%

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%	57%	19%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	52%	10%	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	33%	52%	14%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	38%	52%	10%
Physical effort required	14%	62%	24%

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%	52%	14%

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 AUA reviewed the survey results from 144 urologists (69 of whom indicated a performance rate of 1 or greater in the past year) and determined that the survey 25th percentile work RVU of 20.00 was too high with respect to the physician work associated with this procedure. The AUA's RUC advisors agreed that a direct work RVU crosswalk of 15.18 to CPT code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* (work RVU = 15.18, IST = 120 minutes, total time = 329 minutes) is appropriate given the physician work associated with the procedure.

AUA's RUC advisors determined that the survey intra-service time of 120 minutes is appropriate for this procedure. However, CPT code 55821 has never been reviewed by the RUC and is currently Harvard valued. Therefore, the AUA's advisors determined that it is appropriate to recommend this slightly lower direct crosswalk work RVU value.

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) 55821

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 Urology 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? 4325
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 2019 Medicare utilization data extrapolated using National Health Expenditures breakdown of payer breakdown for hospital care.

Specialty Urology Frequency 4325 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? 1,200
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 Urology Frequency 1200 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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 55821

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:55831 Tracking Number Y2 Original Specialty Recommended RVU: **15.60**
Presented Recommended RVU: **15.60**
Global Period: 090 Current Work RVU: **17.19** RUC Recommended RVU: **15.60**

CPT Descriptor: Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement undergoes subtotal retropubic prostatectomy.

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 99% , 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 3% , Overnight stay-less than 24 hours 24% , Overnight stay-more than 24 hours 73%

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: On the day before the surgery, the patient's medical record, preoperative lab results, prostate imaging and urodynamic reports are reviewed. Preoperative orders are written and sent electronically to the hospital. A preoperative H&P is dictated. On the day of surgery, the surgeon scrubs and gowns. The surgical procedure and postoperative recovery in and out of the hospital are reviewed with the patient and/or the patient's family. Questions from the patient and/or the patient's family are answered, and informed consent is obtained. The expected length of the procedure and any special concerns about this particular patient (eg, teeth, positioning, unusual medical problems) are discussed with the anesthesiologist. The availability of all necessary instruments is verified. The anesthesiologist places the endotracheal tube followed by the orogastric tube and general anesthesia is induced. The patient's wrists, elbows, shoulders, and legs are padded, and sequential compression devices are placed and tested. The patient is then placed in the moderate Trendelenburg position, and all pressure points are padded and adjusted as needed. The abdomen, genitalia, and perineum are prepared and draped in standard fashion. A urinary catheter is placed into the bladder and the balloon is inflated.

Description of Intra-Service Work: A low midline incision is made and the fascia is opened in the midline. The space of Retzius is developed and a self retaining retractor is placed to allow exposure of the bladder and prostate. The anterior surface of the prostate is exposed. The periprostatic fat is removed to expose the pubuprostatic ligaments and superficial dorsal vein of the prostate. The endopelvic fascia is incised and the puboprostatic ligaments are partially incised. The dorsal vascular complex and lateral prostatic pedicles are ligated to control the blood supply to the prostate. A transverse capsulotomy is made just distal to the bladder neck. This incision is deepened to the adenoma and extended laterally. A plane is established to enucleate the adenoma bluntly and sharply. The anterior commisure is sharply divided. All 3 lobes are removed in this fashion sequentially. Bleeding may be significant at this time and various measures are utilized to control the bleeding including packing for 10 minutes, cautery, and suture ligation of bleeders. Once hemostasis is assured, the capsule is closed with suture. A catheter is passed into the bladder, and the closure is tested by placing 200 ml of saline into the bladder to distend it. A drain is placed through a separate counterincision in the abdomen. The rectus fascia is closed using suture, local anesthetic is injected, and the incision is closed with staples. Sterile dressings are placed over the incision, and the catheter is secured to the thigh with a catheter strap.

Description of Post-Service Work: The patient is transferred from the operating table to the postoperative stretcher. The patient is accompanied to the recovery area and transferred to the recovery area bed. Postoperative orders are written, and

recovery area care and medications are reviewed with the recovery staff. The results of the procedure, expected outcome, and planned postoperative care in the hospital and out of the hospital are discussed with the patient's family. After the patient is awake, the outcome of the surgery is discussed with the patient. The referring physician is notified of the outcome of the procedure and of any unusual aspects of postoperative care (eg, cardiac disease, diabetes management). A detailed operative report is dictated for the patient's medical record. After discharge from recovery, the patient is examined and the wound and patient's progress are checked. Hospital notes (ie, nursing, pharmacy, dietary, discharge planner) are reviewed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. A progress note is written for the patient's medical record. During the patient's stay in the hospital, laboratory results and vital signs are checked. The patient is examined. Urine output and output from the drain are checked and the drain is removed if appropriate. Wounds and dressings are checked, and the patient's progress is discussed with the patient and/or the patient's family. The patient's hospital medical records are reviewed. Postoperative care of the wound at home is discussed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. Progress notes are written for the patient's medical record. On day of discharge, the patient is examined. The wounds and the patient's progress are checked. All patient hospital medical records are reviewed, and questions from the patient and/or the patient's family are answered. Orders for postdischarge care and prescriptions for postoperative medications are written. Postoperative care of the wound is discussed with the patient and/or the patient's family. A detailed hospital discharge summary is dictated. During office visits, the patient is examined. Vital signs are checked and all surgical incisions are inspected. The final pathology report, implications, follow-up plan, and the possible need for additional treatments are reviewed in detail. Expectations for the return of bladder control following the removal of the catheter and proper performance of Kegel exercises are discussed. The urinary catheter and staples are removed during the first office visit. Prior to removal of the Foley catheter, the bladder is filled with 250 mL of sterile saline with a Toomey syringe. Penile rehabilitation therapy, including timing, options of oral therapies, injections, and vacuum pump, is discussed and prescriptions of chosen medications are written. Bladder control exercises are reviewed after the catheter is removed. Questions from the patient and/or the patient's family are answered. The next office visit is scheduled. The second office visit is to ensure the patient's voiding has improved, check their post-void residual, and wean any medications they were on pre-operatively for their BPH. The appropriate diagnosis and Current Procedural Terminology (CPT) code are marked on the encounter form (superbill). Patient progress notes for the office medical record and a letter to the referring physician are dictated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richard, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	55831					
Sample Size:	5000	**Resp N:**	139			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	50.00
Survey RVW:	12.00	20.00	**21.36**	25.00	35.23
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**11.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	0.00	100.00	**120.00**	180.00	305.00

Immediate Post Service-Time:	**25.00**	
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)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	55831	**Recommended Physician Work RVU: 15.60**		
		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:		**10.00**	**20.00**	**-10.00**
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)

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:	**25.00**	**33.00**	**-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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 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
55840	090	21.36	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing;

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55845	090	25.18	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

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
63047	090	15.37	**RUC Time**	101,838

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35301	090	21.16	**RUC Time**	35,904

CPT Descriptor 2 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

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: 96 **% of respondents:** 68.5 **%**

Number of respondents who choose 2nd Key Reference Code: 20 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 55831	Top Key Reference CPT Code: 55840	2nd Key Reference CPT Code: 55845
Median Pre-Service Time	53.00	51.00	51.00
Median Intra-Service Time	120.00	180.00	198.00
Median Immediate Post-service Time	25.00	33.00	33.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	60.00	60.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	46.0	86.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**322.00**	**448.00**	**466.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	2%	28%	53%	14%	3%

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	42%	46%	12%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	39%	47%	15%
Physical effort required	14%	61%	26%

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%	60%	19%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	40%	40%	15%	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	25%	55%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	35%	50%	15%
Physical effort required	20%	55%	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	30%	50%	20%

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 AUA reviewed the survey results from 139 urologists (53 of whom indicated a performance rate of 1 or greater in the past year) and determined that the survey 25th percentile work RVU of 20.00 was too high with respect to the physician work associated with this procedure. The AUA's RUC advisors agreed that a direct work RVU crosswalk of 15.60 to CPT code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60, IST = 120 minutes, total time = 313 minutes) is appropriate given the physician work associated with the procedure.

AUA's RUC advisors determined that the survey intra-service time of 120 minutes is appropriate for this procedure. However, CPT code 55831 has never been reviewed by the RUC and is currently Harvard valued. Therefore, the AUA's advisors determined that it is appropriate to recommend this slightly lower direct crosswalk work RVU value.

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) 55831

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 Urology 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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization data extrapolated using National Health Expenditures breakdown of payer breakdown for hospital care.

Specialty Urology Frequency 2000 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? 500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data

Specialty Urology Frequency 500 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:
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 55831

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:55866 Tracking Number Y3 Original Specialty Recommended RVU: **25.18**
Presented Recommended RVU: **25.18**
Global Period: 090 Current Work RVU: **26.80** RUC Recommended RVU: **22.46**

CPT Descriptor: Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with a PSA level of 3.5 undergoes a prostate biopsy that reveals adenocarcinoma with a Gleason score of 7 in both lobes. He is counseled on the risks and benefits of surgery versus radiation and has chosen robotic-assisted laparoscopic radical prostatectomy.

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 99% , In the ASC 0%, 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 4% , Overnight stay-less than 24 hours 61% , Overnight stay-more than 24 hours 34%

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: On the day before the surgery, the patient's medical record, preoperative lab results, and transrectal ultrasound images and pathology reports are reviewed. Preoperative orders are written and sent electronically to the hospital. A preoperative H&P is dictated. On the day of surgery, the surgeon scrubs and gowns. The surgical procedure and postoperative recovery in and out of the hospital are reviewed with the patient and/or the patient's family. Questions from the patient and/or the patient's family are answered, and informed consent is obtained. The expected length of the procedure and any special concerns about this particular patient (eg, teeth, positioning, unusual medical problems) are discussed with the anesthesiologist. The availability of all necessary instruments is verified. The position of the robotic arms, surgical console pedals, and hand controls are reviewed and adjusted as necessary. The anesthesiologist places the endotracheal tube followed by the orogastric tube and general anesthesia is induced. The patient's wrists, elbows, shoulders, and legs are padded, and sequential compression devices are placed and tested. Both legs are placed in stirrups, which are adjusted to assure proper positioning, and both arms are tucked under sheets. The patient is then placed in the maximal Trendelenburg position, and all pressure points are padded and adjusted as needed. Once the patient's position is satisfactory, the table is leveled.

Description of Intra-Service Work: The abdomen, genitalia, and perineum are prepared and draped in standard fashion. A urinary catheter is placed into the bladder and the balloon is inflated. A suprapubic incision is made and a needle is introduced. An intraperitoneal position is confirmed, and a pneumoperitoneum is created. A midline trocar is placed, and a zero-degree lens camera is inserted. The abdomen and pelvis are inspected for visceral injury or abnormal anatomy. Four additional incisions are made after appropriate measurements, and four additional trocars are placed under direct vision. The table is adjusted to place the patient in a steep Trendelenburg position, and the robot is advanced. The four robotic arms are individually docked and pressure points are checked. Appropriate adjustments to the robotic arms are made at the surgical console. Next, the laparoscope is introduced and the seminal vesicles and vas deferens are dissected. The peritoneum is incised at the reflection point of the anterior rectum and the posterior bladder. The vas deferens is identified on each side and then divided. The seminal vesicles are carefully dissected using the harmonic scalpel to divide all bleeding vessels until the structures are completely freed. The space just posterior to the seminal vesicles is dissected to open Denonvilliers' fascia to reveal a prerectal fat plane. Attention is turned to complete mobilization of the opening of the peritoneum and mobilization of the bladder. The median umbilical ligaments and urachus are divided close to the umbilicus. Careful blunt

dissection is used to reflect the bladder away from the abdominal wall and expose the endopelvic fascia. The fat overlying the endopelvic fascia is cleared away and the endopelvic fascia is incised bilaterally to free the prostate away from the lateral pelvic side wall. The superficial dorsal vein complex is circumscribed, cauterized, and divided, and the apex of the prostate is identified and dissected. The deep dorsal vein complex is ligated with sutures or divided with an endoscopic stapling device. The bladder neck-prostate junction is identified using a variety of maneuvers, and then the bladder is separated from the prostate on both sides. The bladder neck is identified and opened. The catheter is brought through the bladder neck and held anteriorly, exposing the posterior bladder neck, which is then divided. The remainder of the prostate is carefully separated off of the bladder posteriorly, and the tissue overlying the seminal vesicles is opened. These structures are withdrawn into the area of dissection and used as traction. The lateral vascular pedicles are isolated, cauterized, or clipped to the base of the prostate and bladder and then divided. Both neurovascular bundles are identified and meticulously and carefully dissected off of the prostate surface from the base to the apex of the gland. The dorsal vein complex is divided using sharp dissection around the apex of the prostate. The prostate is rocked back and forth and dissection is continued along the lateral pedicle plane to define the apex of the prostate posteriorly. The urethra is identified and sharp dissection is used to divide the anterior and posterior urethra and the rectourethralis muscle. The final attachments are unfastened, and the specimen is put into the endosac and placed out of the surgical field. The pneumoperitoneum is decreased, and the entire surgical field is inspected for evidence of bleeding. Once hemostasis is assured, the bladder neck is reconstructed with multiple interrupted sutures, and the vesicourethral anastomosis is performed using interrupted sutures. A catheter is passed into the bladder, and the anastomosis is tested by placing 200 ml of saline into the bladder to distend it. A drain is placed through one of the abdominal side ports. All four trocar sites and all surgical sites are inspected at 5 mm Hg pressure before the trocars are removed under direct vision. The specimen is extracted by enlarging the midline incision and transferring the endosac bag to this area, where it is removed. The rectus fascia is closed using suture, local anesthetic is injected in all five of the trocar incisions, and the trocar incisions are closed with interrupted 2-0 nylon sutures. Sterile dressings are placed over each incision, and the catheter is secured to the thigh with a catheter strap.

Description of Post-Service Work: Dressings are applied. The patient is transferred from the operating table to the postoperative stretcher. The patient is accompanied to the recovery area and transferred to the recovery area bed. Postoperative orders are written, and recovery area care and medications are reviewed with the recovery staff. The results of the procedure, expected outcome, and planned postoperative care in the hospital and out of the hospital are discussed with the patient's family. After the patient is awake, the outcome of the surgery is discussed with the patient. The referring physician is notified of the outcome of the procedure and of any unusual aspects of postoperative care (eg, cardiac disease, diabetes management). A detailed operative report is dictated for the patient's medical record. After discharge from recovery, the patient is examined and the wound and patient's progress are checked. Hospital notes (ie, nursing, pharmacy, dietary, discharge planner) are reviewed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. A progress note is written for the patient's medical record. During the patient's stay in the hospital, laboratory results and vital signs are checked. The patient is examined. Urine output and output from the drain are checked and the drain is removed if appropriate. Wounds and dressings are checked, and the patient's progress is discussed with the patient and/or the patient's family. The patient's hospital medical records are reviewed. Postoperative care of the wound at home is discussed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. Progress notes are written for the patient's medical record. On day of discharge, the patient is examined. The wounds and the patient's progress are checked. All patient hospital medical records are reviewed, and questions from the patient and/or the patient's family are answered. Orders for postdischarge care and prescriptions for postoperative medications are written. Postoperative care of the wound is discussed with the patient and/or the patient's family. A detailed hospital discharge summary is dictated. During office visits, the patient is examined. Vital signs are checked and all surgical incisions are inspected. The final pathology report, implications, follow-up plan, and the possible need for additional therapy are reviewed in detail. Expectations for the return of bladder control following the removal of the catheter and proper performance of Kegel exercises are discussed. Prior to removal of the Foley catheter, the bladder is filled with 250 mL of sterile saline with a Toomey syringe. The urinary catheter is then removed. Penile rehabilitation therapy, including timing, options of oral therapies, injections, and vacuum pump, is discussed and prescriptions of chosen medications are written. Bladder control exercises are reviewed after the catheter is removed. Questions from the patient and/or the patient's family are answered. Sutures are removed. The next office visit is scheduled. The appropriate diagnosis and Current Procedural Terminology (CPT«) code are marked on the encounter form (superbill). Patient progress notes for the office medical record and a letter to the referring physician are dictated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richards, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	55866					
Sample Size:	5000	**Resp N:**	190			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

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Pre-Service Scrub, Dress, Wait Time:			**12.00**		
Intra-Service Time:	4.00	150.00	**180.00**	223.00	400.00

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)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	55866	**Recommended Physician Work RVU: 22.46**		
		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:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**12.00**	**20.00**	**-8.00**
Intra-Service Time:		**180.00**		

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:	**50.00**	**33.00**	**17.00**

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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55845	090	25.18	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50543	090	27.41	**RUC Time**

CPT Descriptor Laparoscopy, surgical; partial nephrectomy

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
32669	090	23.53	**RUC Time**	1,894

CPT Descriptor 1 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34705	090	29.58	**RUC Time**	13,089

CPT Descriptor 2 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)

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: 103 **% of respondents:** 54.2 **%**

Number of respondents who choose 2nd Key Reference Code: 52 **% of respondents:** 27.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 55866	Top Key Reference CPT Code: 55845	2nd Key Reference CPT Code: 50543
Median Pre-Service Time	72.00	51.00	60.00
Median Intra-Service Time	180.00	198.00	240.00
Median Immediate Post-service Time	50.00	33.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	60.00	80.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	46.0	86.00	109.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**367.00**	**466.00**	**557.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	1%	45%	37%	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	5%	61%	34%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	37%	60%
Physical effort required	23%	50%	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	2%	56%	41%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	37%	42%	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	6%	43%	51%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	42%	56%
Physical effort required	0%	52%	48%

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%	56%	44%

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 AUA reviewed the survey results from 190 urologists and determined that the survey 25th percentile work RVU of 25.18 was appropriate given the physician work associated with this procedure. AUA's advisors noted that the main difference between the survey values and the current values (the RUC recently reviewed this 55866 in 2015) is one fewer 99214 visit in the global period; this does not, however, change the work associated with the procedure.

The specialty society added five minutes to the pre-service positioning time for pre-time package U1 Dorsal Lithotomy.

The society added 20 minutes of intra-service time associated with a 99232 subsequent hospital visit to the immediate post-service time per CMS' 23-hour stay outpatient surgical services with subsequent hospital visits policy. This procedure is typically performed in the outpatient setting but generally requires an overnight stay and subsequent hospital visit.

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) 55866

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 Urology 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? 75000
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 2019 Medicare utilization data extrapolated using National Health Expenditures breakdown of payer breakdown for hospital care.

Specialty Urology Frequency 75000 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? 21,000
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 claims data

Specialty Urology Frequency 21000 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:
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 55866

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:558XX Tracking Number Y4 Original Specialty Recommended RVU: **22.00**
Presented Recommended RVU: **22.00**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **19.53**

CPT Descriptor: Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement chose to undergo laparoscopic simple suprapubic prostatectomy.

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 99% , 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 2% , Overnight stay-less than 24 hours 48% , Overnight stay-more than 24 hours 51%

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 93%

Description of Pre-Service Work: On the day before the surgery, the patient's medical record, preoperative lab results, prostate imaging and urodynamic reports are reviewed. Preoperative orders are written and sent electronically to the hospital. A preoperative H&P is dictated. On the day of surgery, the surgeon scrubs and gowns. The surgical procedure and postoperative recovery in and out of the hospital are reviewed with the patient and/or the patient's family. Questions from the patient and/or the patient's family are answered, and informed consent is obtained. The expected length of the procedure and any special concerns about this particular patient (eg, teeth, positioning, unusual medical problems) are discussed with the anesthesiologist. The availability of all necessary instruments is verified. The position of the robotic arms, surgical console pedals, and hand controls are reviewed and adjusted as necessary. The anesthesiologist places the endotracheal tube followed by the orogastric tube and general anesthesia is induced. The patient's wrists, elbows, shoulders, and legs are padded, and sequential compression devices are placed and tested. Both legs are placed in stirrups, which are adjusted to assure proper positioning, and both arms are tucked under sheets. The patient is then placed in the maximal Trendelenburg position, and all pressure points are padded and adjusted as needed. Once the patient's position is satisfactory, the table is leveled. The abdomen, genitalia, and perineum are prepared and draped in standard fashion. A urinary catheter is placed into the bladder and the balloon is inflated.

Description of Intra-Service Work: A suprapubic incision is made and a needle is introduced. An intraperitoneal position is confirmed, and a pneumoperitoneum is created. A midline trocar is placed, and a zero-degree lens camera is inserted. The abdomen and pelvis are inspected for visceral injury or abnormal anatomy. Five additional incisions are made after appropriate measurements, and five additional trocars are placed under direct vision. The table is adjusted to place the patient in a steep Trendelenburg position, and the robot is advanced. The four robotic arms are individually docked and pressure points are checked. Appropriate adjustments to the robotic arms are made at the surgical console. Next, the laparoscope is introduced and the colon is mobilized so it is away from the bladder. An incision is made in the posterior bladder wall. Several stay sutures are placed in the bladder wall to expose the base of the bladder. The ureteral orifices are identified and the prostate anatomy is surveyed to assess for median lobe location and relational anatomy to the bladder. An incision is made at the junction of the prostate and the bladder neck. The incision is carried cirumferentially along the capsule of the prostate out laterally and distally. The prostate is rocked back and forth and dissection is continued along the

lateral pedicle plane to define the apex of the prostate posteriorly. The final attachments are unfastened, and the specimen is put into the endosac and placed out of the surgical field. The pneumoperitoneum is decreased, and the entire surgical field is inspected for evidence of bleeding. Once hemostasis is assured, the bladder neck is advanced to the urethral mucosa using fine monofilament suture. Hemostasis is also achieved using cautery and suture. The posterior bladder wall is closed with suture. A catheter is passed into the bladder, and the closure is tested by placing 200 ml of saline into the bladder to distend it. A drain is placed through one of the abdominal side ports. All six trocar sites and all surgical sites are inspected at 5 mm Hg pressure before the trocars are removed under direct vision. The specimen is extracted by enlarging the midline incision and transferring the endosac bag to this area, where it is removed. The rectus fascia is closed using suture, local anesthetic is injected in all five of the trocar incisions, and the trocar incisions are closed with interrupted 2-0 nylon sutures. Sterile dressings are placed over each incision, and the catheter is secured to the thigh with a catheter strap.

Description of Post-Service Work: The patient is transferred from the operating table to the postoperative stretcher. The patient is accompanied to the recovery area and transferred to the recovery area bed. Postoperative orders are written, and recovery area care and medications are reviewed with the recovery staff. The results of the procedure, expected outcome, and planned postoperative care in the hospital and out of the hospital are discussed with the patient's family. After the patient is awake, the outcome of the surgery is discussed with the patient. The referring physician is notified of the outcome of the procedure and of any unusual aspects of postoperative care (eg, cardiac disease, diabetes management). A detailed operative report is dictated for the patient's medical record. After discharge from recovery, the patient is examined and the wound and patient's progress are checked. Hospital notes (ie, nursing, pharmacy, dietary, discharge planner) are reviewed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. A progress note is written for the patient's medical record. During the patient's stay in the hospital, laboratory results and vital signs are checked. The patient is examined. Urine output and output from the drain are checked and the drain is removed if appropriate. Wounds and dressings are checked, and the patient's progress is discussed with the patient and/or the patient's family. The patient's hospital medical records are reviewed. Postoperative care of the wound at home is discussed. Questions from the patient, the patient's family, and the nursing and other staff are answered. Orders are written as necessary. Progress notes are written for the patient's medical record. On day of discharge, the patient is examined. The wounds and the patient's progress are checked. All patient hospital medical records are reviewed, and questions from the patient and/or the patient's family are answered. Orders for postdischarge care and prescriptions for postoperative medications are written. Postoperative care of the wound is discussed with the patient and/or the patient's family. A detailed hospital discharge summary is dictated. During office visits, the patient is examined. Vital signs are checked and all surgical incisions are inspected. The final pathology report, implications, follow-up plan, and the possible need for additional treatments are reviewed in detail. Expectations for the return of bladder control following the removal of the catheter and proper performance of Kegel exercises are discussed. Prior to removal of the Foley catheter, the bladder is filled with 250 mL of sterile saline with a Toomey syringe. The urinary catheter is then removed during the first office visit. Penile rehabilitation therapy, including timing, options of oral therapies, injections, and vacuum pump, is discussed and prescriptions of chosen medications are written. Bladder control exercises are reviewed after the catheter is removed. Questions from the patient and/or the patient's family are answered. Sutures are removed. The next office visit is scheduled. The second office visit is to ensure the patient's voiding has improved, check their post-void residual, and wean any medications they were on pre-operatively for their BPH. The appropriate diagnosis and Current Procedural Terminology (CPT) code are marked on the encounter form (superbill). Patient progress notes for the office medical record and a letter to the referring physician are dictated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Thomas M.T. Turk, MD and Kyle A. Richards, MD					
Specialty Society(ies):	American Urological Association					
CPT Code:	558XX					
Sample Size:	5000	**Resp N:**	166			
Description of Sample:	The American Urological Association (AUA) selected a simple random sample of 5000 urologists from AUA's Active/Associate members. This sample was chosen based on previous response rates to AUA surveys to ensure an adequate response rate to each survey code. AUA initially proposed to survey several different surgical subspecialties within AUA's Active/Associate membership but determined that taking a simple random sample of these surgical subspecialties would produce an inadequate number of responses to achieve valid survey results.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	15.00	50.00
Survey RVW:	14.00	22.00	**25.00**	27.88	42.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**11.00**		
Intra-Service Time:	0.00	120.00	**180.00**	200.00	405.00

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)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	558XX	**Recommended Physician Work RVU: 19.53**		
		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:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**11.00**	**20.00**	**-9.00**
Intra-Service Time:		**180.00**		

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:	**50.00**	**33.00**	**17.00**

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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55840	090	21.36	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing;

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55845	090	25.18	**RUC Time**

CPT Descriptor Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

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
35301	090	21.16	**RUC Time**	35,904

CPT Descriptor 1 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32669	090	23.53	**RUC Time**	1,894

CPT Descriptor 2 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

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: 62 **% of respondents:** 37.3 **%**

Number of respondents who choose 2nd Key Reference Code: 49 **% of respondents:** 29.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 558XX	Top Key Reference CPT Code: 55840	2nd Key Reference CPT Code: **55845**
Median Pre-Service Time	59.00	51.00	51.00
Median Intra-Service Time	180.00	180.00	198.00
Median Immediate Post-service Time	50.00	33.00	33.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	60.00	60.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	46.0	86.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**354.00**	**448.00**	**466.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	21%	47%	29%	3%

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	31%	47%	23%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	21%	34%	45%
Physical effort required	26%	46%	28%

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	27%	50%	23%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	2%	8%	33%	43%	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	27%	37%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	24%	57%
Physical effort required	15%	44%	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	16%	39%	45%

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 AUA reviewed the survey results from 166 urologists and determined that the survey 25th percentile work RVU value of 22.00 is an appropriate value with respect to the physician work associated with this procedure. AUA's advisors also noted that this work RVU value is appropriate relative to the value of CPT code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed*.

The specialty society added five minutes to the pre-service positioning time for pre-time package U1 Dorsal Lithotomy.

The society added 20 minutes of intra-service time associated with a 99232 subsequent hospital visit to the immediate post-service time per CMS' 23-hour stay outpatient surgical services with subsequent hospital visits policy. This procedure is typically performed in the outpatient setting but generally requires an overnight stay and subsequent hospital visit.

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) 55899

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 Urology 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? 3519
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 analysis using Premier Healthcare Databse (PHD) data as described in the CCA for 558XX.

Specialty Urology Frequency 3519 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? 2,300
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 and estimated current coding of this procedure.

Specialty Urology Frequency 2300 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
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 55866

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: Laparoscopic Simple Prostatectomy

TAB: 9

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	55840	090	Prostatectomy, retropubic radical, with or without nerve	2014	38	0.071	0.048			21.36			448	33	3	15			180			33				1	1	1.0			1	2							
2nd REF	55845	090	Prostatectomy, retropubic radical, with or without nerve	2014	32	0.084	0.054			25.18			466	33	3	15			198			33				1	1	1.0			1	2							
HARVARD	55821	090	Prostatectomy (including control of postoperative	N/A		0.059	0.039			15.76			400	32		25			102			25					6	1.0			2.5							
SVY - Total	55821	090	Prostatectomy (including control of postoperative		144	0.126	0.066	12.00	20.00	21.36	24.85	35.23	324	33	12	10			120			25				1		1.0			2					0	0	0	3	50
Perf > 0	55821	090	Prostatectomy (including		69	0.133	0.070	12.00	20.00	22.00	25.00	35.23	316	30	12	10	2	90	120	150	305	20				1		1.0			2					1	1	3	5	50
Perf = 0	55821	090	Prostatectomy (including		75	0.096	0.057	13.96	20.00	21.00	24.15	30.25	370	40	13	13	0	120	150	180	300	30				1		1.0			2					0	0	0	0	0
XWALK	54410	090	Removal and replacement of all component(s) of a multi-	2011		0.075	0.046			15.18			329	40	10	15			120			40						0.5			3	1							
REC	55821	090	Prostatectomy (including control of postoperative bleeding, vasectomy,			0.076	0.048			15.18			315	33	3	10			120			25				1		1.0			2									

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	55840	090	Prostatectomy, retropubic radical, with or without nerve	2014	38	0.071	0.048			21.36			448	33	3	15			180			33				1	1	1.0			1	2							
2nd REF	55845	090	Prostatectomy, retropubic radical, with or without nerve	2014	32	0.084	0.054			25.18			466	33	3	15			198			33				1	1	1.0			1	2							
HARVARD	55831	090	Prostatectomy (including control of postoperative	N/A		0.062	0.041			17.19			423	31		25			114			27					6.5	1.0			2.5							
SVY - Total	55831	090	Prostatectomy (including control of postoperative		139	0.117	0.058	12.00	20.00	21.36	25.00	35.23	370	40	11	10			120			25				1		1.0			2					0	0	0	2	50
Perf > 0	55831	090	Prostatectomy (including		53	0.124	0.064	12.00	20.00	21.36	25.00	35.23	336	42	15	10	2	90	120	180	305	25				1		1.0			2					1	2	3	6	50
Perf = 0	55831	090	Prostatectomy (including		86	0.113	0.062	13.96	20.00	21.36	24.96	31.10	343	40	11	10	0	120	133	180	300	25				1		1.0			2					0	0	0	0	0
XWALK	60500	090	Parathyroidectomy or exploration of parathyroid(s);	2010		0.086	0.050			15.60			313	40	12	20			120			40						0.5			2	1							
REC	55831	090	Prostatectomy (including control of postoperative bleeding, vasectomy,			0.078	0.048			15.60			322	40	3	10			120			25				1		1.0			2									

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	55845	090	Prostatectomy, retropubic radical, with or without nerve	2014	32	0.084	0.054			25.18			466	33	3	15			198			33				1	1	1.0			1	2							
2nd REF	50543	090	Laparoscopy, surgical; partial nephrectomy	2002	44	0.070	0.049			27.41			557	60					240			30				1	2	1.0			1	3							
CURRENT	55866	090	Laparoscopy, surgical prostatectomy, retropubic	2015	32	0.104	0.061			26.80			442	33	20	15			180			30				1		1.0			1	2							
SVY	55866	090	Laparoscopy, surgical prostatectomy, retropubic		190	0.108	0.061	15.00	25.18	27.00	30.00	45.50	441	40	15	12	4	150	180	223	400	30				1		1.0			2					0	6	20	50	250
XWALK	35606	090	Bypass graft, with other than vein; carotid-subclavian	2005		0.097	0.054			22.46			414	30	15	15			145			30			1	1		1.0			2									
REC	55866	090	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve			0.097	0.062			22.46			362	40	15	12			180			50						0.5			2									

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	55840	090	Prostatectomy, retropubic radical, with or without nerve	2014	38	0.071	0.048			21.36			448	33	3	15			180			33				1	1	1.0			1	2							
2nd REF	55845	090	Prostatectomy, retropubic radical, with or without nerve	2014	32	0.084	0.054			25.18			466	33	3	15			198			33				1	1	1.0			1	2							
CURRENT																																							
SVY	558XX	090	Laparoscopy, surgical prostatectomy, simple subtotal		166	0.097	0.057	14.00	22.00	25.00	27.88	42.00	440	40	15	11	0	120	180	200	405	30				1		1.0			2					0	1	5	15	50
XWALK	42420	090	Excision of parotid tumor or parotid gland; total, with	2011		0.078	0.051			19.53			383	40	12	20			180			50						0.5			2	1							
REC	558XX	090	Laparoscopy, surgical prostatectomy, simple subtotal (including control of			0.081	0.055			19.53			354	40	8	11			180			50						0.5			2									

FACILITY DIRECT PE INPUTS

CPT CODE(S): 55821____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
55821	A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement undergoes subtotal suprapubic prostatectomy.

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:

   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 55821 and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   55821

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):

   c. Post-service period:

9. 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*):

N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA048 and SA052

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

SA052 – Pack, Post-op Incision Care (Staple) (Unit price $4.80): Kit, staple removal (1 kit); Betadine (10 ml); gauze, sterile, 4in X 4in (2 items); gloves, sterile (1 pair); steri-strip (6 strip uou) (2 items); swab-pad, alcohol (2 items); tape, surgical paper 1in (Micropore) (12 inches); tincture of benzoin, swab (1 item).

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

FACILITY DIRECT PE INPUTS

CPT CODE(S): 55821____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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).

1) For current value: Current PE inputs were updated to reflect the inputs in the RUC database: removed 2.5-92213 visits and updated to 0-99213 visits.
2) For recommended value: Reduced the recommended number of SA048 packs from 3 to 2 to reflect the post-operative office visit recommendation.
3) For recommended value: Reduced the recommended number of SM021 sanitizing cloth-wipes from 3 to 1 to reflect their typical use only in the first post-operative office visit.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 55831____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
55831	A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement undergoes subtotal retropubic prostatectomy.

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:

   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 55831 and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   55831

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):

   c. Post-service period:

9. 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*):

N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA048 and SA052

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

SA052 – Pack, Post-op Incision Care (Staple) (Unit price $4.80): Kit, staple removal (1 kit); Betadine (10 ml); gauze, sterile, 4in X 4in (2 items); gloves, sterile (1 pair); steri-strip (6 strip uou) (2 items); swab-pad, alcohol (2 items); tape, surgical paper 1in (Micropore) (12 inches); tincture of benzoin, swab (1 item).

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

FACILITY DIRECT PE INPUTS

CPT CODE(S): 55831____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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).

1) For current value: Current PE inputs were updated to reflect the inputs in the RUC database: removed 2.5-92213 visits and updated to 0-99213 visits.
2) For recommended value: Reduced the recommended number of SA048 packs from 3 to 2 to reflect the post-operative office visit recommendation.
3) For recommended value: Reduced the recommended number of SM021 sanitizing cloth-wipes from 3 to 1 to reflect their typical use only in the first post-operative office visit.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 55866____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
55866	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
55866	A 48-year-old male with a PSA level of 3.5 undergoes a prostate biopsy that reveals adenocarcinoma with a Gleason score of 7 in both lobes. He is counseled on the risks and benefits of surgery versus radiation and has chosen robotic-assisted laparoscopic radical prostatectomy.

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:

   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 55866 and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   55866

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):

   c. Post-service period:

9. 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*):

N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA048

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please

submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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).

1) For current value: Added 1 SA054 pack to reflect current PE inputs in the RUC database and removed 1 SM 021 sanitizing cloth-wipe (patient) to reflect current PE inputs in the RUC database.
2) For recommended value: Reduced the recommended number of SA048 packs from 3 to 2 to reflect the post-operative office visit recommendation.
3) For recommended value: Reduced the recommended number of SM021 sanitizing cloth-wipes from 3 to 1 to reflect their typical use only in the first post-operative office visit.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 558XX____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
558XX	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
558XX	A 65-year-old male who is symptomatic due to obstruction from prostatic enlargement chose to undergo laparoscopic simple suprapubic prostatectomy.

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:
   AUA's RVS Committee Expert Panel reviewed the survey data and time recommendations for CPT code 558XX and updated the direct PE inputs accordingly using standard 090-day global period clinical staff time 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):
   55866

3. Is this code(s) typically reported with an E/M service?
   No

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.
   No.

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):
   c. Post-service period:

9. 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*):
   N/A

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Yes – SA048

15. 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.

SA048 – Pack, Minimum Specialty Visit (Unit price $5.02): Paper, exam table (7 feet); Gloves, non-sterile (2 pair); gown, patient (1 item); pillow case (1 item); cover, thermometer probe (1 item).

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. 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

19. 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:

EQ168 light, exam; and EF023 table, exam

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 558XX____
SPECIALTY SOCIETY(IES): AUA_____
PRESENTER(S):Thomas M.T. Turk, MD and Kyle A. Richards, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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).

1) For current reference value: Current PE inputs were updated to reflect the inputs in the RUC database: increased number of SM021 sanitizing cloth-wipe (patient) from 1 to 3.
2) For recommended value: Reduced the recommended number of SA048 packs from 3 to 2 to reflect the post-operative office visit recommendation.
3) For recommended value: Reduced the recommended number of SM021 sanitizing cloth-wipes from 3 to 1 to reflect their typical use only in the first post-operative office visit.

	A	B	D	E	F	I	J	K	L	O	P	Q	R	U	V	W	X	Y	Z	AC	AD
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2						CPT Code 55821		CPT Code 55821		CPT Code 55831		CPT Code 55831		CPT Code 55866		CPT Code 55866		CPT Code 55845		CPT Code 558XX	
3		*RUC Collaboration Website*				Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic		Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or	
4	Clinical Activity Code	Meeting Date: January 2022 Revision Date (if applicable): Tab: 9 Specialty: American Urological Association	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					090		090		090		090		090		090		090		090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	L037D			0.0	162.0	0.0	144.0	0.0	162.0	0.0	144.0	0.0	197.0	0.0	138.0	0.0	197.0	0.0	138.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D			0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D			0.0	12.0	0.0	12.0	0.0	12.0	0.0	12.0	0.0	12.0	0.0	6.0	0.0	12.0	0.0	6.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D			0.0	90.0	0.0	72.0	0.0	90.0	0.0	72.0	0.0	125.0	0.0	72.0	0.0	125.0	0.0	72.0
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		L037D						5				5		5		5		5		5
16	CA002		L037D						20				20		20		20		20		20
17	CA003		L037D						8				8		8		8		8		8
18	CA004		L037D						20				20		20		20		20		20
19	CA005		L037D						7				7		7		7		7		7
20	CA006		L037D																		
21	CA007		L037D																		
22	CA008		L037D				60				60										
23			L037D																		
26		*Other activity: please include short clinical description here and type new in*	L037D																		
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		L037D																		
34	CA010		L037D																		
35	CA011		L037D																		
36	CA012		L037D																		
37	CA013		L037D																		
38	CA014		L037D																		
39	CA015		L037D																		
40	CA016		L037D																		
41	CA017		L037D																		
42			L037D																		
45		*Other activity: please include short clinical description here and type new in*	L037D																		
48		Intra-service (of service period)																			
49	CA018		L037D																		
50	CA019		L037D																		
51	CA020		L037D																		
52	CA021		L037D																		
55			L037D																		
56		*Other activity: please include short clinical description here and type new in*	L037D																		
59		Post-Service (of service period)																			
60	CA022		L037D																		
61	CA023		L037D																		
62	CA024		L037D																		
63	CA025		L037D																		
64	CA026		L037D																		
65	CA027		L037D																		
66	CA028		L037D																		
67	CA029		L037D																		
68	CA030		L037D																		
69	CA031		L037D																		
70	CA032		L037D																		
71	CA033		L037D																		
72	CA034		L037D																		
73	CA035		L037D																		
74	CA036		L037D			n/a	12	n/a	12	n/a	12	n/a	12	n/a	12	n/a	6	n/a	12	n/a	6
75			L037D																		
78		*Other activity: please include short clinical description here and type new in*	L037D																		
81		End: Patient leaves office/facility																			
82		POST-SERVICE PERIOD																			
83		Start: Patient leaves office/facility																			
84	CA037		L037D																		
85	CA038		L037D				90				90										
86		*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
87		99211 16 minutes	16																		
88		99212 27 minutes	27																		
89		99213 36 minutes	36				0		2		0		2		2		2		2		2
90		99214 53 minutes	53												1				1		
91		99215 63 minutes	63																		
92	CA039		L037D			0.0	0.0	0.0	72.0	0.0	0.0	0.0	72.0	0.0	125.0	0.0	72.0	0.0	125.0	0.0	72.0
93			L037D																		
96		*Other activity: please include short clinical description here and type new in*	L037D																		
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				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102	SA048						3		**2**		3		**2**		3		**2**		3		**2**
103	SA052						1		1		1		1						1		
104	SA054														**1**						
105	SM021						20		**1**		20		**1**		**0**		**1**		**3**		**1**
106	SC051								1				1				1		1		1
107	SC062								1				1				1				1
108	SH069								1				1				1				1
110	SJ009								1				1				1				1
111	SK054								1				1				1		1		1

	A	B	D	E	F	I	J	K	L	O	P	Q	R	U	V	W	X	Y	Z	AC	AD
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 55821**		**CPT Code 55821**		**CPT Code 55831**		**CPT Code 55831**		**CPT Code 55866**		**CPT Code 55866**		**CPT Code 55845**		**CPT Code 558XX**	
3		***RUC Collaboration Website***				Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation,		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic		Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or	
4	**Clinical Activity Code**	**Meeting Date: January 2022 Revision Date (if applicable): Tab: 9 Specialty: American Urological Association**	**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**					**090**		**090**		**090**		**090**		**090**		**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**162.0**	**0.0**	**144.0**	**0.0**	**162.0**	**0.0**	**144.0**	**0.0**	**197.0**	**0.0**	**138.0**	**0.0**	**197.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**90.0**	**0.0**	**72.0**	**0.0**	**90.0**	**0.0**	**72.0**	**0.0**	**125.0**	**0.0**	**72.0**	**0.0**	**125.0**	**0.0**	**72.0**
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.*																			
113																					
114	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**																
115		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
116	EF031			Office Visits			90		72.0		90		72.0		125		72.0		125		72.0
117	EF014			Office Visits					72.0				72.0		125		72.0		**0**		72.0
118	EQ168																		**125**		
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.*																			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2022

Transcutaneous Passive Implant-Temporal Bone – Tab 10

In October 2020, the CPT Editorial Panel revised codes 69714 and 69716 to replace "temporal bone" with "skull" and delete "or transcutaneous" and "cochlear stimulator: without mastoidectomy" from the descriptors. The Panel also replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

At the January 2021 RUC meeting, following an initial survey, the RUC reviewed this family of services and determined that they needed to be resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically to include the lower end of the RVU spectrum. The RUC submitted interim recommendations to CMS for CY 2022. The specialty society submitted a letter to the RUC requesting that this code family be referred to the CPT Editorial Panel in May 2021 to clarify the percutaneous implant removal by describing the procedure as removal of the entire implant and adding a parenthetical.

At the April 2021 RUC meeting, the RUC recommended temporarily affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting. In May 2021, for CPT 2023, the CPT Editorial Panel established three new codes 69XX0, 69XX1, 69XX2 and added a parenthetical note reporting transcutaneous, passive bone anchored implants for bone conduction hearing appliances. The coding structure was changed to describe the different techniques more appropriately for transcutaneous passive implant procedures that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, the specialties proposed, and the CPT Editorial Panel had agreed, to make coding changes to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex.

The specialty society surveyed the codes for the October 2021 RUC meeting. However, prior to the meeting, it was discovered that one of the survey codes was inadvertently listed on the RSL and was selected as the top Key Reference Service (KRS) code for every code surveyed. After discussion at the October 2021 RUC meeting, the specialty society indicated, and the RUC agreed, that the survey results were invalid and that the codes should be resurveyed for the January 2022 RUC meeting with a revised RSL to be approved by the Research Subcommittee. The Research Subcommittee approved the RSL and a survey was successfully administered for the January 2022 RUC meeting.

Osseointegrated Implant – Description of Family

Within this code family, the least intense services are the removal procedures, the next most intense are the implantation procedures and the most intense are the revision/replacement procedures. To describe the three levels of intensity, the specialty provided the RUC with a detailed explanation about how hearing sensation occurs, what bone anchored hearing aids do to treat patients with certain types of hearing loss and the intensity and risk involved in performing these procedures. Hearing sensation occurs by sound coming into the ear and entering the ear canal; the ear drum vibrates which sends those vibrations to three bones in the middle ear. Those bones increase the vibrations and transmit them to the cochlea, a small snail shaped structure filled with fluid. The fluid in the cochlea moves, activating hair cells, causes stereocilia to bend, which leads to an electrical signal which then is carried by the auditory nerve to the brain, which turns into sound.

When people have hearing loss, it is either conductive hearing loss, which is an issue up to that electric stimulation of the nerve or it iss sensory-neural hearing loss, which involves a nerve issue. Hearing loss could also be related to a combination of both conductive and sensory-neural hearing loss. These bone anchored hearing aids treat the conductive portion of hearing loss. Whether it's exclusively conductive or mixed, these devices bypass the external auditory meatus to deliver sound vibrations directly to the inner ear, so it's useful for patients who have conditions such as malformed outer middle ears. For percutaneous bone anchored hearing aids, the patient has a titanium bone implant that is anchored into the skull and is protruding through the skin from the skull. It is then attached to an external microphone and a processor, so these patients have a screw projecting out from their head all the time, through the skin. For transcutaneous bone anchored hearing aids, everything is implanted under the skin within the cranium. That is secured and the skin is closed, and then it eventually attaches to a processor via a magnet which the patient can take on and off, so they do not have anything sticking out through the skin.

Osseointegrated Implant – Implantation

69714 ***Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 45 physicians and determined the survey 25th percentile work RVU of 8.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 8 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty society noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that the recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the Medicare Physician Payment Schedule (MFS). It was noted that the current CY 2022 CMS times and RVUs in place were based on a flawed survey and interim RUC recommendations from January 2021. The RUC noted that the survey only from one year ago included 10 more minutes of intra-service time and one more post-operative visit.

The RUC noted that the recommended work RVU of 8.00 is almost half that of the 2021 work RVU (14.45). For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the cerebrospinal fluid (CSF), breaching the intracranial space. All these attributes make these procedures very intense and complex to perform.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively low skin-to-skin times. To justify a work value of 8.00, the RUC compared the surveyed code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45 minutes, total time of 159 minutes) and noted that reference code involves 13 more minutes of total time and supports the proposed value of the survey code. The RUC also compared the surveyed code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that the surveyed code involves 9 fewer minutes of total time though is more intense than the reference code. **The RUC recommends a work RVU of 8.00 for CPT code 69714.**

69716 ***Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 mm2 surface area of bone deep to the outer cranial cortex***
The RUC reviewed the survey results from 41 physicians and determined the survey 25th percentile work RVU of 9.03 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 50 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation maintains appropriate relativity both within the family and across the RBRVS.

The implantation procedure described by CPT code 69716 requires more work than CPT code 69714, as it often requires removal of a portion of the cranium. These cases are technically more difficult, time consuming, and risky. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 9.03, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that the survey code involves more intra-service and total

time, though the reference codes is a slightly more intense service to perform. The RUC also compared the survey code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that the survey code involves somewhat more intra-service and total time relative to the reference code and is also a more intense service to perform. **The RUC recommends a work RVU of 9.03 for CPT code 69716.**

69XX0 ***Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of bone deep to the outer cranial cortex***
The RUC reviewed the survey results from 40 physicians and determined the survey 25th percentile work RVU of 9.97 appropriately accounts for the physician work required to perform this service. The RUC recommends 29 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 9 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package.

This service requires more work than the other two implantation procedures in the code family as it requires removal of a significant amount of cranium down to, or sometimes beyond, the inner cortex in the retrosigmoid area or temporal squama. These cases are more technically difficult, time consuming, and risky. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make this procedure the most intense and complex to perform when compared to the codes describing implantation of an osseointegrated implant.

To justify a work value of 9.97, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and a similar amount of total time. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and very similar total times, though the survey code is a more intense procedure to perform. **The RUC recommends a work RVU of 9.97 for CPT code 69XX0.**

Osseointegrated Implant – Revision/Replacement

69717 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 42 physicians and determined the survey 25th percentile work RVU of 8.48 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 44 minutes of intra-service time, 15 minutes of immediate post-service time, ½

discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

The RUC noted that the recommended work RVU of 8.48 is almost half that of the 2021 work RVU (15.43). For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform. The specialty noted and the RUC agreed that the revision/replacement procedures are the most intense and complex procedures in this code family

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 8.48, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159) and noted that both services involve a very similar amount of intra-service time and an identical amount of total time, though the reference code is a slightly intense service to perform. The RUC also compared the survey code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that both services involve very similar intra-service times), though the survey code involves 4 more minutes of total time. **The RUC recommends a work RVU of 8.48 for CPT code 69717.**

69719 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex***

The RUC reviewed the survey results from 38 physicians and determined the survey 25th percentile work RVU of 9.46 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 9 minutes of pre-service scrub/dress/wait time, 55 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation maintains appropriate relativity both within the family and across the RBRVS.

For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform. The specialty noted and the RUC agreed that the revision/replacement procedures are the most intense and complex procedures in this code family.

To justify a work value of 9.46, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that the survey code involves 5 more minutes of intra-service time and somewhat less total time. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and that although the survey code involves somewhat less intra-service and total time, it is also a more intense procedure to perform. **The RUC recommends a work RVU of 9.46 for CPT code 69719.**

69XX1 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm2 surface area of bone deep to the outer cranial cortex***

The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 10.25 appropriately accounts for the physician work required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

This service requires more work than the other two revision/replacement procedures in the code family as it requires work outside the mastoid and the added complexity of involvement of a bony defect. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make this procedure the most intense and complex to perform within the revision/replacement procedures. The specialty noted, and the RUC agreed, that the revision/replacement procedures are the most intense and complex procedures in this code family.

To justify a work value of 10.25, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and very similar total time, though the survey code is slightly more intense to perform. The RUC also compared the survey code to

MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times, the survey code involves 5 more minutes of total time and is a more intense procedure to perform. **The RUC recommends a work RVU of 10.25 for CPT code 69XX1.**

Osseointegrated Implant – Removal

69726 *Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor*
The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 7.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 35 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make these procedures very intense and complex to perform.

The specialty society asserted that two incorrect assumptions were made for the January 2021 interim value for this procedure: first, that a flawed crosswalk was chosen in the previous valuation of this code, and second, that the January 2021 survey was flawed in that a rank order anomaly existed between the value of 69726 and the other codes in the family. Due to the dearth of potential crosswalks, the RUC chose to crosswalk the interim value for CPT code 69726 to CPT code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 5.93, intra-service time of 30 minutes and total time of 142 minutes). The service did have an identical intra time and similar total time; however, surveyed code 69726 is more intense than the code used for crosswalk. In the latest survey for the January 2022 RUC meeting, there was an increase of 5 minute of intra-service time when compared to the January 2021 survey.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 7.50, the RUC compared the surveyed code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that reference code involves 10 more minutes of intra-service time and supports the proposed value of the survey code. Within this code family, the least intense services are the removal procedures. **The RUC recommends a work RVU of 7.50 for CPT code 69726.**

69727 ***Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex***
The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 7.38 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 50 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make these procedures very intense and complex to perform. While still complex, the removal procedures are the least intense services within this code family.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 7.38, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that reference code involves less intra-service and total time, though is a more intense service than the survey code, supporting the survey code's proposed value. The RUC also compared the survey code to CPT code 67911 *Correction of lid retraction* (work RVU= 7.50, intra-service time of 50 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 7.38 for CPT code 69727.**

69XX2 ***Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex***
The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 8.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 8 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

This service requires more work than the other two removal procedures in the code family as it requires work outside the mastoid and the added complexity of involvement of a bony defect. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make this procedure very intense and complex to perform. While still complex, the removal procedures are the least intense services within this code family.

To justify a work value of 8.50, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and similar total time, though the reference code is slightly more intense to perform. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 8.50 for CPT code 69XX2.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The RUC noted that the proposed clinical labor times are based on the standard 090-day global packages. For CA026 *clean surgical instrument package*, which was recommended at 20 minutes, this is twice the standard of 10 minutes because the surgical instrument package is used for both post-operative office visits and the instruments are cleaned after each visit. The PE Subcommittee had confirmed that the two post-operative offices typically require the operating microscope and a set of instruments. The operating microscope is used during each post-operative office visit and is present in the room the entire time during each visit. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Auditory System** **Middle Ear** ***Osseointegrated Implants*** *The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other reparative middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately when performed.*				
▲69714	N1	Implantation, osseointegrated implant, ~~temporal bone~~skull~~, with percutaneous attachment to external speech processor/cochlear stimulator~~; ~~without mastoidectomy~~with percutaneous attachment to external speech processor	090	8.00
~~69715~~	-	~~*with mastoidectomy*~~ (69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	090	~~N/A~~
▲69716	N2	*with magnetic transcutaneous attachment to external speech processor* within the mastoid and/or resulting in removal of less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	9.03
●69XX0	N3	with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	~~090~~	9.97

▲69717	N4	*Revision/r~~R~~eplacement (including removal of existing device), osseointegrated implant, ~~temporal bone~~skull~~, with percutaneous attachment to external speech processor/cochlear stimulator~~; with percutaneous attachment to external speech processor~~without mastoidectomy~~*	090	8.48
~~69718~~	-	~~with mastoidectomy~~ (69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	~~N/A~~

▲69719	N5	*with magnetic transcutaneous attachment to external speech processor*, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	9.46
●69XX1	N6	with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	090	10.25
▲69726	N7	*Removal,* entire *osseointegrated implant, skull; with percutaneous attachment to external speech processor* (To report partial removal of the device [ie, abutment only], use appropriate evaluation and management code)	090	7.50
▲69727	N8	*with magnetic transcutaneous attachment to external speech processor*, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	7.38
●69XX2	N9	with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	090	8.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69714 Tracking Number Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: 090 Current Work RVU: **8.69** RUC Recommended RVU: **8.00**

CPT Descriptor: Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. He is unable to wear traditional hearing aids. Implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 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: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the bolster in place and with appropriate pressure.

Description of Post-Service Work: The prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications.There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Discharge Management / Post-Operative Visits
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The sutures are removed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing and long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69714					
Sample Size:	3268	**Resp N:**	45			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	10.00	56.00
Survey RVW:	5.00	8.00	**10.00**	13.00	18.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**8.00**		
Intra-Service Time:	10.00	22.00	**30.00**	45.00	150.00

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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69714	**Recommended Physician Work RVU: 8.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**8.00**	**15.00**	**-7.00**
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)

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:	**15.00**	**30.00**	**-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:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 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
21013	090	5.42	**RUC Time**

CPT Descriptor Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14040	090	8.60	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 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
67904	000	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	2,079

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

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: 5 **% of respondents:** 11.1 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 8.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 69714	Top Key Reference CPT Code: 21013	2nd Key Reference CPT Code: **14040**
Median Pre-Service Time	43.00	56.00	30.00
Median Intra-Service Time	30.00	45.00	90.00
Median Immediate Post-service Time	15.00	15.00	25.00
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	0.00
Median Office Visit Time	39.0	39.00	78.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**146.00**	**174.00**	**223.00**
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%	40%	60%	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	20%	40%	40%
Physical effort required	40%	40%	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	20%	60%	20%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	75%	25%	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%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	75%	25%
Physical effort required	0%	100%	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	25%	25%	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:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated

implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters

during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the ANS (American Neurotology Society), and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2cm valued at 5.42 RVUs with a pre time of 56 / intra time of 45 / post time of 15, totaling 174 minutes. 5 respondents selected this as their primary KRS.

The second KRS selected was CPT 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less valued at 8.60 RVUs with a pre time of 30 / intra time of 90 / post time of 25, totaling 223 minutes. 4 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.00 and 30 minutes of intra service time**. Our expert panel felt this value, which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We recognize that our total time has decreased, due to respondents indicating less intra service time and one less post operative visit, however, we feel our RVU reduction in our recommendation takes that time modification into account.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 25 minutes of evaluation time which less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees,

which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 8 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 43 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although not indicated for the this particular code by survey respondents. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure. The survey respondents also indicated two post-operative office visits occur following the initial procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The sutures are removed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing and long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value
It is worth noting that while there are many codes in the fee schedule to support our requested value. The MPC codes provided in the required section of the SOR above do not have identical intra time, as there are no 090 globals in the database with 30 minutes intra time on the MPC list. Therefore, to offer supporting MPC codes, we utilized codes with slightly longer intra times from the MPC list.

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	IWPUT
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,	90	7.03	30	15	15	30	20	81	191	2020-01	0.0798

	articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])											
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.03	33	10	15	40	15	81	194	2011-04	0.0637
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	90	7.07	35	10	10	45	20	97	217	2007-02	0.0443
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	90	7.12	7	10	2	30	5	142	196	2007-09	0.063
37718	Ligation, division, and stripping, short saphenous vein	90	7.13	35	10	10	45	20	58	178	2005-04	0.0778
23120	Claviculectomy; partial	90	7.39	40	15	15	45	15	97	227	2008-04	0.048
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.39	33	10	15	45	15	81	199	2011-04	0.0647
19328	Removal of intact breast implant	90	7.44	40	10	10	45	20	74	199	2020-01	0.0716
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	90	7.44	33	10	10	45	15	113	226	2016-01	0.0453
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	90	7.44	40	10	15	45	20	97	227	2007-02	0.0491
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	90	7.44	35	10	15	45	15	97	217	2007-02	0.0541

56620	Vulvectomy simple; partial	90	7.53	45	10	5	45	30	104	239	2008-02	0.0346
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	90	7.89	40	10	15	45	20	136	266	2007-02	0.028
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	90	7.91	40			45	20	74	179	2000-08	0.0888
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	90	7.97	10	10	15	45	15	90	185	2005-08	0.0892
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	90	8.13	33	15	15	45	20	81	209	2009-02	0.0761
`25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	90	8.31	40	10	15	45	30	120	260	2006-02	0.0419
67255	Scleral reinforcement (separate procedure); with graft	90	8.38	19	1	5	45	10	136	216	2014-01	0.0595
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	90	8.56	30	15	15	45	30	120	255	2005-08	0.0511
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	90	8.69	72.5	10	15	40	25	35	197.5	2008-04	0.126
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	90	8.8	45	10	15	45	20	136	271	2007-02	0.0457

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 223
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 223 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? 74 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new

transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 74 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:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69714

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69716 Tracking Number Original Specialty Recommended RVU: **9.03**
Presented Recommended RVU: **9.03**
Global Period: 090 Current Work RVU: **9.77** RUC Recommended RVU: **9.03**

CPT Descriptor: Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with a congenital left conductive hearing loss seeks intervention for improved quality of life at work and socially. A magnetic transcutaneous bone anchored hearing device is placed behind the left ear.

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 59% , In the ASC 41%, 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 96% , Overnight stay-less than 24 hours 4% , 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 100%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and a subpericranial pocket for the implant coil and magnet are created. The area for the transducer is then identified using the template and marked on the outer table of the skull in the region of the sinodural angle. Surgical guide and fixation holes are then drilled taking care not to penetrate the sigmoid sinus or the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull overlying the sinodural angle, less than or equal to 100 sq mm, is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura and sigmoid sinus. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then

carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped area of the recipient sites is cleaned. A dressing is applied to the recipient site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69716					
Sample Size:	3268	**Resp N:**	41			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**3.00**	5.00	12.00
Survey RVW:		6.00	9.03	**13.00**	16.00	30.00
Pre-Service Evaluation Time:				**25.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		20.00	45.00	**50.00**	60.00	150.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69716	**Recommended Physician Work RVU: 9.03**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
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:		**50.00**		

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):	39.00	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
30410	090	14.00	**RUC Time**

CPT Descriptor Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

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
28003	090	9.06	**RUC Time**	5,470

CPT Descriptor 2 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

Other Reference CPT Code	Global	Work RVU	Time Source
67036	090	12.13	**RUC Time**

CPT Descriptor Vitrectomy, mechanical, pars plana approach;

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 5 **% of respondents:** 12.1 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 9.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 69716	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **30410**
Median Pre-Service Time	45.00	95.00	45.00
Median Intra-Service Time	50.00	180.00	120.00
Median Immediate Post-service Time	15.00	30.00	53.00
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	0.00
Median Office Visit Time	39.0	63.00	144.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**168.00**	**387.00**	**362.00**
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%	40%	40%	20%	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%	25%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	80%	20%	0%

Physical effort required	60%	40%	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	60%	40%	0%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	25%	50%	25%	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%	75%	0%
Physical effort required	0%	100%	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	0%	100%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU

range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 5 respondents selected this as their primary KRS.

The second KRS selected was CPT 30410 Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip valued at 14.00 RVUs with a pre time of 45 / intra time of 120 / post time of 53, totaling 362 minutes. 4 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **9.03 and 50 minutes of intra service time.** Our expert panel felt this value which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We recognize that our total time has decreased, due to respondents indicating less intraservice time, however, we feel our RVU reduction in our recommendation takes that time modification into account.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 25 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	MPC
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	90	0.0618	8.01	33	10	10	50	15	97	215	2016-01	

28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	90	0.0072	9.06	33	3	15	53	20	199	323	2010-10	Yes
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	90	0.0899	9.23	15	10	5	60	15	78	183	2005-08	
67036	Vitrectomy, mechanical, pars plana approach;	90	0.1075	12.13	33	3	15	50	15	134	250	2013-10	
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	90	0.1156	14	19	1	5	55	10	182	272	2014-01	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2532
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume

For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 2532 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? 844 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 844 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69716

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:69XX0 Tracking Number Original Specialty Recommended RVU: **9.97**
Presented Recommended RVU: **9.97**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **9.97**

CPT Descriptor: Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with a right mixed hearing loss from chronic ear disease and its surgical treatment seeks intervention for improved quality of life at work and socially. A magnetic transcutaneous bone anchored hearing device is placed in the right retrosigmoid location because the right mastoid is contracted and inflamed.

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 58% , In the ASC 42%, 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 91% , Overnight stay-less than 24 hours 9% , 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 100%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and a subpericranial pocket for the implant coil and magnet are created. The area for the transducer is then identified using the template and marked on the outer table of the skull in the region of the sinodural angle. Surgical guide and fixation holes are then drilled taking care not to penetrate the sigmoid sinus or the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull overlying the sinodural angle, greater than or equal to 100 sq mm, is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura and sigmoid sinus. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then

carefully measured and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped area of the surgical site is cleaned. A dressing is applied to the surgical site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Post-Operative Visits

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69XX0					
Sample Size:	3268	**Resp N:**	40			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	2.00	20.00
Survey RVW:		7.00	9.97	**14.00**	16.33	30.00
Pre-Service Evaluation Time:				**29.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		30.00	45.00	**60.00**	90.00	165.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69XX0	**Recommended Physician Work RVU: 9.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**29.00**	**33.00**	**-4.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**9.00**	**15.00**	**-6.00**
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:	**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):	39.00	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21199	090	16.73	**RUC Time**

CPT Descriptor Osteotomy, mandible, segmental; with genioglossus advancement

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
57240	090	10.08	**RUC Time**	9,026

CPT Descriptor 1 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
14060	090	9.23	**RUC Time**	90,113

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
49520	090	9.99	**RUC Time**

CPT Descriptor Repair recurrent inguinal hernia, any age; reducible

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 22.5 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 69XX0	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **21199**
Median Pre-Service Time	48.00	95.00	30.00
Median Intra-Service Time	60.00	180.00	90.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	40.00
Median Discharge Day Management Time	19.0	19.00	38.00
Median Office Visit Time	39.0	63.00	55.00
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**	**387.00**	**283.00**
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%	11%	56%	22%	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	12%	63%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	44%	34%	22%
Physical effort required	33%	56%	11%

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	44%	34%	22%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	0%	60%	20%

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%	60%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	40%	20%
Physical effort required	0%	80%	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	0%	40%	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.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated

implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters

during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 9 respondents selected this as their primary KRS.

The second KRS selected was CPT 21199 Osteotomy, mandible, segmental; with genioglossus advancement valued at 16.73 RVUs with a pre time of 30 / intra time of 90 / post time of 30, totaling 283 minutes. 5 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **9.97 and 60 minutes of intra service time**. Our expert panel felt this value which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 29 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide

tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 9 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 48 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	MPC
49590	Repair spigelian hernia	090	0.0855	8.90	45			60	30	58	193	2000-08	
49525	Repair inguinal hernia, sliding, any age	090	0.086	8.93	45			60	30	58	193	2000-08	

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	090	0.0836	8.97	10	10.0	15.0	60	15	90	200	2005-08	
49550	Repair initial femoral hernia, any age; reducible	090	0.087	8.99	45			60	30	58	193	2000-08	
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	090	0.0855	9.03	40	10.0	10.0	60	20	61	201	2014-01	
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	090	0.0899	9.23	15	10.0	5.0	60	15	78	183	2005-08	Yes
49520	Repair recurrent inguinal hernia, any age; reducible	090	0.1065	9.99	45			60	22.5	58	185.5	2000-08	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 223
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 223 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? 74 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year

69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 74 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:
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. 69714

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69717 Tracking Number Original Specialty Recommended RVU: **8.48**
Presented Recommended RVU: **8.48**
Global Period: 090 Current Work RVU: **8.80** RUC Recommended RVU: **8.48**

CPT Descriptor: Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. The device is removed and a new device is placed at a different site.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 57% , In the ASC 43%, 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: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A subpericranial dissection is performed and the previous implant abutment is removed. The cranial bone surrounding the osseointegrated titanium fixture in the patient's skull is drilled around the implant. The fixture is removed. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The area for the new placement of the implant is then identified, templated, and marked on the outer table of the skull. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A new pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is

then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the small abutment bolster in place and with appropriate pressure.

Description of Post-Service Work: The prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Discharge Management / Post-Operative Visits
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The sutures are removed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing and long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69717					
Sample Size:	3268	**Resp N:**	42			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**2.00**	4.00	20.00
Survey RVW:		5.50	8.48	**11.70**	14.94	20.00
Pre-Service Evaluation Time:				**25.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**7.00**		
Intra-Service Time:		5.00	27.00	**44.00**	55.00	195.00
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):	**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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69717	**Recommended Physician Work RVU: 8.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**7.00**	**15.00**	**-8.00**
Intra-Service Time:		**44.00**		

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:	**15.00**	**30.00**	**-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:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 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
42120	090	11.86	**RUC Time**

CPT Descriptor Resection of palate or extensive resection of lesion

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21013	090	5.42	**RUC Time**

CPT Descriptor Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm

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
67904	000	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	2,079

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

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: 4 **% of respondents:** 9.5 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 9.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 69717	**Top Key Reference CPT Code:** 42120	**2nd Key Reference CPT Code:** **21013**
Median Pre-Service Time	42.00	60.00	56.00
Median Intra-Service Time	44.00	80.00	45.00
Median Immediate Post-service Time	15.00	30.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	20.00	0.00
Median Discharge Day Management Time	19.0	38.00	19.00
Median Office Visit Time	39.0	78.00	39.00
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**	**306.00**	**174.00**
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%	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%	25%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	75%	25%

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	0%	75%	25%

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%	25%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	50%	25%	25%
Physical effort required	50%	25%	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%	50%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU

range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 42120 Resection of palate or extensive resection of lesion valued at 11.86 RVUs with a pre time of 60 / intra time of 80 / post time of 30, totaling 306 minutes. 4 respondents selected this as their primary KRS.

The second KRS selected was CPT 21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2cm valued at 5.42 RVUs with a pre time of 56 / intra time of 45 / post time of 15, totaling 174 minutes. 4 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.48 and 44 minutes of intra service time.** Our expert panel felt this value, which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We recognize that our total time has decreased, due to respondents indicating one less post operative visit, however, we feel our RVU reduction in our recommendation takes that time modification into account.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 25 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides."

Scrub, Dress, Wait Time – We are recommending 7 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 42 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although not indicated for the this particular code by survey respondents. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure. The survey respondents also indicated two post-operative office visits occur following the initial procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The sutures are removed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing and long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	IWPUT
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.03	33	10	15	40	15	81	194	2011-04	0.0637

26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	90	7.07	35	10	10	45	20	97	217	2007-02	0.0443
37718	Ligation, division, and stripping, short saphenous vein	90	7.13	35	10	10	45	20	58	178	2005-04	0.0778
23120	Claviculectomy; partial	90	7.39	40	15	15	45	15	97	227	2008-04	0.048
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.39	33	10	15	45	15	81	199	2011-04	0.0647
19328	Removal of intact breast implant	90	7.44	40	10	10	45	20	74	199	2020-01	0.0716
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	90	7.44	33	10	10	45	15	113	226	2016-01	0.0453
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	90	7.44	40	10	15	45	20	97	227	2007-02	0.0491
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	90	7.44	35	10	15	45	15	97	217	2007-02	0.0541
56620	Vulvectomy simple; partial	90	7.53	45	10	5	45	30	104	239	2008-02	0.0346
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	90	7.89	40	10	15	45	20	136	266	2007-02	0.028
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	90	7.91	40			45	20	74	179	2000-08	0.0888
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	90	7.97	10	10	15	45	15	90	185	2005-08	0.0892
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	90	8.13	33	15	15	45	20	81	209	2009-02	0.0761

`25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	90	8.31	40	10	15	45	30	120	260	2006-02	0.0419
67255	Scleral reinforcement (separate procedure); with graft	90	8.38	19	1	5	45	10	136	216	2014-01	0.0595
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	90	8.56	30	15	15	45	30	120	255	2005-08	0.0511
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	90	8.69	72.5	10	15	40	25	35	197.5	2008-04	0.126
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	90	8.8	45	10	15	45	20	136	271	2007-02	0.0457

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

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 Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 13 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? 4 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 4 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:
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 69717

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:69719 Tracking Number Original Specialty Recommended RVU: **9.46**
Presented Recommended RVU: **9.46**
Global Period: 090 Current Work RVU: **9.77** RUC Recommended RVU: **9.46**

CPT Descriptor: Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with a right conductive hearing loss previously had placement of a right magnetic transcutaneous bone anchored hearing device that has malfunctioned. She undergoes removal and replacement of the device.

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 63% , In the ASC 37%, 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: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is removed. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. A subpericranial pocket for the implant coil and magnet are created. The area for the new placement of the transducer is then identified using the template and marked on the outer table of the skull. Surgical guide and fixation holes are then drilled taking care not to penetrate the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull is then drilled, less than 100 sq mm, to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet

and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped area of the surgical site is cleaned. A dressing is applied to the surgical site. A compression dressing is fashioned and is wrapped around the head to compress the surgical site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Post-Operative Visits

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69719					
Sample Size:	3268	**Resp N:**	38			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	2.00	10.00
Survey RVW:		7.00	9.46	**14.00**	16.23	30.00
Pre-Service Evaluation Time:				**27.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**9.00**		
Intra-Service Time:		20.00	45.00	**55.00**	84.00	195.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69719	**Recommended Physician Work RVU: 9.46**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**27.00**	**33.00**	**-6.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**9.00**	**15.00**	**-6.00**
Intra-Service Time:		**55.00**		

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):	**39.00**	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31587	090	15.27	**RUC Time**

CPT Descriptor Laryngoplasty, cricoid split, without graft placement

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
14060	090	9.23	**RUC Time**	90,113

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
28003	090	9.06	**RUC Time**

CPT Descriptor Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 5 **% of respondents:** 13.1 **%**

Number of respondents who choose 2nd Key Reference Code: 3 **% of respondents:** 7.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 69719	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **31587**
Median Pre-Service Time	46.00	95.00	58.00
Median Intra-Service Time	55.00	180.00	95.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	155.00
Median Discharge Day Management Time	19.0	19.00	38.00
Median Office Visit Time	39.0	63.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**174.00**	**387.00**	**445.00**
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	20%	40%	20%	20%	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	75%	0%	25%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	80%	20%	0%
Physical effort required	80%	0%	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	60%	20%	20%

2nd 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%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	67%	0%	33%
Physical effort required	67%	33%	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	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.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated

implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters

during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 5 respondents selected this as their primary KRS.

The second KRS selected was CPT 31587 Laryngoplasty, cricoid split, without graft placement valued at 15.27 RVUs with a pre time of 58 / intra time of 95 / post time of 30, totaling 445 minutes. 3 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **9.46 and 55 minutes of intra service time.** Our expert panel felt this value which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We recognize that our total time has decreased, due to respondents indicating less intraservice time, however, we feel our RVU reduction in our recommendation takes that time modification into account.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 27 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be

properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 9 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	MPC
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	90	0.0618	8.01	33	10	10	50	15	97	215	2016-01	
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	90	0.0072	9.06	33	3	15	53	20	199	323	2010-10	Yes
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	90	0.0899	9.23	15	10	5	60	15	78	183	2005-08	

67036	Vitrectomy, mechanical, pars plana approach;	90	0.1075	12.13	33	3	15	50	15	134	250	2013-10	
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	90	0.1156	14	19	1	5	55	10	182	272	2014-01	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

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 Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year

69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 25 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? 8 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 8 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:
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 69719

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:69XX1 Tracking Number Original Specialty Recommended RVU: **10.25**
Presented Recommended RVU: **10.25**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **10.25**

CPT Descriptor: Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49-year-old female with a right mixed hearing loss and history of right therapeutic mastoidectomy with tympanoplasty previously had placement of a magnetic transcutaneous bone anchored hearing device in the right retrosigmoid region that has malfunctioned. She undergoes removal and replacement of the device.

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 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 87% , Overnight stay-less than 24 hours 13% , 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 100%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential repeat post-surgical skin breakdown, pain, and possible implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed NEW implant recipient site is precisely measured and then marked using the implant template. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is removed. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. A subpericranial pocket for the implant coil and magnet are created. The area for the new placement of the transducer is then identified using the template and marked on the outer table of the skull. Surgical guide and fixation holes are then drilled taking care not to penetrate the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull is then drilled, greater than or equal to 100 sq mm, to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying

the magnet and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped area of the surgical site is cleaned. A dressing is applied to the surgical site. A compression dressing is fashioned and is wrapped around the head to compress the surgical site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Post-Operative Visits

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69XX1					
Sample Size:	3268	**Resp N:**	39			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	1.00	10.00
Survey RVW:		7.00	10.25	**15.00**	17.77	32.00
Pre-Service Evaluation Time:				**31.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		30.00	50.00	**60.00**	90.00	125.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69XX1	**Recommended Physician Work RVU: 10.25**		
		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:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

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):	**39.00**	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21199	090	16.73	**RUC Time**

CPT Descriptor Osteotomy, mandible, segmental; with genioglossus advancement

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
54437	090	11.50	**RUC Time**	54

CPT Descriptor 1 Repair of traumatic corporeal tear(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57240	090	10.08	**RUC Time**	9,023

CPT Descriptor 2 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed

Other Reference CPT Code	Global	Work RVU	Time Source
43284	090	10.13	**RUC Time**

CPT Descriptor Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty 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: 12 **% of respondents:** 30.7 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 69XX1	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **21199**
Median Pre-Service Time	53.00	95.00	30.00
Median Intra-Service Time	60.00	180.00	90.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	40.00
Median Discharge Day Management Time	19.0	19.00	38.00
Median Office Visit Time	39.0	63.00	55.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**186.00**	**387.00**	**283.00**
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	8%	17%	33%	42%	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	27%	46%	27%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	50%	17%	33%

Physical effort required	42%	33%	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%	50%	25%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	20%	0%	60%	20%

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%	40%	60%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	60%	40%
Physical effort required	20%	80%	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	40%	20%	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.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU

range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 12 respondents selected this as their primary KRS.

The second KRS selected was CPT 21199 Osteotomy, mandible, segmental; with genioglossus advancement valued at 16.73 RVUs with a pre time of 30 / intra time of 90 / post time of 30, totaling 283 minutes. 5 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **10.25 and 60 minutes of intra service time**. Our expert panel felt this value which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the

patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 53 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post op visit 1: 99212
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Time Package	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	90	0.0812	10	3	33	12	15	60	20	88	228	2013-01

57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	90	0.0965	10.08	3	33	8	15	60	30	65	211	2017-01
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	90	0.0965	10.08	3	33	8	15	60	30	65	211	2017-01
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	90	0.0934	10.13		30	10	15	60	20	81	216	2007-02
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	90	0.0947	10.13	3	33	15	15	60	30	65	218	2016-01
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	90	0.0648	10.14		45	15	15	60	15	129	279	2007-04
23430	Tenodesis of long tendon of biceps	90	0.0842	10.17	3	33	12	15	60	20	97	237	2009-10
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	90	0.0528	10.41		45	10	10	60	20	143	288	2005-08
45190	Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	90	0.076	10.42		80			60	45	81	266	2000-08
44950	Appendectomy;	90	0.0778	10.6		50			60	25	117	252	2000-08
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	90	0.0426	10.7		45	10	15	60	18	175	323	2007-02
38740	Axillary lymphadenectomy; superficial	90	0.0937	10.7		60			60	30	81	231	2000-08
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	90	0.0198	10.78		60	20	15	60	20	209	384	2007-04
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	90	0.038	10.85		50			60	25	184	319	2000-08
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	90	0.049	10.93		75			60	30	157	322	2000-08
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	90	0.0546	10.93		60			60	30	157	307	2000-08

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 2 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 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69717 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 1 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:
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. 69714

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69726 Tracking Number Original Specialty Recommended RVU: **7.50**
Presented Recommended RVU: **7.50**
Global Period: 090 Current Work RVU: **5.93** RUC Recommended RVU: **7.50**

CPT Descriptor: Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female with a left single sided deafness previously had placement of a percutaneous bone anchored implant. It worked well but has now developed discomfort at the device site. The device is removed in its entirety.

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 54% , In the ASC 44%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 95% , Overnight stay-less than 24 hours 5% , 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 100%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked in the region of the previous incision. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium fixture in the patient's skull is drilled around the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound where the external abutment of the implant is debrided then closed followed by closure of the linear incision anterior to the implant site in a layered fashion.

Description of Post-Service Work: The prepped area of the surgical site is cleaned. A dressing is applied to the surgical site. A compression dressing is fashioned and is wrapped around the head to compress the surgical site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is

reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Discharge Management / Post-Operative Visits
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69726					
Sample Size:	3268	**Resp N:**	39			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	2.00	10.00
Survey RVW:		4.00	7.50	**10.00**	14.50	25.00
Pre-Service Evaluation Time:				**25.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**7.00**		
Intra-Service Time:		15.00	30.00	**35.00**	45.00	120.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69726	**Recommended Physician Work RVU: 7.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**7.00**	**15.00**	**-8.00**
Intra-Service Time:		**35.00**		

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:	**15.00**	**30.00**	**-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:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 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
21013	090	5.42	**RUC Time**

CPT Descriptor Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
42120	090	11.86	**RUC Time**

CPT Descriptor Resection of palate or extensive resection of lesion

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
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	2,079

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
27268	090	7.12	**RUC Time**

CPT Descriptor Closed treatment of femoral fracture, proximal end, head; with manipulation

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: 5 **% of respondents:** 12.8 **%**

Number of respondents who choose 2nd Key Reference Code: 3 **% of respondents:** 7.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 69726	Top Key Reference CPT Code: 21013	2nd Key Reference CPT Code: **42120**
Median Pre-Service Time	42.00	56.00	60.00
Median Intra-Service Time	35.00	45.00	80.00
Median Immediate Post-service Time	15.00	15.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	20.00
Median Discharge Day Management Time	19.0	19.00	38.00
Median Office Visit Time	39.0	39.00	78.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**150.00**	**174.00**	**306.00**
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%	40%	20%

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%	40%	40%
Physical effort required	20%	40%	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	20%	40%	40%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	34%	33%

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%	100%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	100%	0%
Physical effort required	0%	100%	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	0%	100%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated

implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters

during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2cm valued at 5.42 RVUs with a pre time of 56 / intra time of 45 / post time of 15, totaling 174 minutes. 5 respondents selected this as their second KRS.

The second KRS selected was CPT 42120 Resection of palate or extensive resection of lesion valued at 11.86 RVUs with a pre time of 60 / intra time of 80 / post time of 30, totaling 306 minutes. 3 respondents selected this as their primary KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **7.50 and 35 minutes of intra service time**. Our expert panel felt this value, which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We also feel the increase in intra time justifies an increase in RVW. Additionally, our specialty felt this was a poorly chosen crosswalk at the January 2021 RUC meeting and was not in agreement that this value was appropriate for the work involved.

Compelling Evidence:
As referenced above, we believe compelling evidence exists to support an increase in RVW for this code. Specifically, evidence that incorrect assumptions were made in the previous valuation of the service. We believe two incorrect assumptions were made: first, that a flawed crosswalk was chosen in the previous valuation of this code, and second, that the January 2021 survey was flawed in that a rank order anomaly existed between the value of 69726 and the remainder of the family of codes.

Regarding the flawed crosswalk, the RUC chose to crosswalk this code to 53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy (work RVU = 5.93, intra-service time of 30 minutes and total time of 142 minutes). They justified this saying it had identical intra time and similar total time. It was also noted that our service, 69726, was more intense than the crosswalk code. We agree that 69726 is more intense than the code used for crosswalk,

indicating 69726 should have a higher value. There were a dearth of codes with similar total and intraservice times, and the crosswalk chosen does not reflect the intensity and complexity of 69726. In our new survey, we also now see an increase of 5 minute of intratime when compared to our January 2021 survey. Based on the increase in intra time from the survey data being presented today, as well as the fact that the increase complexity and intensity of 69726 was not accounted for previously, we believe this crosswalk is no longer appropriate and compelling evidence exists to modify the work value.

Regarding the flaw in a previous survey, this was documented by our specialty's request to take the family back to CPT after the January 2021 meeting and request three additional codes to better, and more clearly, define the work involved in each procedure. We believe this also supports compelling evidence to revisit the value of this procedure.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 25 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides

Scrub, Dress, Wait Time – We are recommending 7 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 42 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although not indicated for the this particular code by survey respondents. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure. The survey respondents also indicated two post-operative office visits occur following the initial procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	IWPUT
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])	90	7.03	30	15	15	30	20	81	191	2020-01	0.0798
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.03	33	10	15	40	15	81	194	2011-04	0.0637
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	90	7.07	35	10	10	45	20	97	217	2007-02	0.0443
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	90	7.12	7	10	2	30	5	142	196	2007-09	0.063
37718	Ligation, division, and stripping, short saphenous vein	90	7.13	35	10	10	45	20	58	178	2005-04	0.0778
23120	Claviculectomy; partial	90	7.39	40	15	15	45	15	97	227	2008-04	0.048
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	90	7.39	33	10	15	45	15	81	199	2011-04	0.0647
19328	Removal of intact breast implant	90	7.44	40	10	10	45	20	74	199	2020-01	0.0716
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any	90	7.44	33	10	10	45	15	113	226	2016-01	0.0453

	method											
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	90	7.44	40	10	15	45	20	97	227	2007-02	0.0491
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	90	7.44	35	10	15	45	15	97	217	2007-02	0.0541
56620	Vulvectomy simple; partial	90	7.53	45	10	5	45	30	104	239	2008-02	0.0346
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	90	7.89	40	10	15	45	20	136	266	2007-02	0.028
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	90	7.91	40			45	20	74	179	2000-08	0.0888
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	90	7.97	10	10	15	45	15	90	185	2005-08	0.0892

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

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 Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 25 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? 8 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 8 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:
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 69726

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:69727 Tracking Number Original Specialty Recommended RVU: **7.38**
Presented Recommended RVU: **7.38**
Global Period: 090 Current Work RVU: **7.13** RUC Recommended RVU: **7.38**

CPT Descriptor: Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well but has now become infected. The device is removed.

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 61% , In the ASC 39%, 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 95% , Overnight stay-less than 24 hours 5% , 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 100%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium transducer and the respective fixture screws in the patient's skull is drilled out to free the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped area of the surgical site is cleaned. A dressing is applied to the surgical site. A compression dressing is fashioned and is wrapped around the head to compress the surgical site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are

discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Post-Operative Visits

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69727					
Sample Size:	3268	**Resp N:**	39			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	1.00	10.00
Survey RVW:		4.00	7.38	**12.00**	15.00	32.00
Pre-Service Evaluation Time:				**27.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		20.00	40.00	**50.00**	60.00	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:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69727	**Recommended Physician Work RVU: 7.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**27.00**	**33.00**	**-6.00**
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:		**50.00**		

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):	39.00	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
42240	090	6.14	**RUC Time**

CPT Descriptor Excision of submandibular (submaxillary) gland

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
21556	090	7.66	**RUC Time**	2,337

CPT Descriptor 1 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26113	090	7.13	**RUC Time**	1,832

CPT Descriptor 2 Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater

Other Reference CPT Code	Global	Work RVU	Time Source
67911	090	7.50	**RUC Time**

CPT Descriptor Correction of lid retraction

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:** 18.1 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 69727	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **42240**
Median Pre-Service Time	47.00	95.00	55.00
Median Intra-Service Time	50.00	180.00	60.00
Median Immediate Post-service Time	15.00	30.00	25.00
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	39.0	63.00	39.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**170.00**	**387.00**	**198.00**
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	17%	17%	50%	16%	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	60%	20%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	50%	50%	0%
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	67%	17%	16%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	25%	25%	5000%	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	50%	25%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	25%	50%
Physical effort required	25%	25%	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	25%	50%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated

implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters

during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 6 respondents selected this as their primary KRS.

The second KRS selected was CPT 42440 Excision of submandibular (submaxillary) gland valued at 6.14 RVUs with a pre time of 55 / intra time of 60 / post time of 25, totaling 198 minutes. 4 respondents selected this as their second KRS.

Compelling Evidence:
As referenced above, we believe compelling evidence exists to support an increase in RVW for this code. Specifically, evidence that incorrect assumptions were made in the previous valuation of the service. We believe two incorrect assumptions were made: first, that a flawed crosswalk was chosen in the previous valuation of this code, and second, that the January 2021 survey was flawed in that a rank order anomaly existed between the value of 69726 and the remainder of the family of codes.

Regarding the flawed crosswalk, the RUC chose to crosswalk this code to 37718 Ligation, division, and stripping, short saphenous vein (work RVU = 7.13, intra-service time of 45 minutes and total time of 178 minutes). They justified this saying it had identical intra time and similar total time. It was also noted that our service, 69726, was more intense than the crosswalk code. We agree that 69726 is more intense than the code used for crosswalk, indicating 69726 should have a higher value. There were a dearth of codes with similar total and intraservice times, and the crosswalk chosen does not reflect the intensity and complexity of 69726. In our new survey, we also now see an increase of 5 minutes of intratime when compared to our January 2021 survey. Based on the increase in intra time from the survey data being presented today, as well as the fact that the increase complexity and intensity of 69726 was not accounted for previously, we believe this crosswalk is no longer appropriate and compelling evidence exists to modify the work value.

Regarding the flaw in a previous survey, this was documented by our specialty's request to take the family back to CPT after the January 2021 meeting and request three additional codes to better, and more clearly, define the work involved in

each procedure. We believe this also supports compelling evidence to revisit the value of this procedure.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **7.38 and 50 minutes of intra service time.** Our expert panel felt this value, which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule. We also feel the increase in intra time justifies an increase in RVW. Additionally, our specialty felt this was a poorly chosen crosswalk at the January 2021 RUC meeting and was not in agreement that this value was appropriate for the work involved.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 27 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. The ear is examined, and the wound is cleaned, inspected, and palpated for full healing prior to fitting the sound processor. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review	MPC
35702	Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)	90	0.0537	7.12		40	10	15	50	30	74	2019-01	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	90	0.0744	7.12		35	10	15	50	30	51	2004-04	
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	90	0.0307	7.31	3	33	10	15	50	30	113	2011-02	
67911	Correction of lid retraction	90	0.0807	7.5		10	10	15	50	15	83	2005-08	
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	90	0.0423	7.81	1b	19	1	5	50	10	145	2015-04	
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])	90	0.0669	7.98	3	30	15	15	50	20	81	2020-01	
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	90	0.0618	8.01	33	10	10	50	15	97	215	2016-01	
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	90	0.0072	9.06	33	3	15	53	20	199	323	2010-10	Yes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 13 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? 4 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume
Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 4 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:
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 69727

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:69XX2 Tracking Number Original Specialty Recommended RVU: **8.50**
Presented Recommended RVU: **8.50**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **8.50**

CPT Descriptor: Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female with a left mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant in the retrosigmoid cranium which worked well but has now become infected. The device is removed.

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 57% , In the ASC 43%, 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 86% , Overnight stay-less than 24 hours 14% , 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 100%

Description of Pre-Service Work: Meet with the patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation and marking of site of proposed insertion, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium transducer and the respective fixture screws in the patient’s skull is drilled out to free the implant. The wound is thoroughly inspected for the cause of the patient’s original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after

emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, and signs and symptoms of complication. The written postoperative instructions are reviewed.

Post-Operative Visits

Discharge Management
These patients are typically discharged same day from the hospital. As a 90 day global, the standard .5 discharge management visit has been included. This visit is required given that general anesthesia sedation is utilized, and patients must be monitored closely following the procedure.

Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	R. Peter Manes, MD, Ari Wirtschafter, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69XX2					
Sample Size:	3263	**Resp N:**	39			
Description of Sample:	Targeted, random selection of members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	0.00	10.00
Survey RVW:		6.00	8.50	**12.00**	15.25	34.00
Pre-Service Evaluation Time:				**27.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**8.00**		
Intra-Service Time:		30.00	45.00	**60.00**	80.00	120.00
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):	**39.00**	99211x **0.00** 12x **1.00** 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)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69XX2	**Recommended Physician Work RVU: 8.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**27.00**	**33.00**	**-6.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**8.00**	**15.00**	**-7.00**
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:	**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):	**39.00**	99211x **0.00** 12x **1.00** 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
69930	090	17.73	**RUC Time**

CPT Descriptor Cochlear device implantation, with or without mastoidectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21013	090	5.42	**RUC Time**

CPT Descriptor Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm

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
54530	090	8.46	**RUC Time**	1,190

CPT Descriptor 2 Orchiectomy, radical, for tumor; inguinal approach

Other Reference CPT Code	Global	Work RVU	Time Source
49525	090	8.93	**RUC Time**

CPT Descriptor Repair inguinal hernia, sliding, any age

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 25.6 **%**

Number of respondents who choose 2nd Key Reference Code: 3 **% of respondents:** 7.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 69XX2	Top Key Reference CPT Code: 69930	2nd Key Reference CPT Code: **21013**
Median Pre-Service Time	45.00	95.00	56.00
Median Intra-Service Time	60.00	180.00	45.00
Median Immediate Post-service Time	15.00	30.00	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	39.0	63.00	39.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**178.00**	**387.00**	**174.00**
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	10%	10%	30%	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	22%	56%	22%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	40%	40%	20%
Physical effort required	40%	50%	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	40%	20%	40%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	100%	0%	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%	67%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	67%	0%
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	0%	100%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69X50-X53 (now 69716-69727). Those codes

represented implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The Panel approved the CCA and the codes were subsequently valued at the January 2021 RUC meeting. During that review, several issues were identified by our reviewers, facilitation committee, and the broader RUC panel. This included concerns that for at least one code in the family, there were rank order anomalies with the intraservice time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believed there were problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, the Academy requested the RUC's permission to return to the CPT Editorial Panel to further clarify and revise the code set. That request was approved by the RUC in April 2021, and the Academy submitted a revised CCA for the May 2021 meeting which clarified the percutaneous implant removal by describing the procedure as removal of the entire implant. We also added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

During our preparation of this CCA, we also noticed there was variation in the method of transcutaneous implant placement and noted problems with the distribution of the intraservice times with the previous 69716 code that was intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, we chose to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT 69716. Mirroring replacement and removal codes were also proposed and approved by the CPT panel.

In preparation for the October 2021 resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting in the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes

from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses that error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation of the family at the October 2021 meeting, the RUC determined that the survey was invalid, and required resurvey for the January 2022 meeting. The data from the most recent survey is being presented at this meeting, however, we believe survey fatigue played a significant factor in our ability to elicit responses. It was extremely difficult to get sufficient response rates exceeding the 30 minimum threshold, and while we acknowledge not every code has over 30 responses from those with experience in the past 12 months, we assure the RUC we did everything possible to maximize the response rate, including leaving the survey open until December 6th, just over a week before the RUC submission deadline. We feel confident that, although some codes in the family have responses predominantly from those without experience in the past 12 months, those respondents are adequately able to value these procedures. There is a significant amount of crossover between these procedures and other otologic procedures, allowing respondents to use their clinical expertise to adequately describe the time and value of this family of procedures.

The new family of codes is now being re-presented to the RUC for valuation. The result is the trios of codes, one for implantation, replacement, and removal of each procedure (e.g., percutaneous, transcutaneous greater than 100 sq cm, transcutaneous less than 100 sq cm). ***A simplified summary spreadsheet of the family has also been supplied, for ease of review.***

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3268 members from the AAO-HNS, the (ANS) American Neurotology Society, and the AOS (American Otological Society).

Discussion of Key Reference Codes

The first KRS selected was CPT 69930 Cochlear device implantation, with or without mastoidectomy valued at 17.73 RVUs with a pre time of 95 / intra time of 180 / post time of 30, totaling 387 minutes. 10 respondents selected this as their primary KRS.

The second KRS selected was CPT 21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm valued at 16.73 RVUs with a pre time of 56 / intra time of 45 / post time of 15, totaling 174 minutes. 3 respondents selected this as their second KRS.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.50 and 60 minutes of intra service time**. Our expert panel felt this value which is our survey's 25th percentile, maintains relativity throughout the family and fits well in terms of the fee schedule.

Time package selection: We have selected pre-time package 3 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 27 minutes of evaluation time which is less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is more than the preservice package, but mirrors our survey median time. We feel this additional time is justified based on the actual time needed to position the

patient for this procedure, as indicated by our survey respondents. We need to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, SCD wires and anesthetic tubing that inevitably needs to be properly positioned in order to complete the turn. The head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed in order to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time the package provides.

Scrub, Dress, Wait Time – We are recommending 8 minutes of scrub, dress and wait time which is less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9B General Anesthesia or Complex Regional Block/ Complex Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

Post-Operative Visits

Discharge Management
Survey respondents also indicated that these patients are typically discharged same day from the hospital. As a 90 day global, the **standard .5 discharge management visit** has been included, although survey respondents indicated for this particular code that a full discharge management visit occurs. This visit is required based on the complexity and inherent risk of the procedure itself, as well as the post-operative care needed. It is also standard for 90 global procedures where discharge occurs on the same day as the procedure.

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Post op visit 1: 99212
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The ear is examined, and the wound is cleaned, inspected, and palpated. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Time Package	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Post-op Visit Time	Total Time	Most Recent RUC Review
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	090	0.0737	8.16		40	10.0	10.0	60	20	58	198	2005-04
28175	Radical resection of tumor; phalanx of toe	090	0.062	8.29	1b	19	3.0	5.0	60	20	98	205	2009-02
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	090	0.0683	8.39		40			60	15	81	196	2003-02
49590	Repair spigelian hernia	090	0.0855	8.90		45			60	30	58	193	2000-08
49525	Repair inguinal hernia, sliding, any age	090	0.086	8.93		45			60	30	58	193	2000-08
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	090	0.0836	8.97		10	10.0	15.0	60	15	90	200	2005-08
49550	Repair initial femoral hernia, any age; reducible	090	0.087	8.99		45			60	30	58	193	2000-08

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National volume
For national volume predictions, we typically multiply Medicare volume by three (2979 cases anticipated across all codes annually). See the Medicare methodology below which was used to generate the national recommendations. Of the percutaneous cases, 6% get revised or removed. For the transcutaneous codes, 1% is anticipated to get revised or removed annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 223 cases per year
69717 perc revision - 6% of 223 69714 cases = 13 cases per year
69726 perc removal - 6% of 223 69714 cases = 13 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 2532 cases per year
69719 trans less than 100 sq cm revision - 1% of 2532 69X51 cases = 25 cases per year
69727 trans less than 100 sq cm removal - 1% of 2532 69x52 cases = 25 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 223 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 223 69xx0 cases = 2 cases per year
69xx2 trans greater than 100 sq cm removal - 1% of 223 69xx0 cases = 2 cases per year

Specialty Otolaryngology Frequency 2 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 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare volume

Current Medicare volume for 69714 (perc implantation) is 993 cases. Of those, 6% get revised under 69717, annually. With the creation of the new transcutaneous codes, experts anticipate that 85% of cases will now be reported under the new transcutaneous less than 100 sq cm codes. The remaining 15% will be reported evenly between the percutaneous codes and the transcutaneous greater than 100 sq cm codes. The transcutaneous codes are anticipated to be revised or removed 1% of the time. Thus, the math follows for each code trio:

69714 perc implantation - 7.5% of existing volume = 74 cases per year
69717 perc revision - 6% of 74 69714 cases = 4 cases per year
69726 perc removal - 6% of 74 69714 cases = 4 cases per year

69716 trans less than 100 sq cm implantation - 85% of existing volume = 844 cases per year
69719 trans less than 100 sq cm revision - 1% of 844 69X51 cases = 8 cases per year
69727 trans less than 100 sq cm removal - 1% of 844 69x52 cases = 8 cases per year

69xx0 trans greater than 100 sq cm implantation - 7.5% of existing volume = 74 cases per year
69xx1 trans greater than 100 sq cm revision - 1% of 74 69xx0 cases = 1 case per year
69xx2 trans greater than 100 sq cm removal - 1% of 74 69xx0 cases = 1 case per year

Specialty Otolaryngology Frequency 1 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:
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. 69714

SS Rec Summary

ISSUE: Transcutaneous Passive Implant - Temporal Bone

TAB: 10

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	21013	090	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal,	2009	5	0.043	0.031			5.42			174	33	8	15			45			15						0.5				1	1						
2nd REF	14040	090	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin,	2008	4	0.050	0.039			8.60			223	15	10	5			90			25										2	2						
INITIAL VALUE	69714	090	Implantation, osseointegrated implant, temporal bone, with percutaneous	2000	21	0.098	0.051			14.45			284	55					90			30						1.0				1	3						
INTERIM VALUE FOR CY2022	69714	090	Implantation, osseointegrated implant, skull; with percutaneous attachment to	2021	73	0.110	0.048			8.69			182	33	3	10			40			15						0.5				2	1						
SVY	69714	090	Implantation, osseointegrated implant, skull; with percutaneous attachment to		45	0.246	0.079	5.00	8.00	10.00	13.00	18.00	127	25	10	8	10	22	30	45	150	15										1	1	0	3	5	10	56
SVY w Exp		090			41	0.246	0.079	5.00	8.60	10.00	13.00	18.00	126	25	10	7	10	20	30	45	150	15										1	1	1	4	6	12	56
SVY w/out Exp		090			4	0.139	0.056	6.00	6.04	8.03	10.75	13.00	144	23	6	15	30	30	38	49	60	23										1	1	0	0	0	0	0
REC	69714	090	Implantation, osseointegrated implant, skull; with percutaneous attachment to			0.158	0.055			8.00			146	25	10	8			30			15						0.5				1	1						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	5	0.067	0.046			17.73			387	60	15	20			180			30						0.5				1	1						
2nd REF	30410	090	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and	1993	4	0.057	0.039			14.00			362	45					120			53										2	4						
INTERIM VALUE FOR CY2022	69716	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous	2021		0.100	0.053			9.77			185	32	3	10			60			15						0.5				2							
SVY	69716	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous		41	0.207	0.087	6.00	9.03	13.00	16.00	30.00	149	25	10	10	20	45	50	60	150	15										1	1	0	1	3	5	12
SVY w Exp		090			36	0.219	0.088	6.00	10.43	13.00	15.81	30.00	148	28	10	9	20	44	47	60	150	15										1	1	1	2	4	5	12
SVY w/out Exp		090			5	0.138	0.063	7.01	9.00	11.00	16.00	17.73	176	25	10	15	45	50	55	75	120	25										2		0	0	0	0	0
REC	69716	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous			0.115	0.054			9.03			168	25	10	10			50			15						0.5				1	1						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	9	0.067	0.046			17.73			387	60	15	20			180			30						0.5				1	1						
2nd REF	21199	090	Osteotomy, mandible, segmental; with genioglossus advancement	2000	5	0.120	0.059			16.73			283	30					90			30				1		1.0				1	2						
NEW	69XX0	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous	NEW		#DIV/0!	#DIV/0!						0																										
SVY	69XX0	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous		40	0.188	0.086	7.00	9.97	14.00	16.33	30.00	162	29	10	9	30	45	60	90	165	15										1	1	0	0	1	2	20
SVY w Exp		090			23	0.189	0.088	7.00	10.59	14.00	16.05	20.00	159	27	10	8	40	50	60	85	120	15										1	1	1	2	2	5	20
SVY w/out Exp		090			17	0.184	0.080	7.00	10.00	14.00	18.00	30.00	174	35	10	10	30	45	60	90	165	20										1	1	0	0	0	0	0
REC	69XX0	090	Implantation, osseointegrated implant, skull; with magnetic transcutaneous			0.110	0.055			9.97			181	29	10	9			60			15						0.5				1	1						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	42120	090	Resection of palate or extensive resection of lesion	2005	4	0.064	0.039			11.86			306	30	15	15			80			30					1	1.0				2	2						
2nd REF	21013	090	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal,	2009	4	0.043	0.031			5.42			174	33	8	15			45			15						0.5				1	1						
INITIAL VALUE	69717	090	Replacement (including removal of existing device), osseointegrated implant,	2000	18	0.105	0.055			15.43			282	50					95			28						1.0				1	3						
INTERIM VALUE FOR CY2022	69717	090	Revision/replacement (including removal of existing device), osseointegrated	2021	64	0.100	0.047			8.80			187	33	3	10			45			15						0.5				2	1						
SVY	69717	090	Revision/replacement (including removal of existing device), osseointegrated		42	0.195	0.080	5.50	8.48	11.70	14.94	20.00	147	25	10	7	5	27	44	55	195	15										2		0	0	2	4	20
SVY w Exp		090			31	0.217	0.083	5.50	8.65	11.80	15.00	20.00	143	25	10	7	5	20	40	55	90	15										2		1	2	3	5	20
SVY w/out Exp		090			11	0.195	0.075	6.10	8.83	11.60	13.38	15.00	154	30	10	15	30	40	45	63	195	15										1	1	0	0	0	0	0
REC	69717	090	Revision/replacement (including removal of existing device), osseointegrated			0.118	0.053			8.48			159	25	10	7			44			15						0.5				1	1						

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AI	AJ	AK	AL	AM	AR	AS	AT	AU	AV
15									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
57									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
58	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
59	1st REF	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	5	0.067	0.046			17.73			387	60	15	20			180			30						0.5		1	1									
60	2nd REF	31587	090	Laryngoplasty, cricoid split, without graft placement	2016	3	0.038	0.034			15.27			445	40	3	15			95			30			1	1	3	1.0				3								
61	INTERIM VALUE FOR CY2022	69719	090	Revision/replacement (including removal of existing device), osseointegrated	2021		0.099	0.034			9.77			186	33	3	10			60			15						0.5			2								
62	SVY	69719	090	Revision/replacement (including removal of existing device), osseointegrated		38	0.206	0.090	7.00	9.46	14.00	16.23	30.00	155	27	10	9	20	45	55	84	195	15									1	1				0	0	1	2	10
63	SVY w Exp		090			19	0.218	0.091	9.00	11.45	14.00	16.15	20.00	154	25	10	8	20	44	50	60	90	15									2					1	1	2	5	10
64	SVY w/out Exp		090			19	0.184	0.081	7.00	8.00	14.00	16.37	30.00	173	34	10	10	30	50	60	88	195	20									1	1				0	0	0	0	0
65	REC	69719	090	Replacement (including removal of existing device), osseointegrated implant,			0.111	0.054			9.46			174	27	10	9			55			15						0.5			1	1								
66																																								
67									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
68	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
69	1st REF	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	12	0.067	0.046			17.73			387	60	15	20			180			30						0.5		1	1								
70	2nd REF	21199	090	Osteotomy, mandible, segmental; with genioglossus advancement	2000	5	0.120	0.059			16.73			283	30					90			30				1		1.0			1	2								
71	NEW	69XX1	090		NEW									0																										
72	SVY	69XX1	090	Replacement (including removal of existing device), osseointegrated implant,		39	0.204	0.091	7.00	10.25	15.00	17.77	32.00	165	31	10	10	30	50	60	90	125	15									1	1				0	0	0	1	10
73	SVY w Exp		090			11	0.194	0.084	7.00	10.70	14.00	17.00	22.00	167	30	15	6	40	45	55	75	90	15									2					1	2	2	6	10
74	SVY w/out Exp		090			28	0.203	0.089	7.30	10.19	15.75	17.75	32.00	177	35	10	10	30	52	63	105	215	20									1	1				0	0	0	0	0
75	REC	69XX1	090	Replacement (including removal of existing device), osseointegrated implant,			0.113	0.055			10.25			186	33	10	10			60			15						0.5			1	1								
76																																								
77									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
78	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
79	1st REF	21013	090	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal,	2009	5	0.043	0.031			5.42			174	33	8	15			45			15						0.5			1	1								
80	2nd REF	42120	090	Resection of palate or extensive resection of lesion	2005	3	0.064	0.039			11.86			306	30	15	15			80			30					1	1.0			2	2								
81	INTERIM VALUE FOR CY2022	69726	090	Removal, osseointegrated implant, skull; with percutaneous attachment to external	2021		0.088	0.040			5.93			148	32	3	10			30			15						0.5			1	1								
82	SVY	69726	090	Removal, osseointegrated implant, skull; with percutaneous attachment to external		39	0.211	0.076	4.00	7.50	10.00	14.50	25.00	131	25	10	7	15	30	35	45	120	15									1	1				0	0	1	2	10
83	SVY w Exp		090			27	0.254	0.083	4.00	7.50	10.00	14.25	16.00	120	25	10	7	15	28	31	43	90	15									2					1	1	2	4	10
84	SVY w/out Exp		090			12	0.146	0.061	6.00	7.75	10.00	14.93	25.00	163	29	10	9	15	34	45	61	120	24									2					0	0	0	0	0
85	REC	69726	090	Removal, entire osseointegrated implant, skull; with percutaneous attachment to			0.121	0.050			7.50			150	25	10	7			35			15						0.5			1	1								
86																																								
87									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
88	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
89	1st REF	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	6	0.067	0.046			17.73			387	60	15	20			180			30						0.5		1	1								
90	2nd REF	42440	090	Excision of submandibular (submaxillary) gland	2010	4	0.041	0.031			6.14			198	30	10	15			60			25						0.5			1	1								
91	INTERIM VALUE FOR CY2022	69727	090	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment	2021		0.085	0.043			7.13			164	33	3	10			45			15						0.5			1	1								
92	SVY	69727	090	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment		39	0.186	0.079	4.00	7.38	12.00	15.00	32.00	151	27	10	10	20	40	50	60	90	15									1	1				0	0	0	1	10
93	SVY w Exp		090			17	0.217	0.091	4.00	11.40	13.50	15.00	20.00	148	27	10	7	20	45	50	60	90	15									1	1				1	1	2	5	10
94	SVY w/out Exp		090			22	0.113	0.053	5.00	7.00	8.77	13.89	32.00	164	34	10	10	25	35	55	71	90	23									2					0	0	0	0	0
95	REC	69727	090	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous			0.081	0.043			7.38			170	27	10	10			50			15						0.5			1	1								
96																																								

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AI	AJ	AK	AL	AM	AR	AS	AT	AU	AV
15					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
97					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
98	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
99	1st REF	69930	090	Cochlear device implantation, with or without mastoidectomy	2008	10	0.067	0.046			17.73			387	60	15	20			180			30						0.5		1	1									
100	2nd REF	21013	090	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal,	2009	3	0.043	0.031			5.42			174	33	8	15			45			15						0.5				1	1							
101	NEW	69XX2	090		NEW									0																										
102	SVY	69XX2	090	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous		39	0.155	0.075	6.00	8.50	12.00	15.25	34.00	159	27	10	8	30	45	60	80	120	15										1	1			0	0	0	0	10
103	SVY w Exp		090			9	0.186	0.084	10.00	14.00	14.00	16.00	20.00	167	40	10	8	30	45	60	80	90	10										1	1			1	1	2	5	10
104	SVY w/out Exp		090			30	0.136	0.065	6.00	8.00	11.60	14.88	34.00	178	30	10	9	30	45	60	76	120	23										2				0	0	0	0	0
105	REC	69XX2	090	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous			0.086	0.048			8.50			178	27	10	8			60			15						0.5				1	1							
106																																								
107																																								

FACILITY DIRECT PE INPUTS **CPT CODE(S):_69714, 69716, 69717, 69719, 69XX0-69XX2_____**
SPECIALTY SOCIETY(IES):_AAO-HNS_____
PRESENTER(S):_R. Peter Manes, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69726	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex	090
CPT Code	**Long Descriptor**	**Global Period**
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	090
CPT Code	**Long Descriptor**	**Global Period**
69727	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	090
CPT Code	**Long Descriptor**	**Global Period**
69XX0	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	090
CPT Code	**Long Descriptor**	**Global Period**
69XX1	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor,	090

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	
CPT Code	**Long Descriptor**	**Global Period**
69XX2	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	**Vignette**
69714	a 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. he is unable to wear traditional hearing aids. implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.
CPT Code	**Vignette**
69717	a 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. the device is removed and a new device is placed at a different site.
CPT Code	**Vignette**
69726	a 48-year-old female with a left single sided deafness previously had placement of a percutaneous bone anchored implant. it worked well but has now developed discomfort at the device site. the device is removed in its entirety.
CPT Code	**Vignette**
69716	a 48-year-old male with a congenital left conductive hearing loss seeks intervention for improved quality of life at work and socially. a magnetic transcutaneous bone anchored hearing device is placed behind the left ear.
CPT Code	**Vignette**
69719	a 59-year-old female with a right conductive hearing loss previously had placement of a right magnetic transcutaneous bone anchored hearing device that has malfunctioned. she undergoes removal and replacement of the device.
CPT Code	**Vignette**
69727	a 62-year-old male with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well but has now become infected. the device is removed.
CPT Code	**Vignette**
69XX0	a 59-year-old female with a right mixed hearing loss from chronic ear disease and its surgical treatment seeks intervention for improved quality of life at work and socially. a magnetic

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	transcutaneous bone anchored hearing device is placed in the right retrosigmoid location because the right mastoid is contracted and inflamed.
CPT Code	**Vignette**
69XX1	a 49-year-old female with a right mixed hearing loss and history of right therapeutic mastoidectomy with tympanoplasty previously had placement of a magnetic transcutaneous bone anchored hearing device in the right retrosigmoid region that has malfunctioned. she undergoes removal and replacement of the device.
CPT Code	**Vignette**
69XX2	a 52-year-old female with a left mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant in the retrosigmoid cranium which worked well but has now become infected. the device is removed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, sleep medicine, and otology. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   The RUC and CMS approved values from January 2021 for codes 69714, 69717, and 69726 were utilized as comparison codes for all new codes in the family.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   n/a

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

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N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

During the pre-service clinical staff are completing pre-service diagnostic and referral forms, coordinating pre-surgery services including test results, scheduling space and equipment in the facility, providing pre-service education and obtaining consent from the patient, and completing pre-procedure phone calls and prescriptions.

   b. Service period (includes pre, intra and post):

During the service period the clinical staff assist with a half discharge management visit for the patient. This includes post-procedure care instructions. They also clean the instruments used during each post operative visit.

   c. Post-service period:

During post operative visits the patient is checked in via front-desk staff. Clinical staff collects vitals from the patient. An exam chair/table and light are required with paper covering for the exam furniture. A postoperative wound kit for removal of sutures/staples is required. The clinical staff assists the physician with removal of the sutures.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**

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, cleaning, surgical instruments	**SA043**	**pack**	1	**10.7922**
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**
pack, post-op incision care (suture)	**SA054**	**pack**
kit, suture removal		kit
povidone soln (Betadine)		ml
gauze, sterile 4in x 4in		item
gloves, sterile		pair
steri-strip (6 strip uou)		item
swab-pad, alcohol		item
tape, surgical paper 1in (Micropore)		inch
tincture of benzoin, swab		item

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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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:

EQ234 suction and pressure cabinet, ENT (SMR)
EQ183 microscope, operating
EQ170 light, fiberoptic headlight w-source
EF008 chair with headrest, exam, reclining

The office visit formula was used for all these pieces of equipment.

EQ137 basic instrument pack

The instrument pack formula was used for this item.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_69714, 69716, 69717, 69719, 69XX0-69XX2_____**
SPECIALTY SOCIETY(IES):_AAO-HNS_____
PRESENTER(S):_R. Peter Manes, MD_____

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Clinical staff time in the preservice period remains unchanged for all codes in the family. All codes have cleaning time in the intra service time period to allocate time to cleaning the instruments used at each post op visit. Post-operative time has changed, commensurate with the survey data and recommended post op visits. All codes in the family have 2 post op visits.

In January 2021, some supplies were reduced commensurate with reducing the post-operative visits per our survey data. Additionally, we added a minimum multi-specialty pack for each post op visit and reduced individual, unnecessary line items. We also added a basic instrument pack and cleaning pack for the instruments which will be used at each post op visit. The instrument pack includes a tuning fork, Frasier tip suctions, and ear curettes. We removed the suture/staple pack and replaced it with just a suture pack. Our January 2022 recommendations are identical except in cases where respondents indicated LESS post-op visits overall, or a different level of post-op visit.

Equipment times were modified accordingly with changes to office visit frequency and level.

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1						PERCUTANEOUS CODES															
2	Expense Spreadsheet					2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS	
3						CPT Code 69714		CPT Code 69714		CPT Code 69714		CPT Code 69717		CPT Code 69717		CPT Code 69717		CPT Code 69717		CPT Code 69726	
4		*RUC Collaboration Website*				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	
5	Clinical Activity Code	Meeting Date: January 2022 Revision Date (if applicable): Tab: 10 Specialty: AAO-HNS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute																
6		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
7		GLOBAL PERIOD				090	090	090	090	090	090	090	090	090	090	090	090	090	090	090	090
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -
9		TOTAL CLINICAL STAFF TIME	L037D			0.0	183.0	0.0	195.0	0.0	149.0	0.0	183.0	0.0	195.0	0.0	149.0	0.0	183.0	0.0	149.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D			0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D			0.0	6.0	0.0	36.0	0.0	26.0	0.0	6.0	0.0	36.0	0.0	26.0	0.0	6.0	0.0	26.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D			0.0	117.0	0.0	99.0	0.0	63.0	0.0	117.0	0.0	99.0	0.0	63.0	0.0	117.0	0.0	63.0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14		PRE-SERVICE PERIOD																			
15		Start: Following visit when decision for surgery/procedure made																			
16	CA001		L037D				5		5		5		5		5		5		5		5
17	CA002		L037D				20		20		20		20		20		20		20		20
18	CA003		L037D				8		8		8		8		8		8		8		8
19	CA004		L037D				20		20		20		20		20		20		20		20
20	CA005		L037D				7		7		7		7		7		7		7		7
21	CA006		L037D																		
22	CA007		L037D																		
23	CA008		L037D																		
24			L037D																		
27		*Other activity: please include short clinical description here and type new*	L037D																		
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		L037D																		
35	CA010		L037D																		
36	CA011		L037D																		
37	CA012		L037D																		
38	CA013		L037D																		
39	CA014		L037D																		
40	CA015		L037D																		
41	CA016		L037D																		
42	CA017		L037D																		
43			L037D																		
46		*Other activity: please include short clinical description here and type new*	L037D																		
49		Intra-service (of service period)																			
50	CA018		L037D																		
51	CA019		L037D																		
52	CA020		L037D																		
53	CA021		L037D																		
56			L037D																		
57		*Other activity: please include short clinical description here and type new*	L037D																		
60		Post-Service (of service period)																			
61	CA022		L037D																		
62	CA023		L037D																		
63	CA024		L037D																		
64	CA025		L037D																		
65	CA026		L037D						30		20				30		20				20
66	CA027		L037D																		
67	CA028		L037D																		
68	CA029		L037D																		
69	CA030		L037D																		
70	CA031		L037D																		
71	CA032		L037D																		
72	CA033		L037D																		
73	CA034		L037D																		
74	CA035		L037D																		
75	CA036		L037D			n/a	6	n/a	6	n/a	6	n/a	6	n/a	6	n/a	6	n/a	6	n/a	6
76			L037D																		
79		*Other activity: please include short clinical description here and type new*	L037D																		
82		End: Patient leaves office/facility																			
83		POST-SERVICE PERIOD																			
84		Start: Patient leaves office/facility																			
85	CA037		L037D																		
86	CA038		L037D																		
87		*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
88		99211 16 minutes	16																		
89		99212 27 minutes	27				3		1		1		3		1		1		3		1
90		99213 36 minutes	36				1		2		1		1		2		1		1		1
91		99214 53 minutes	53																		
92		99215 63 minutes	63																		
93	CA039		L037D			0.0	117.0	0.0	99.0	0.0	63.0	0.0	117.0	0.0	99.0	0.0	63.0	0.0	117.0	0.0	63.0
94			L037D																		

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
2	Expense Spreadsheet					2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS	
3						CPT Code 69714		CPT Code 69714		CPT Code 69714		CPT Code 69717		CPT Code 69717		CPT Code 69717		CPT Code 69717		CPT Code 69726	
4		*RUC Collaboration Website*				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	
5	Clinical Activity Code	**Meeting Date: January 2022** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute																
6		**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
7		**GLOBAL PERIOD**				090	090	090	090	090	090	090	090	090	090	090	090	090	090	090	090
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -
9		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**183.0**	**0.0**	**195.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**195.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**117.0**	**0.0**	**99.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**99.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**
97		*Other activity: please include short clinical description here and type new*	L037D																		
100		**End: with last office visit before end of global period**																			
101	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**																	
102		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -	$ -	$ -	$ -	$ 27.20	$ -	$ -
103	SA043								3		2				3		2				2
104	SA048								3		2				3		2				2
105	SA053						1		**0**		**0**		1		**0**		**0**		1		**0**
106	SA054								**1**		**1**				**1**		**1**				**1**
107	SB012						4						4						4		
108	SB024						1						1						1		
109	SB026						4						4						4		
110	SB027						8						8						8		
111	SB034		3.4				8						8						8		
112	SB044						4						4						4		
113	SD009						4		1		1		4		1		1		4		1
114	SD132						8		2		2		8		2		2		8		2
115	SG006						1						1						1		
116	SG016						1						1						1		
117	SG020						1						1						1		
118	SG031						4						4						4		
119	SG042						1						1						1		
120	SG055						14		2		2		14		2		2		14		2
121	SG079						48						48						48		
122	SG081						16		1		1		16		1		1		16		1
123	SG082						4						4						4		
124	SH024						4						4						4		
125	SJ007						20		1		1		20		1		1		20		1
126	SJ010						4						4						4		
127	SJ028						40						40						40		
128	SJ046						20						20						20		
129	SJ060						1						1						1		
130	SM001						4						4						4		
131																					
132		*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.*																			
134	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**																
135		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	EQ234			Office Visits			117		99.0		63.0		117		99.0		63.0		117		63.0
137	EQ183			Office Visits			117		99.0		63.0		117		99.0		63.0		117		63.0
138	EQ170			Office Visits			117		99.0		63.0		117		99.0		63.0		117		63.0
139	EF008			Office Visits			117		99.0		63.0		117		99.0		63.0		117		63.0
140	EQ137			Instrument Packs					30.0		20.0				30.0		20.0				20.0
147																					
148		*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	W	X	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP
1			TRANSCUTANEOUS LESS THAN 100 SQ CM CODES																		
2	Expense Spreadsheet		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOM
3			CPT Code 69726		CPT Code 69714		CPT Code 69716		CPT Code 69716		CPT Code 69717		CPT Code 69719		CPT Code 69719		CPT Code 69717		CPT Code 69727		CPT Co
4		*RUC Collaboration Website*	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Remov osseointeg skull; wit transcutane to extern processo mastoid and bony defect sq mm su bone deep cranial
5	Clinical Activity Code	**Meeting Date: January 2022** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**																			
6		**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**	**Non Fac**	**Facility**	**Non Fac**
7		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**#VALUE!**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**0.0**	**149.0**	**0.0**	**#VALUE!**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**63.0**	**0.0**	**#VALUE!**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**#VALUE!**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
14		**PRE-SERVICE PERIOD**																			
15		**Start: Following visit when decision for surgery/procedure made**																			
16	CA001			5		5		5		5		5		5		5		5		5	
17	CA002			20		20		20		20		20		20		20		20		20	
18	CA003			8		8		8		8		8		8		8		8		8	
19	CA004			20		20		20		20		20		20		20		20		20	
20	CA005			7		7		7		7		7		7		7		7		7	
21	CA006																				
22	CA007																				
23	CA008																				
24																					
27		*Other activity: please include short clinical description here and type new*																			
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																				
35	CA010																				
36	CA011																				
37	CA012																				
38	CA013																				
39	CA014																				
40	CA015																				
41	CA016																				
42	CA017																				
43																					
46		*Other activity: please include short clinical description here and type new*																			
49		**Intra-service (of service period)**																			
50	CA018																				
51	CA019																				
52	CA020																				
53	CA021																				
56																					
57		*Other activity: please include short clinical description here and type new*																			
60		**Post-Service (of service period)**																			
61	CA022																				
62	CA023																				
63	CA024																				
64	CA025																				
65	CA026			20				20		20				20		20				20	
66	CA027																				
67	CA028																				
68	CA029																				
69	CA030																				
70	CA031																				
71	CA032																				
72	CA033																				
73	CA034																				
74	CA035																				
75	CA036		**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**
76																					
79		*Other activity: please include short clinical description here and type new*																			
82		**End: Patient leaves office/facility**																			
83		**POST-SERVICE PERIOD**																			
84		**Start: Patient leaves office/facility**																			
85	CA037																				
86	CA038																				
87		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
88		99211 16 minutes																			
89		99212 27 minutes		1		3				1		3				1		3		1	
90		99213 36 minutes		1		1		2		1		1		2		1		1		1	
91		99214 53 minutes				SS															
92		99215 63 minutes																			
93	CA039		**0.0**	**63.0**	**0.0**	**#VALUE!**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**
94																					

	A	B	W	X	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP
2	**Expense Spreadsheet**		**RECOMMENDED**		**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOMMENDED**		**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOMMENDED**		**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOM**
3			**CPT Code 69726**		**CPT Code 69714**		**CPT Code 69716**		**CPT Code 69716**		**CPT Code 69717**		**CPT Code 69719**		**CPT Code 69719**		**CPT Code 69717**		**CPT Code 69727**		**CPT Co**
4		***RUC Collaboration Website***	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Remov osseointeg skull; wit transcutane to extern processo mastoid and bony defect sq mm su bone deep cranial
5	**Clinical Activity Code**	**Meeting Date: January 2022** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**																			
6		**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**	**Non Fac**	**Facility**	**Non Fac**
7		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**#VALUE!**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**0.0**	**149.0**	**0.0**	**#VALUE!**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**63.0**	**0.0**	**#VALUE!**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**
97		*Other activity: please include short clinical description here and type new*																			
100		**End: with last office visit before end of global period**																			
101	**Supply Code**	**MEDICAL SUPPLIES**																			
102		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**
103	SA043			2				2		2				2		2				2	
104	SA048			2				2		2				2		2				2	
105	SA053			**0**		1		**0**		**0**		1		**0**		**0**		1		**0**	
106	SA054			**1**				**1**		**1**				**1**		**1**				**1**	
107	SB012					4						4						4			
108	SB024					1						1						1			
109	SB026					4						4						4			
110	SB027					8						8						8			
111	SB034					8						8						8			
112	SB044					4						4						4			
113	SD009			1		4		1		1		4		1		1		4		1	
114	SD132			2		8		2		2		8		2		2		8		2	
115	SG006					1						1						1			
116	SG016					1						1						1			
117	SG020					1						1						1			
118	SG031					4						4						4			
119	SG042					1						1						1			
120	SG055			2		14		2		2		14		2		2		14		2	
121	SG079					48						48						48			
122	SG081			1		16		1		1		16		1		1		16		1	
123	SG082					4						4						4			
124	SH024					4						4						4			
125	SJ007			1		20		1		1		20		1		1		20		1	
126	SJ010					4						4						4			
127	SJ028					40						40						40			
128	SJ046					20						20						20			
129	SJ060					1						1						1			
130	SM001					4						4						4			
131																					
132		*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.*																			
134	**Equipment Code**	**EQUIPMENT**																			
135		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
136	EQ234			63.0		117		72.0		63.0		117		72.0		63.0		117		63.0	
137	EQ183			63.0		117		72.0		63.0		117		72.0		63.0		117		63.0	
138	EQ170			63.0		117		72.0		63.0		117		72.0		63.0		117		63.0	
139	EF008			63.0		117		72.0		63.0		117		72.0		63.0		117		63.0	
140	EQ137			20.0				20.0		20.0				20.0		20.0				20.0	
147																					
148		*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	AQ	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI	BJ
1				TRANSCUTANEOUS GREATER THAN 100 SQ CM CODES																	
2	Expense Spreadsheet		MENDED	2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED		2021 RUC DATABASE		JAN 2021 RUC / CMS		RECOMMENDED	
3			de 69727	CPT Code 69714		CPT Code 69716		CPT Code 69XX0		CPT Code 69717		CPT Code 69719		CPT Code 69XX1		CPT Code 69717		CPT Code 69727		CPT Code 69XX2	
4		*RUC Collaboration Website*	al, entire	Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	
5	Clinical Activity Code	**Meeting Date: January 2022** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**	rated implant, h magnetic ous attachment al speech r, within the /or involving a less than 100 face area of to the outer al cortex																		
6		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
7		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**149.0**
10		**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**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**63.0**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
14		**PRE-SERVICE PERIOD**																			
15		**Start: Following visit when decision for surgery/procedure made**																			
16	CA001		5		5		5		5		5		5		5		5		5		5
17	CA002		20		20		20		20		20		20		20		20		20		20
18	CA003		8		8		8		8		8		8		8		8		8		8
19	CA004		20		20		20		20		20		20		20		20		20		20
20	CA005		7		7		7		7		7		7		7		7		7		7
21	CA006																				
22	CA007																				
23	CA008																				
24																					
27		*Other activity: please include short clinical description here and type new*																			
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																				
35	CA010																				
36	CA011																				
37	CA012																				
38	CA013																				
39	CA014																				
40	CA015																				
41	CA016																				
42	CA017																				
43																					
46		*Other activity: please include short clinical description here and type new*																			
49		**Intra-service (of service period)**																			
50	CA018																				
51	CA019																				
52	CA020																				
53	CA021																				
56																					
57		*Other activity: please include short clinical description here and type new*																			
60		**Post-Service (of service period)**																			
61	CA022																				
62	CA023																				
63	CA024																				
64	CA025																				
65	CA026		20				20		20				20		20				20		20
66	CA027																				
67	CA028																				
68	CA029																				
69	CA030																				
70	CA031																				
71	CA032																				
72	CA033																				
73	CA034																				
74	CA035																				
75	CA036		**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**
76																					
79		*Other activity: please include short clinical description here and type new*																			
82		**End: Patient leaves office/facility**																			
83		**POST-SERVICE PERIOD**																			
84		**Start: Patient leaves office/facility**																			
85	CA037																				
86	CA038																				
87		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
88		99211 16 minutes																			
89		99212 27 minutes	1		3				1		3				1		3		1		1
90		99213 36 minutes	1		1		2		1		1		2		1		1		1		1
91		99214 53 minutes																			
92		99215 63 minutes																			
93	CA039		**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**63.0**
94																					

	A	B	AQ	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI	BJ
2	**Expense Spreadsheet**		**MENDED**	**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOMMENDED**		**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOMMENDED**		**2021 RUC DATABASE**		**JAN 2021 RUC / CMS**		**RECOMMENDED**	
3			**de 69727**	**CPT Code 69714**		**CPT Code 69716**		**CPT Code 69XX0**		**CPT Code 69717**		**CPT Code 69719**		**CPT Code 69XX1**		**CPT Code 69717**		**CPT Code 69727**		**CPT Code 69XX2**	
4		***RUC Collaboration Website***	ral, entire	Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	
5	**Clinical Activity Code**	**Meeting Date: January 2022** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**	ral, entire rated implant, h magnetic us attachment al speech r, within the /or involving a less than 100 face area of to the outer al cortex																		
6		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
7		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**158.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**149.0**
10		**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**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**26.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**72.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**63.0**
97		*Other activity: please include short clinical description here and type new*																			
100		**End: with last office visit before end of global period**																			
101	**Supply Code**	**MEDICAL SUPPLIES**																			
102		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ -**
103	SA043		2				2		2				2		2				2		2
104	SA048		2				2		2				2		2				2		2
105	SA053		**0**		1		**0**		**0**		1		**0**		**0**		1		**0**		**0**
106	SA054		**1**				**1**		**1**				**1**		**1**				**1**		**1**
107	SB012				4						4						4				
108	SB024				1						1						1				
109	SB026				4						4						4				
110	SB027				8						8						8				
111	SB034				8						8						8				
112	SB044				4						4						4				
113	SD009		1		4		1		1		4		1		1		4		1		1
114	SD132		2		8		2		2		8		2		2		8		2		2
115	SG006				1						1						1				
116	SG016				1						1						1				
117	SG020				1						1						1				
118	SG031				4						4						4				
119	SG042				1						1						1				
120	SG055		2		14		2		2		14		2		2		14		2		2
121	SG079				48						48						48				
122	SG081		1		16		1		1		16		1		1		16		1		1
123	SG082				4						4						4				
124	SH024				4						4						4				
125	SJ007		1		20		1		1		20		1		1		20		1		1
126	SJ010				4						4						4				
127	SJ028				40						40						40				
128	SJ046				20						20						20				
129	SJ060				1						1						1				
130	SM001				4						4						4				
131																					
132		*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.*																			
134	**Equipment Code**	**EQUIPMENT**																			
135		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
136	EQ234		63.0		117		72.0		63.0		117		72.0		63.0		117		63.0		63.0
137	EQ183		63.0		117		72.0		63.0		117		72.0		63.0		117		63.0		63.0
138	EQ170		63.0		117		72.0		63.0		117		72.0		63.0		117		63.0		63.0
139	EF008		63.0		117		72.0		63.0		117		72.0		63.0		117		63.0		63.0
140	EQ137		20.0				20.0		20.0				20.0		20.0				20.0		20.0
147																					
148		*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
Screen: New Technology/New Services*

January 2022

Neuromuscular Ultrasound – Tab 11

CPT codes 76881 and 76882 were reviewed as New Technology/New Services by the Relativity Assessment Workgroup (RAW) in January 2015. The RAW recommended that the specialty societies develop a *CPT Assistant* article to define the proper coding of extremity ultrasound, particularly as it applies to the elements necessary to report a complete study and that the RAW should review in October 2016 after additional Medicare utilization data are available. This coding clarification was published in the September 2016 *CPT Assistant*.

In October 2016, the RAW re-reviewed these codes and agreed with the specialty that the dominant specialties providing the complete versus the limited ultrasound of extremity services were different causing variation in the typical practice expense inputs. The RAW recommended to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs for January 2017; 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).

At the January 2017 RUC meeting, the Practice Expense Subcommittee reviewed the direct practice expense inputs for 76881 and 76882 and adjusted the clinical staff time. In June 2017, the CPT Editorial Panel editorially revised ultrasound of extremity codes 76881 and 76882 to clarify the distinction between complete and limited studies and revised the introductory guidelines to clarify reference to one joint in the complete ultrasound procedure.

In October 2019, the RAW reviewed and recommended to again review in two years after additional data are available (January 2022). However, in October 2021, the CPT Editorial Panel approved the addition of code 76XX0 for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity and the revision of 76882 to add focal evaluation. CPT code 76881 is included as part of this family, therefore, review by the RAW was no longer necessary.

CPT codes 76881 and 76882 were identified as part of the neuromuscular ultrasound code family with CPT code 76XX0 and surveyed for the January 2022 RUC meeting.

Compelling Evidence
The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for the code family based on a documented change in technique and physician time, as supported by the survey. In 2009, CPT code 76880 was deleted, and two new codes were created to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound. When CPT code 76881 was created and surveyed in 2010, radiology was expected to be the dominant provider. This would have typically included initial scanning by a diagnostic medical sonographer and subsequent scanning by a radiologist. When 76882 was created and surveyed in 2010, podiatry was expected to be the dominant provider. This would have typically included scanning performed only by the podiatrist. In 2016, the RUC PE Subcommittee

noted that the "dominant specialties providing the complete versus the limited ultrasound of extremity services are different, causing variation in PE" leading to revised PE direct inputs in January 2017. The physician work was not reviewed at that time. In 2022, rheumatology is the top provider for 76881 (25.7% of Medicare claims across all sites) and that specialty did not participate in the original survey. For rheumatology, physicians typically scan the patients with portable ultrasound devices rather than utilizing sonographers as originally described in the 2010 survey. Therefore, the physician work has changed. In 2022, radiology is the dominant physician provider for 76882 (57.3% of Medicare claims across all sites) and typically performs examinations with preliminary ultrasound scanning by a sonographer and additional imaging performed by the physician. Since radiologists do not use portable ultrasound devices as originally described in the 2010 survey or in the 2017 practice expense update, the physician work has changed due to supervision of the sonographer in addition to the radiologist performing the scanning.

In addition, ultrasound technology has evolved immensely since 2010, including proliferation of high-frequency ultrasound probes dedicated to musculoskeletal imaging, as well as producing images with higher fidelity and more detail. This modality is increasingly used for a greater range of musculoskeletal injuries and has replaced MRI as the first line investigation for many pathologies. Furthermore, ultrasound can also be used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work. **The RUC concurred that there is compelling evidence that the physician work for these services has changed due to change in physician time and technique/technology.**

76881 ***Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation***
The RUC reviewed the survey results from 88 physicians and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the work involved in this service. CPT code 76881 represents a complete evaluation of a specific joint in an extremity. This service requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. Code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (e.g., absent secondary to surgery or trauma). The RUC recommends 5 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of post-service time as supported by the survey. The RUC discussed the change in intra-service time and determined that the increase relates to the compelling evidence argument, as previously there was 15 minutes of intra-service time for the radiologist to scan and/or review the sonographer-obtained images. Whereas now, the rheumatologist is performing the scanning and it typically takes 20 minutes in the current patient population. The RUC noted that this code is reported with an office Evaluation and Management (E/M) visit 58.9% and a non-facility office E/M visit 66.3%; however, the code is imaging-specific so the physician work described would not overlap with the E/M service.

The RUC compared CPT code 76881 to the top key reference service MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, 11 minutes intra-service time and 21 minutes total time) which is a clinically similar ultrasound code and noted that the reference code has identical pre and post-service time but less intra-service time than the surveyed code. The RUC noted that 76881 has 9 minutes more intra-service and total time than the reference code, which appropriately reflects the evaluation of multiple surrounding structures in addition to the joint, and therefore is appropriately valued higher. In addition, for the reference code, the physician is typically supervising a sonographer and performing additional scanning, as needed instead of directly performing the entire image acquisition potion of the ultrasound study. The RUC also compared the surveyed code to the second highest key reference service MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination*

and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter (work RVU = 1.92, 47 minutes total time) and noted that the surveyed code has far less physician time than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76881 to MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (e.g., high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 15 minutes intra-service time and 22 minutes total time) and noted that the comparator code has less intra-service and total time compared to the surveyed code but is more intense. MPC code 74246 involves examination of a much larger anatomic area compared to the typical anatomic area examined for the surveyed code. The RUC concluded that CPT code 76881 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.90 for CPT code 76881.**

76882 ***Ultrasound, limited, joint or focal evaluation of 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***
The RUC reviewed the survey results from 100 physicians and determined that the survey 25th percentile work RVU of 0.69 appropriately accounts for the work involved in this service. CPT code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). This evaluation includes assessment of a specific anatomic structure(s) (e.g., joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all the elements included in CPT code 76881, although it does include all surrounding anatomy and any associated pathology or contralateral comparison as indicated. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated. The CPT Editorial Panel revised the CPT descriptor for this service in October 2021 to include focal evaluation of a nerve. The RUC recommends 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time as supported by the survey. The RUC discussed the change in intra-service time given that this limited code is performed with a sonographer and determined that the increase relates to the compelling evidence argument, as previously there was 11 minutes of intra-service time, whereas now the radiologist is working with the sonographer to obtain and interpret the images in addition to the physician performing additional scanning as needed. Therefore, it takes 15 minutes. The change in physician time is also due to the enhancement of the ultrasound technology whereby the number and quality of images that can be reviewed and the pathology to evaluate have greatly increased since 2010.

The RUC compared CPT code 76882 to the top key reference service code 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* (work RVU = 0.59, 8 minutes intra-service time and 18 minutes total time) which is a clinically similar ultrasound code and noted that the reference code has identical pre and post-service time but less intra-service time than the surveyed code. The RUC noted that CPT code 76882 has 7 minutes more intra-service and total time than the reference code, which appropriately reflects that the limited ultrasound examination of a musculoskeletal structure typically involves evaluation of more adjacent structures and tissues compared to the limited abdominal examination of a single structure, and therefore is appropriately valued higher. The RUC also compared the surveyed code to the second highest key reference service MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 30 minutes total time) and noted that the surveyed code has less intra-service and total time than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76882 to MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 15 minutes intra-service time and 20 minutes total time) and noted that the codes have identical intra-service time and a similar amount and type of physician work including analysis, interpretation and report of clinical data. The RUC concluded that CPT code 76882 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.69 for CPT code 76882.**

76XX0 ***Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity***

The RUC reviewed the survey results from 66 physicians and determined that the survey 25th percentile work RVU of 1.21 appropriately accounts for the work involved in this service. CPT code 76XX0 is for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. This code will examine a nerve throughout its length, within one extremity, including evaluation of multiple areas for potential nerve compression, measurement of cross-sectional areas, evaluation of echogenicity, vascularity, mobility including dynamic maneuvers when indicated, evaluation for any associated muscular denervation, with comparison to unaffected muscles or nerves within that extremity as needed. CPT code 76XX0 also requires permanently recorded images and cine loop and a written report containing a description of each of the elements evaluated. The RUC recommends 7 minutes of pre-service time, 25 minutes of intra-service time and 7 minutes of post-service time as supported by the survey. The RUC clarified that this service would not typically be reported with an office E/M visit.

The RUC compared CPT code 76XX0 to the second highest key reference service MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service time and 49 minutes total time) and noted that the surveyed code has less intra-service and total time than the reference code and therefore is appropriately valued lower. For additional support, the RUC compared CPT code 76XX0 to MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20, 20 minutes intra-service time and 50 minutes total time) and noted that the comparator code has less intra-service time and lower intensity than the surveyed code and an almost identical amount of physician work. The RUC concluded that CPT code 76XX0 should be valued at the 25th percentile work RVU as supported by the survey. Moreover, the RUC noted that consistency of intensity measures is demonstrated across the range of codes ascending from the limited code to this newest, most complex 76XX0 code and the recommendations maintain relatively both among the neuromuscular ultrasound family as well as the larger family of ultrasound imaging codes. **The RUC recommends a work RVU of 1.21 for CPT code 76XX0.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made updates to reflect the appropriate specialty providing the service in the global and technical component reporting only in the *non-facility setting*: rheumatology (76881), podiatry (76882), and neurology (76XX0). For the physician work component for CPT code 76882, the radiologist is the dominant provider for physician work at all sites of service; however, for the non-facility global and technical component utilization which determines the top specialty for non-facility practice expense inputs, Podiatry is the dominant specialty. Thus, the radiology inputs were removed from the PE for code 76882 because podiatry is dominant, and there is no sonographer or ultrasound room included in the PE spreadsheet as the physician performs the image acquisition with a portable ultrasound machine instead. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Service
The RUC recommends that CPT code 76XX0 be placed on the New Technology list to 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 Ultrasound** **Extremities** *Code 76881 represents a complete evaluation of a specific joint in an extremity. Code 76881 requires ultrasound examination of all of the following joint elements: joint space (eg, effusion), peri-articular soft-tissue structures that surround the joint (ie, muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. Code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (eg, absent secondary to surgery or trauma).* *When fewer than all of the required elements for a "complete" exam (76881) are performed, report the "limited" code (76882).* Code 76882 represents a limited evaluation of a joint or ~~an~~ focal evaluation of a structure(s) in an extremity other than a joint (eg, soft-tissue mass, fluid collection, or nerve[s]). Limited evaluation of a joint includes assessment of a specific anatomic structure(s) (eg, joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all of the required elements included in 76881. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated. Comprehensive evaluation of a nerve is defined as evaluation of the nerve throughout its course in an extremity. Documentation of the entire course of a nerve throughout an extremity includes the acquisition and permanent archive of cine clips and static images to demonstrate the anatomy. *For spectral and color Doppler evaluation of the extremities, use 93925, 93926, 93930, 93931, 93970, or 93971 as appropriate.*				

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(f)76881	Z1	Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation	XXX	0.90

▲76882	Z2	Ultrasound, limited, joint or focal evaluation of 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 (Do not report 76882 in conjunction with 76XX0)	XXX	0.69
●76XX0	Z3	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity	XXX	1.21

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76881 Tracking Number Z1 Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.90**
Global Period: XXX Current Work RVU: **0.63** RUC Recommended RVU: **0.90**

CPT Descriptor: Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with sore, swollen ankle, which developed gradually over a period of several weeks. He is an avid basketball player but can no longer play because of the pain. Plain radiographs were negative for fracture. The decision is made to perform a diagnostic ultrasound examination.

Percentage of Survey Respondents who found Vignette to be Typical: 57%

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 pertinent clinical information. Review any prior applicable imaging studies.

Description of Intra-Service Work: Perform the examination by scanning the patient, including perform dynamic maneuvers as needed. Interpret real-time and stored images of the ankle including: muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality. Evaluate the lateral structures of the ankle, including: (1) The peroneus longus and peroneus brevis tendons for tears, tendinosis, or tenosynovitis. Also perform dynamic imaging with circumduction of the ankle to assess for peroneal subluxation in real time; and (2) The anterior talofibular ligament, calcaneofibular ligament, and anterior inferior tibiofibular ligament for tears or scarring. Perform stress maneuvers to evaluate for ligamentous laxity and anterolateral ankle impingement. Evaluate the medial structures of the ankle, including: (1) The posterior tibial, flexor digitorum longus and flexor hallucis longus tendons for tears, tendinosis, or tenosynovitis; (2) The deltoid ligament for tears or scarring; and (3) The neurovascular bundle for signs of nerve swelling or compression. Evaluate the anterior structures of the ankle, including: (1) The tibialis anterior tendon for tears, tendinosis, or tenosynovitis; and (2) The ankle joint for effusions, synovitis, arthritic changes, and adjacent ganglion cysts. Evaluate the posterior structures of the ankle, including: (1) The Achilles' tendon for tears, tendinosis, or peritendinitis; and (2) The retrocalcaneal and retroachilles bursa for fluid collections or inflammation. Compare the exam and correlate findings to any prior studies. Dictate a report for the medical record.

Description of Post-Service Work: Discuss and explain findings to the patient as needed. Review and sign final report. Communicate findings to referring clinician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Andy Moriarity, MD; Carlo Milani, MD; David Reece, DO; Andrea Boon, MD; Fredrica Smith, MD; Marianna V. Spanaki, MD, PhD; Brooke Bisbee, DPM					
Specialty Society(ies):	ACR, AAN, AANEM, AAPM&R, ACRh, APMA					
CPT Code:	76881					
Sample Size:	7339	**Resp N:**	88			
Description of Sample:	The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community. The ACRh surveyed a random sample of 1000 current US members. The APMA surveyed a random sample of 1500 current US members.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.00	**30.00**	98.00	1500.00
Survey RVW:	0.48	0.90	**1.43**	2.03	4.50
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	15.00	**20.00**	30.00	70.00

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:	76881	**Recommended Physician Work RVU: 0.90**		
		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:		**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)
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
76700	XXX	0.81	**RUC Time**

CPT Descriptor Ultrasound, abdominal, real time with image documentation; complete

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	908,859

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74246	XXX	0.90	**RUC Time**	34,438

CPT Descriptor 2
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

Other Reference CPT Code	Global	Work RVU	Time Source
85097	XXX	0.94	**RUC Time**

CPT Descriptor Bone marrow, smear interpretation

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:** 21.5 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 12.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 76881	**Top Key Reference CPT Code:** 76700	**2nd Key Reference CPT Code:** **99214**
Median Pre-Service Time	5.00	5.00	7.00
Median Intra-Service Time	20.00	11.00	30.00
Median Immediate Post-service Time	5.00	5.00	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	**30.00**	**21.00**	**47.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	68%	32%	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	5%	74%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	63%	37%
Physical effort required	0%	74%	26%

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%	68%	11%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	45%	45%	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	9%	55%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	9%	91%
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	18%	27%	55%

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 Neuromuscular Ultrasound code family consists of the following three codes:

- CPT code 76881: *Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation*
- CPT code 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*
- CPT code 76XX0: *Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*

The Neuromuscular Ultrasound code family was brought forth to the RUC due to the addition of CPT code 76XX0, a code for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. This code will examine a nerve throughout its length, within one extremity, including evaluation of multiple areas for potential nerve compression, measurement of cross-sectional areas, evaluation of echogenicity, vascularity, mobility including dynamic maneuvers when indicated, evaluate for any associated muscular denervation, with comparison to unaffected muscles or nerves within that extremity as needed. Code 76XX0 also requires permanently recorded images and cine loop, and a written report containing a description of each of the elements evaluated. Additionally, the CPT Panel revised the CPT descriptor of code 76882 to include focal evaluation clarifying language.

CPT code 76881 represents a complete evaluation of a specific joint in an extremity. CPT code 76881 requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. In addition, CPT code 76881 requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (e.g., absent secondary to surgery or trauma).

CPT code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). This evaluation includes assessment of a specific anatomic structure(s) (e.g., joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all the elements included in 76881 although does include all surrounding anatomy and any associated pathology or contralateral comparison as indicated. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated.

The American College of Radiology (ACR), American Academy of Neurology (AAN), American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), American Academy of Physical Medicine and Rehabilitation (AAPM&R), American College of Rheumatology (ACRh), and American Podiatric Medical Association (APMA) convened an expert panel familiar with these services to provide value and time recommendations for the January 2022 RUC meeting.

Survey Process
The ACR, AAN, AANEM, and AAPM&R surveyed for CPT codes 76881, 76882 and 76XX0. The ACRh and APMA surveyed only CPT codes 76881 and 76882.

The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community. The ACRh surveyed a random sample of 1000 current US members. The APMA surveyed a random sample of 1500 current US members.

Compelling Evidence
We believe that there is compelling evidence to consider an increase in the value for CPT code 76881 based on a documented change in the physician work due to differences in technique and physician time, which is supported by the survey respondent times. In 2022, a different specialty is dominant than the original survey of the previously approved RUC values which necessarily results in different physician work. In 2009, CPT code 76880 *(Ultrasound, extremity, nonvascular, real time with image documentation)* was deleted and two new codes were created to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound. When 76881 was created and surveyed in 2010, radiology was expected to be the dominant provider and formed the basis for RUC valuation. This would have typically included initial scanning by a diagnostic medical sonographer and subsequent scanning by a radiologist. In 2016, the RUC PE Subcommittee noted that the "dominant specialties providing the complete versus the limited ultrasound of extremity services are different causing variation in PE" leading to revised PE direct inputs in January 2017. The physician work was not reviewed at that time. In 2021, rheumatology is now the dominant provider for 76881 and that specialty did not participate in the original survey. For rheumatology, physicians typically scan the patients themselves with portable US devices rather than the use of sonographers as originally described in the 2010 survey. Therefore, the physician work must be different. Additionally, since 2010, ultrasound is increasingly used for a greater range of musculoskeletal injuries and has replaced MRI as the first line investigation for many pathologies. Furthermore, ultrasound can also be used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work.

Work RVU and Time Recommendations
The expert panel recommends the survey 25th percentile value at 0.90 work RVU and a survey median time of 20 minutes intra-service. Additionally, we are recommending maintaining the current times of 5 minutes pre-service and 5 minutes post-service.

Key Reference Services
Our recommended work RVU of 0.90 compares favorably to the most commonly chosen key reference service, CPT code 76700 *(Ultrasound, abdominal, real time with image documentation; complete),* which is a clinically similar ultrasound code and on the MPC list. CPT code 76700 has times of 5 minutes pre-service and 5 minutes post-service time but includes less intra-service time at 11 minutes compared to the surveyed code. CPT code 76881 has a survey median time of 20 minutes, which appropriately reflects the increased complexity of the service as the code involves evaluation of multiple surrounding structures in addition to the joint. Additionally, the recommended 0.90 work RVU is appropriately higher than that of key reference code 76700 at 0.81 work RVU. Similarly, survey respondents reported that the surveyed code was more intense overall than key reference code 76700.

The second key reference service code, CPT code 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.)* supports the recommendation as well and is also an MPC code. Service times (7 minutes pre-service, 30 minutes intra-service, and 5 minutes post-service time) are higher for the reference code, 99214, than those recommended for the surveyed code (5 minutes pre-service, 20 minutes intra-service, and 5 minutes post-service time). Additionally, the recommended 0.90 work RVU for the surveyed code is appropriately lower than that of key reference code 99214 at 1.92 work RVU and has an appropriately lower IWPUT.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76700	Ultrasound, abdominal, real time with image documentation; complete	0.81	5	11	5	21	0.053	0.039
76881	**Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation**	**0.90**	**5**	**20**	**5**	**30**	**0.034**	**0.030**
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.	1.92	7	30	10	47	0.051	0.041

MPC Codes

Our recommendation for surveyed code 76881 compares favorably to the MPC codes depicted in the table below. This includes the most commonly chosen key reference service, CPT code 76700 *(Ultrasound, abdominal, real time with image documentation; complete),* which is a clinically similar ultrasound code. In addition, the value recommendation is identical to MPC code 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)*, which is another radiology code. MPC code 74246 has 5 minutes less intra-service time at 15 minutes compared to the surveyed code; however this results in an appropriately higher IWPUT. MPC code 74246 involves examination of a much larger anatomic area as well as multiple patient dynamic maneuvers including changes in positioning compared to the typical anatomic area and fixed position for scanning performed for the surveyed code. Finally, MPC code 85097 *(Bone marrow, smear interpretation)* is a pathology code that has a slightly higher RVU and an appropriately higher IWPUT compared to the surveyed code as the pathology code has 5 minutes greater intra-service time which is more intense during service performance.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76700	Ultrasound, abdominal, real time with image documentation; complete	0.81	5	11	5	21	0.053	0.039
76881	**Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation**	**0.90**	**5**	**20**	**5**	**30**	**0.034**	**0.030**
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	0.90	4	15	3	22	0.050	0.041
85097	Bone marrow, smear interpretation	0.94	0	25	0	25	0.038	0.038

Neuromuscular Ultrasound Family

The recommendations maintain relatively both among the neuromuscular ultrasound family, as well as the larger family of ultrasound imaging codes as indicated by the top key reference services. These relationships are summarized in the following table demonstrating the consistency of the IWPUT measurements across the range of codes at the recommended values ascending from the limited code to the newest, most complex 76XX0 code. The table below is sorted by IWPUT for reference.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76882	**Ultrasound, limited, joint or focal evaluation of 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**	**0.69**	**5**	**15**	**5**	**25**	**0.031**	**0.028**
76881	**Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation**	**0.90**	**5**	**20**	**5**	**30**	**0.034**	**0.030**
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-**	**1.21**	**7**	**25**	**7**	**39**	**0.036**	**0.031**

	time cine imaging with image documentation, per extremity							
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	0.59	5	8	5	18	0.046	0.033
76700	Ultrasound, abdominal, real time with image documentation; complete	0.81	5	11	5	21	0.053	0.039

Summary

In summary, our expert panel recommends the survey 25th percentile value at 0.90 work RVU and a survey median time of 20 minutes intra-service. Additionally, we are recommending maintaining the current times of 5 minutes pre-service and 5 minutes post-service. The recommended value compares favorably with the key reference services, 76700 and 99214, 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) CPT code 76881 is billed with office E/M 58.9% of the time.

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. According to the RUC database, 76881 is billed with: a) 99213 (Office outpatient visit 15 minutes) at 21.1% b) 99214 (Office outpatient visit 25 minutes) at 17.4%, c) 99203 (Office outpatient new 30 minutes) at 8%, and d) 99204 (Office outpatient new 45 minutes) at 6% of the time.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76881

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 Radiology How often? Commonly

Specialty Rheumatology How often? Commonly

Specialty Podiatry How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 561000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 76881 is estimated to be provided 561000 times nationally in a one-year period.

Specialty Radiology	Frequency 78540	Percentage 14.00 %
Specialty Rheumatology	Frequency 151470	Percentage 27.00 %
Specialty Podiatry	Frequency 84150	Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 187,000 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 76881 is estimated to be provided 187000 times in a one-year period to Medicare patients.

Specialty Radiology	Frequency 26180	Percentage 14.00 %
Specialty Rheumatology	Frequency 50490	Percentage 27.00 %
Specialty Podiatry	Frequency 28050	Percentage 15.00 %

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:
Echography/ultrasonography

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 76881

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:76882 Tracking Number Z2 Original Specialty Recommended RVU: **0.69**
Presented Recommended RVU: **0.69**
Global Period: XXX Current Work RVU: **0.49** RUC Recommended RVU: **0.69**

CPT Descriptor: Ultrasound, limited, joint or focal evaluation of 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

(Do not report 76882 in conjunction with 76XX0)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male presents with an acute injury to his Achilles tendon, sustained while playing soccer. No open wounds are noted. X-rays are negative for osseous pathology. Mild erythema and edema are noted at the posterior lower leg. Ultrasound is performed to evaluate the Achilles tendon

Percentage of Survey Respondents who found Vignette to be Typical: 64%

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 pertinent clinical information. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the sonographer performing the examination, as well as personally scanning the patient to perform dynamic maneuvers and/or confirm the sonographer's impression as needed. This includes obtain images in multiple planes through the specific area of concern (i.e., Achilles' tendon) and evaluate for abnormalities of a specific structure or any pathology in the area. Document normal anatomic structure and assess any pathologic findings including evidence of tendinosis, tendon tear, or paratenonitis. Perform measurements of tendon thinning and tear seperation to assist in determining patient management options. Compare to the contralateral side as needed. Dictate a report for the patient's chart.

Description of Post-Service Work: Discuss and explain findings to the patient as needed. Review and sign final report. Communicate findings to referring clinician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Andy Moriarity, MD; Carlo Milani, MD; David Reece, DO; Andrea Boon, MD; Fredrica Smith, MD; Marianna V. Spanaki, MD, PhD; Brooke Bisbee, DPM					
Specialty Society(ies):	ACR, AAN, AANEM, AAPM&R, ACRh, APMA					
CPT Code:	76882					
Sample Size:	7339	**Resp N:**	100			
Description of Sample:	The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community. The ACRh surveyed a random sample of 1000 current US members. The APMA surveyed a random sample of 1500 current US members.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**40.00**	100.00	600.00
Survey RVW:	0.30	0.69	**1.00**	1.51	4.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**15.00**	20.00	60.00

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:	76882	**Recommended Physician Work RVU: 0.69**		
		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:		**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)
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
76705	XXX	0.59	**RUC Time**

CPT Descriptor Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**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 low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74220	XXX	0.60	**RUC Time**	196,573

CPT Descriptor 1 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76830	XXX	0.69	**RUC Time**	442,342

CPT Descriptor 2 Ultrasound, transvaginal

Other Reference CPT Code	Global	Work RVU	Time Source
95251	XXX	0.70	**RUC Time**

CPT Descriptor Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 21 **% of respondents:** 21.0 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 14.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 76882	**Top Key Reference CPT Code:** 76705	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	5.00	5.00	5.00
Median Intra-Service Time	15.00	8.00	20.00
Median Immediate Post-service Time	5.00	5.00	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	**25.00**	**18.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	81%	10%	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	10%	76%	14%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	86%	10%
Physical effort required	5%	90%	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	19%	76%	5%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	43%	43%	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	21%	36%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	7%	93%
Physical effort required	7%	7%	86%

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%	36%	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.

Background

The Neuromuscular Ultrasound code family consists of the following three codes:

- CPT code 76881: *Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation*
- CPT code 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*
- CPT code 76XX0: *Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*

The Neuromuscular Ultrasound code family was brought forth to the RUC due to the addition of CPT code 76XX0, a code for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. This code will examine a nerve throughout its length, within one extremity, including evaluation of multiple areas for potential nerve compression, measurement of cross-sectional areas, evaluation of echogenicity, vascularity, mobility including dynamic maneuvers when indicated, evaluate for any associated muscular denervation, with comparison to unaffected muscles or nerves within that extremity as needed. Code 76XX0 also requires permanently recorded images and cine loop, and a written report containing a description of each of the elements evaluated. Additionally, the CPT Panel revised the CPT descriptor of code 76882 to include focal evaluation *of a nerve*.

CPT code 76881 represents a complete evaluation of a specific joint in an extremity. Code 76881 requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. In addition, CPT code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (e.g., absent secondary to surgery or trauma).

CPT code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). This evaluation includes assessment of a specific anatomic structure(s) (e.g., joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all the elements included in 76881 although does include all surrounding anatomy and any associated pathology or contralateral comparison as indicated. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated.

The American College of Radiology (ACR), American Academy of Neurology (AAN), American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), American Academy of Physical Medicine and Rehabilitation (AAPM&R), American College of Rheumatology (ACRh), and American Podiatric Medical Association (APMA) convened an expert panel familiar with these services to provide value and time recommendations for the January 2022 RUC meeting.

Survey Process
The ACR, AAN, AANEM, and AAPM&R surveyed for CPT codes 76881, 76882 and 76XX0. The ACRh and APMA surveyed only CPT codes 76881 and 76882.

The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community. The ACRh surveyed a random sample of 1000 current US members. The APMA surveyed a random sample of 1500 current US members.

Compelling Evidence
We believe that there is compelling evidence to consider an increase in the value for CPT code 76882 based on a documented change in the physician work due to differences in technique and physician time, which is supported by the survey respondent times. In 2022, a different specialty is dominant than the original survey of the previously approved RUC values which necessarily results in different physician work. In 2009, CPT code 76880 *(Ultrasound, extremity, nonvascular, real time with image documentation)* was deleted and two new codes were created to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound. When 76882 was created and surveyed in 2010, podiatry was expected to be the dominant provider and formed the basis for RUC valuation. In 2016, the RUC PE Subcommittee noted that the "dominant specialties providing the complete versus the limited ultrasound of extremity services are different causing variation in PE" leading to revised PE direct inputs in January 2017. The physician work was not reviewed at that time, and since radiologists do not use portable US devices as originally described in the 2010 survey or in the 2017 PE update, the physician work must be different. In 2022, radiology is the dominant physician provider and typically performs examinations with preliminary ultrasound scanning by a sonographer and additional imaging performed by the physician. Additionally, since 2010, ultrasound is increasingly used for a greater range of musculoskeletal injuries and has replaced MRI as the first line investigation for many pathologies. Furthermore, ultrasound can also be used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work.

Work RVU and Time Recommendations
The expert panel recommends the survey 25th percentile value at 0.69 work RVU and a survey median time of 15 minutes intra-service. Additionally, we are recommending maintaining the current times of 5 minutes pre-service and 5 minutes post-service.

Key Reference Services
Our recommended work RVU of 0.69 compares favorably to the most commonly chosen key reference service, CPT code 76705 *(Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)),* which is a clinically similar ultrasound code. CPT code 76705 has times of 5 minutes pre-service and 5 minutes post-service time but includes less intra-service time at 8 minutes compared to the surveyed code. CPT code 76882 has a survey median time of 15 minutes which appropriately reflects the increased complexity of the service, as the limited ultrasound examination of a musculoskeletal structure will typically involve evaluation of more adjacent structures and tissues compared to the limited abdominal

examination of a single structure. Additionally, the recommended 0.69 work RVU is appropriately higher than that of key reference code 76705 at 0.59 work RVU.

The second key reference service code, CPT code 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.)* supports the recommendation and is an MPC code as well. Service times (5 minutes pre-service, 20 minutes intra-service, and 5 minutes post-service time) are higher for the reference code 99213 than those for the surveyed code (5 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service time). Additionally, the recommended 0.69 work RVU for the surveyed code is appropriately lower than that of key reference code 99213 at 1.30 work RVU.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	0.59	5	8	5	18	0.046	0.033
76882	**Ultrasound, limited, joint or focal evaluation of 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**	**0.69**	**5**	**15**	**5**	**25**	**0.031**	**0.028**
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.	1.30	5	20	5	30	0.054	0.043

MPC Codes

Our recommendation for surveyed code 76882 compares favorably to the MPC codes depicted in the table below. The surveyed code has 5 minutes more intra-service time compared to MPC code 74220 *(Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study)* although it also has an appropriately lower IWPUT when considering how MPC code 74220 involves a greater area of patient anatomy and real time repositioning to obtain optimal views. This results in greater intensity of the intra-service time relative to the RVU. The second MPC code, 76830 *(Ultrasound, transvaginal),* is also an ultrasound code which is performed by multiple specialties and has an

identical work RVU of 0.69 compared to the surveyed code. However, code 76830 involves evaluation of a larger number of structures in the pelvis via a transvaginal (endoluminal) approach compared to the surveyed code, resulting in greater intensity and IWPUT despite similar total service times. Finally, the surveyed code compares well to MPC code 95251 *(Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report)* which has 0.01 greater RVU with an identical intra-service time compared to 76882. MPC code 95251 has a similar type of work compared to 76882 including analysis, interpretation and report of clinical data.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
74220	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	0.60	3	10	3	16	0.047	0.038
76882	**Ultrasound, limited, joint or focal evaluation of 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**	**0.69**	**5**	**15**	**5**	**25**	**0.031**	**0.028**
76830	Ultrasound, transvaginal	0.69	5	10	8	23	0.040	0.030
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	0.70	2	15	3	20	0.039	0.035

Neuromuscular Ultrasound Family

The recommendations maintain relatively both among the neuromuscular ultrasound family, as well as the larger family of ultrasound imaging codes as indicated by the top key reference services. These relationships are summarized in the following table demonstrating the consistency of the IWPUT measurements across the range of codes at the recommended values ascending from the limited code to the newest, most complex 76XX0 code. The table below is sorted by IWPUT for reference.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76882	**Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue**	**0.69**	**5**	**15**	**5**	**25**	**0.031**	**0.028**

	mass[es]), real-time with image documentation							
76881	**Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation**	**0.90**	**5**	**20**	**5**	**30**	**0.034**	**0.030**
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity**	**1.21**	**7**	**25**	**7**	**39**	**0.036**	**0.031**
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	0.59	5	8	5	18	0.046	0.033
76700	Ultrasound, abdominal, real time with image documentation; complete	0.81	5	11	5	21	0.053	0.039

Summary

In summary, our expert panel recommends the survey 25th percentile value at 0.69 work RVU and a survey median time of 15 minutes intra-service. Additionally, we are recommending maintaining the current times of 5 minutes pre-service and 5 minutes post-service. The recommended value compares favorably with the key reference services, 76705 and 99213, 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: 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) 76882

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 Podiatry How often? Commonly

Specialty Rheumatology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 821000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 76882 is estimated to be provided 821000 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 114940 Percentage 14.00 %

Specialty Podiatry Frequency 123150 Percentage 15.00 %

Specialty Rheumatology Frequency 213460 Percentage 26.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 274,000 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 76882 is estimated to be provided 274000 times in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 38360 Percentage 14.00 %

Specialty Podiatry Frequency 41100 Percentage 15.00 %

Specialty Rheumatology Frequency 71240 Percentage 26.00 %

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:
Echography/ultrasonography

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 76882

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:76XX0 Tracking Number Z3 Original Specialty Recommended RVU: **1.21**
Presented Recommended RVU: **1.21**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **1.21**

CPT Descriptor: Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female presents with progressive atrophy and weakness of the intrinsic muscles on the left hand, associated with altered sensation on the medial aspect of the hand. An ultrasound of the left ulnar nerve and accompanying structures is ordered to assess for a disorder involving the ulnar nerve.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review available clinical data, including x-rays, MRI, and/or EMG if available. Consider the potential anatomic lesions that could cause the clinical manifestations and consider the questions posed by the referring physician. The nerve course and surrounding structures to be studied are considered.

Description of Intra-Service Work: The physician takes a focused history and physical examination, positions the patient for the procedure and instructs them to report any pain or paresthesiae felt during the examination from the ultrasound probe as this may reflect nerve entrapment. A high frequency linear transducer is used, and the nerve of interest is first identified distally, inspecting the nerve itself and any pertinent surrounding structures such as a ganglion cyst, anomalous muscle, bone spur, or tenosynovitis. The nerve is then followed proximally, throughout the entire length of the limb, making measurements of cross-sectional area and quantifying vascularity, mobility and echogenicity of the nerve at potential sites of entrapment, as well as taking long axis views to evaluate for changes in morphology. For the ulnar nerve, this would include Guyon's canal in the wrist, the cubital tunnel distal to the elbow, the retrocondylar groove at the elbow, the upper arm (ligament of Struthers), and the axilla. At areas of enlargement, the underlying joint is assessed for osteophytes or effusions, and the affected muscles are examined for signs of denervation (in the case of the ulnar nerve, atrophy and increased echogenicity of the first dorsal interosseous, abductor digiti minimi, flexor digitorum profundus and flexor carpi ulnaris muscles), with comparison to unaffected muscles as clinically indicated. Comparison of suspected abnormalities will also be made to the contralateral side. Record cine loops of any identified areas of entrapment or pathology. Dictate a report for the patient's chart.

Description of Post-Service Work: Discuss and explain findings to the patient as needed. Review and sign final report. Communicate findings to referring clinician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022		
Presenter(s):	Andy Moriarity, MD; Carlo Milani, MD; David Reece, DO; Andrea Boon, MD; Marianna V. Spanaki, MD, PhD		
Specialty Society(ies):	ACR, AAN, AANEM, AAPM&R		
CPT Code:	76XX0		
Sample Size:	4839	**Resp N:**	66
Description of Sample:	The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community. The ACRh surveyed a random sample of 1000 current US members. The APMA surveyed a random sample of 1500 current US members.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**22.00**	58.00	600.00
Survey RVW:	0.49	1.21	**1.80**	2.58	4.04
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	15.00	**25.00**	30.00	70.00

Immediate Post Service-Time:	**7.00**	
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:	76XX0	**Recommended Physician Work RVU: 1.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
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:		**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)
XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**7.00**	**0.00**	**7.00**

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
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.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95861	XXX	1.54	**RUC Time**

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas

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
95805	XXX	1.20	**RUC Time**	3,017

CPT Descriptor 1 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95861	XXX	1.54	**RUC Time**	44,204

CPT Descriptor 2 Needle electromyography; 2 extremities with or without related paraspinal areas

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: 11 **% of respondents:** 16.6 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 76XX0	**Top Key Reference CPT Code:** 99215	**2nd Key Reference CPT Code:** **95861**
Median Pre-Service Time	7.00	10.00	10.00
Median Intra-Service Time	25.00	45.00	29.00
Median Immediate Post-service Time	7.00	15.00	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	**39.00**	**70.00**	**49.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	9%	55%	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	0%	55%	45%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	9%	91%

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%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	63%	25%	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%	88%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	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	38%	38%	25%

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 Neuromuscular Ultrasound code family consists of the following three codes:

- CPT code 76881: *Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation*
- CPT code 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*
- CPT code 76XX0: *Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*

The Neuromuscular Ultrasound code family was brought forth to the RUC due to the addition of CPT code 76XX0, a code for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. This code will examine a nerve throughout its length, within one extremity, including evaluation of multiple areas for potential nerve compression, measurement of cross-sectional areas, evaluation of echogenicity, vascularity, mobility including dynamic maneuvers when indicated, evaluate for any associated muscular denervation, with comparison to unaffected muscles or nerves within that extremity as needed. Additionally, the CPT Panel revised the CPT descriptor of code 76882 to include focal evaluation of a nerve. Code 76XX0 also requires permanently recorded images and cine loop, and a written report containing a description of each of the elements evaluated.

CPT code 76881 represents a complete evaluation of a specific joint in an extremity. Code 76881 requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. Code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (e.g., absent secondary to surgery or trauma).

CPT code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). This evaluation includes assessment of a specific anatomic structure(s) (e.g., joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all the elements included in 76881 although does include all surrounding anatomy and any associated pathology or contralateral comparison as indicated. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated.

The American College of Radiology (ACR), American Academy of Neurology (AAN), American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), American Academy of Physical Medicine and Rehabilitation (AAPM&R), American College of Rheumatology (ACRh), and American Podiatric Medical Association (APMA) convened an expert panel familiar with these services to provide value and time recommendations for the January 2022 RUC meeting.

Survey Process

The ACR, AAN, AANEM, and AAPM&R surveyed for CPT codes 76881, 76882 and 76XX0. The ACRh and APMA surveyed only CPT codes 76881 and 76882.

The ACR surveyed a random sample of 1000 individuals from its membership as well as a random subset of 1000 members who indicated that they perform ultrasound, musculoskeletal, and neuro imaging procedures (total of 2000). The AAN surveyed a sample of 1000 current US members from the Neuromuscular Section and Clinical Neurophysiology Sections. The AANEM surveyed a random sample of 811 current US members, and 83 current US members with neuromuscular subspecialty designation (total of 894). The AAPM&R surveyed a random sample of 945 members who selected musculoskeletal medicine as an area of interest as well as our sports medicine community and our neuromuscular medicine community.

Work RVU and Time Recommendations

The expert panel recommends the survey 25th percentile value at 1.21 work RVU and survey median times of 7 minutes pre-service, 25 minutes intra-service, and 7 minutes post-service.

Key Reference Services

Our recommended work RVU of 1.21 compares favorably to the most commonly chosen key reference service, CPT code 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.)*. CPT code 76XX0 has a survey median time of 25 minutes intra service which appropriately reflects the lower complexity of the service compared to key reference code 99215, which has a substantially higher intra service time of 45 minutes. Additionally, the work RVU of the key reference code is appropriately higher than that of the surveyed code at 2.80 work RVU.

The second key reference service code, CPT code 95861 *(Needle electromyography; 2 extremities with or without related paraspinal areas),* supports the recommendation favorably. CPT codes 76XX0 and 95861 has slightly higher intra service, pre service and post service times than CPT code 76XX0 with similar intensity, and the work RVU of the reference code is appropriately higher than that of the surveyed code at 1.54 work RVU (compared to 1.21 work RVU for 76XX0).

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity**	**1.21**	**7**	**25**	**7**	**39**	**0.036**	**0.031**
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	1.54	10	29	10	49	0.038	0.031
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	10	45	15	70	0.050	0.040

MPC Codes

Our recommendation for surveyed code 76XX0 compares favorably to the MPC codes depicted in the table below. MPC code 95805 *(Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness)* has 5 minutes less intra service time and lower intensity than the surveyed code and an almost identical work RVU. We therefore feel the recommended 25th percentile work RVU for 76XX0 is appropriate.

The second MPC code, 95861 *(Needle electromyography; 2 extremities with or without related paraspinal areas),* is also commonly reported by the anticipated dominant specialty and was the key reference service selected by survey respondents. Code 95861 supports the surveyed code, as it has a near identical IWPUT and WPUT. 95861 has 10 more minutes of total time and an appropriately higher work RVU.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	1.20	15	20	15	50	0.026	0.024
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity**	**1.21**	**7**	**25**	**7**	**39**	**0.036**	**0.031**
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	1.54	10	29	10	49	0.038	0.031

Neuromuscular Ultrasound Family

The recommendations maintain relatively both among the neuromuscular ultrasound family, as well as the larger family of ultrasound imaging codes as indicated by the top key reference services. These relationships are summarized in the following table demonstrating the consistency of the IWPUT measurements across the range of codes at the recommended values ascending from the limited code to the newest, most complex 76XX0 code. The table below is sorted by IWPUT for reference.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76882	**Ultrasound, limited, joint or focal evaluation of 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**	**0.69**	**5**	**15**	**5**	**25**	**0.031**	**0.028**

76881	**Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation**	**0.90**	**5**	**20**	**5**	**30**	**0.034**	**0.030**
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity**	**1.21**	**7**	**25**	**7**	**39**	**0.036**	**0.031**
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	0.59	5	8	5	18	0.046	0.033
76700	Ultrasound, abdominal, real time with image documentation; complete	0.81	5	11	5	21	0.053	0.039

Summary

In summary, our expert panel recommends the survey 25th percentile value at 1.21 work RVU and survey median times of 7 minutes pre-service, 25 minutes intra-service, and 7 minutes post-service. The recommended value compares favorably with the key reference services, 95861 and 99215, 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: 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) 76881

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 Neurology How often? Commonly

Specialty Physical Medicine and Rehabilitation How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 71400
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 76XX0 is estimated to be provided 71400 times nationally in a one-year period. The national estimate is the product of the estimated Medicare patient utilization (seen below) multiplied by 3.

Specialty Neurology Frequency 49980 Percentage 70.00 %

Specialty Physical Medicine and Rahabilitation Frequency 17850 Percentage 25.00 %

Specialty Diagnostic Radiology Frequency 3570 Percentage 5.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,800
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 76XX0 is estimated to be provided 23800 times in a one-year period to Medicare patients. This estimate is the sum of 5% of CPT code 76881's Medicare utilization and 5% of CPT code 76882's Medicare's utilization. This estimation formula was derived from the Neuromuscular Ultrasound CCP.

Specialty Neurology Frequency 17850 Percentage 75.00 %

Specialty Physical Medicine & Rebilitation Frequency 5950 Percentage 25.00 %

Specialty Diagnostic Radiology Frequency 1190 Percentage 5.00 %

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:
Echography/ultrasonography

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 95860

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: Neuromuscular Ultrasound
TAB: 11

Source	CPT	Globa	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	76700	XXX	Ultrasound, abdominal, real time with image documentation; complete	Oct-13	19	0.053	0.039			0.81			21	5					11			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	Apr-19	11	0.051	0.041			1.92			47	7					30			10					
CURRENT	76881	XXX	Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image	Apr-10		0.027	0.025			0.63			25	5					15			5					
SVY - Combined	76881	XXX	Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image		88	0.055	0.041	0.48	0.90	1.43	2.03	4.50	35	7			0	15	20	30	70	8	0	7	30	98	1500
REC	76881	XXX	Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image			0.034	0.030			0.90			30	5					20			5					

Source	CPT	Globa	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	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	76705	XXX	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant,	Oct-13	21	0.046	0.033			0.59			18	5					8			5					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	Apr-19	14	0.054	0.043			1.30			30	5					20			5					
CURRENT	76882	XXX	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-	Apr-10		0.024	0.023			0.49			21	5					11			5					
SVY - Combined	76882	XXX	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-		100	0.050	0.038	0.30	0.69	1.00	1.51	4.00	26	5			0	10	15	20	60	6	0	10	40	100	600
REC	76882	XXX	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-			0.031	0.028			0.69			25	5					15			5					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
4					RUC Review Year			Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
5	Source	CPT	Globa	DESC		Resp	IWPUT		MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
36					RUC Review Year			Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
37	Source	CPT	Globa	DESC		Resp	IWPUT		MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
38	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and	Apr-19	11	0.050	0.040			2.80			70	10					45			15					
39	2nd REF	95861	XXX	Needle electromyography; 2 extremities with or without related paraspinal areas	Apr-12	8	0.038	0.031			1.54			49	10					29			10					
40	CURRENT	76881	XXX	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image	Apr-10		0.027	0.025			0.63			25	5					15			5					
41	SVY - Combined	76XX0	XXX	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity,		66	0.059	0.046	0.49	1.21	1.80	2.58	4.04	39	7			7	15	25	30	70	7	0	3	22	58	600
48	REC	76XX0	XXX	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity,			0.036	0.031			1.21			39	7					25			7					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):76881, 76882, 76XX0**

SPECIALTY SOCIETY(IES): ACR, AAN, AANEM, AAPM&R, ACRh, APMA

PRESENTER(S):

Andy Moriarity, MD; Carlo Milani, MD; David Reece, DO; Andrea Boon, MD; Fredrica Smith, MD; Marianna V. Spanaki, MD, PhD; Brooke Bisbee, DPM

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2022

Surveyed CPT Code	**76881**	**Global Period: XXX**
CPT Code Descriptor	Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation	
Typical Patient/Service	A 45-year-old male presents with sore, swollen ankle, which developed gradually over a period of several weeks. He is an avid basketball player but can no longer play because of the pain. Plain radiographs were negative for fracture. The decision is made to perform a diagnostic ultrasound examination.	

Surveyed CPT Code	**76882**	**Global Period: XXX**
CPT Code Descriptor	Ultrasound, limited, joint or focal evaluation of 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 (Do not report 76882 in conjunction with 76XX0)	
Typical Patient/Service	A 36-year-old male presents with an acute injury to his Achilles tendon, sustained while playing soccer. No open wounds are noted. X-rays are negative for osseous pathology. Mild erythema and edema are noted at the posterior lower leg. Ultrasound is performed to evaluate the Achilles tendon.	

Surveyed CPT Code	**76XX0**	**Global Period: XXX**
CPT Code Descriptor	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity	
Typical Patient/Service	A 45-year-old female presents with progressive atrophy and weakness of the intrinsic muscles on the left hand, associated with altered sensation on the medial aspect of the hand. An ultrasound of the left ulnar nerve and accompanying structures is ordered to assess for a disorder involving the ulnar nerve.	

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, American Academy of Neurology, American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation, American College of Rheumatology, and American Podiatric Medical Association convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for neuromuscular ultrasound.

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

For our reference codes, the societies are providing the current codes for CPT codes 76881 and 76882. We are also providing CPT code 76706 as our reference code to CPT code 76XX0 because it is a recently valued ultrasound code with a similar amount of expected clinical staff and physician time to the newly created 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 the *Billed Together* tab in the RUC Database)

CPT code 76881 is typically reported with an E/M service at 58.9%.
CPT code 76881 is typically reported with an E/M service in the nonfacility at 66.3%.

CPT code 76882 is typically reported with an E/M service at 26.9%.
CPT code 76882 is typically reported with an E/M service in the nonfacility at 53.2%.

For CPT code 76XX0, the societies do not expect 76XX0 to be billed with an E/M based on expert panel consensus.

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 the *Billed Together* tab in the RUC Database)

According to the RUC database in the non-facility (Global & 26), Rheumatology is the dominant provider at 27.3% for 76881. Podiatry is the dominant provider at 28.2% for 76882.

For 76XX0, the expert panel believes that the dominant provider will be Neurology.

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

For CPT code 76881, we are requesting an increase over the aggregate current cost for clinical activities pertaining to the addition of minutes for CA011 (Provide education/obtain consent) and CA014 (Confirm order, protocol exam). These values are standard for ultrasound codes. Additionally, we are allocating 20 minutes for both EF031 and EQ250 based on the recommended physician work intra service time of 20 minutes as these equipment items remain in the room when the patient is being cared for during the intra service period.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If

the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A.

8. 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.

9. 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 is currently allocated to "obtain vital signs". The specialties are recommending 2 minutes of this clinical activity for CPT code 76XX0 for height and weight, which can impact nerve size.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

• Confirm availability of prior images – Staff ensures that prior imaging is available prior to starting the examination. • Review clinical history and questionnaire – Staff ensures that all needed patient information is available prior to the examination.

    b. Service period (includes pre, intra and post):

• Greet patient, provide gowning, ensure appropriate medical records are available. • Provide education and obtain consent for the examination – Staff discusses the examination with the patient, answers any questions, and confirms consent. • Prepare room, equipment, and supplies – Staff ensures that all needed supplies are available and organized. • Confirm order and protocol exam. • Initial positioning and monitoring of patient – Staff positions the patient for optimal technique and comfort. • Clean room/equipment by clinical staff – after the patient has left the room. • Technologist QC's images in PACS, checking for al images, reformats, and dose page.

- Review examination with interpreting provider. Scan documents into PACS. Complete exam in RIS system – These steps ensure that the examination can be reviewed and completed by the physician.

c. Post-service period:

N/A.

11. 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 clinical staff works directly with the physician during the entire physician scanning.
- Position patient on the exam table. Apply ultrasound gel. Set appropriate scan parameters on the ultrasound machine.
- Reposition patient and assist in adjusting scanning parameters throughout the examination as needed.
- Clean gel from patient's skin.
- Clean the room and equipment

Note: the physician typically performs the ultrasound scanning for CPT codes 76881, 76882, and 76XX0.

12. 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.

13. 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*):

N/A.

14. 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.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A.

19. 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.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A.

22. 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.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

• **Table, power (EF031) =** Default formula • **Ultrasound unit, portable (EQ250)** = Highly technical formula Note: For codes 76881, 76882, and 76XX0, we did not use equipment formulas for equipment items EF031 and EQ250. We allocated minutes to EF031 and EQ250 as both of those items remain in the room and are not used for other patients during the entire intraservice time.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, 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	K	O	Q	S	V
1	**RUC Practice Expense Spreadsheet**					**CURRENT**	**RECOMMENDED**	**CURRENT**	**RECOMMENDED**	**REFERENCE CODE**	**RECOMMENDED**
2						**76881**	**76881**	**76882**	**76882**	**76706**	**76XX0**
3		***RUC Collaboration Website***				Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation **(January 2017)**	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation **(January 2022)**	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 **(January 2017)**	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 **(January 2022)**	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA) **(October 2015)**	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity **(January 2022)**
4	**Clinical Activity Code**	**Meeting Date: January 2022 Revision Date (if applicable): Tab: Neuromuscular Ultrasound Specialty: ACR, AAN, AANEM, AAPM&R, ACRh, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -	$ -
20		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -
21		**PRE-SERVICE PERIOD**									
22		**Start: Following visit when decision for surgery/procedure made**									
23	CA001										
24	CA002										
25	CA003										
26	CA004										
27	CA005										
28	CA006		L026A			2	2		2		2
29	CA006		L051B					2			
30	CA006		L050B							2	
31	CA007		L026A			2	1		1		1
32	CA007		L051B					2			
33	CA007		L050B							2	
34	CA008										
41		**End: When patient enters office/facility for surgery/procedure**									
42		**SERVICE PERIOD**									
43		**Start: When patient enters office/facility for surgery/procedure:**									
44		**Pre-Service (of service period)**									
45	CA009		L051B					3			
46	CA009		L050B							3	
47	CA009		L026A								3
48	CA010		L026A								2
49	CA011		L026A				2		2		2
50	CA011		L051B					2			
51	CA011		L050B							2	
52	CA012	Review requisition, assess for special needs									
53	CA013		L026A			2	2		2		2
54	CA013		L051B					2			
55	CA013		L050B							2	
56	CA014		L026A				1		1		1
57	CA014		L050B								
58	CA015										
59	CA016		L026A			2	2		2		2
60	CA016		L051B					2			
61	CA016		L050B							2	
62	CA017										
69		**Intra-service (of service period)**									
70	CA018		L051B					15			
71	CA018		L050B							15	
72	CA019										
73	CA020										
74	CA021		L050B								
81		**Post-Service (of service period)**									
82	CA022										
83	CA023										
84	CA024		L026A			3	3		3		3
85	CA024		L051B					3			
86	CA024		L050B							3	
92	CA030		L051B					2			
93	CA030		L050B							2	
94	CA031		L051B					2			
95	CA031		L050B							2	
97	CA032		L051B					1			
98	CA032		L050B							1	
109		**End: Patient leaves office/facility**									
110		**POST-SERVICE PERIOD**									
111		**Start: Patient leaves office/facility**									
127		**End: with last office visit before end of global**									
128	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
129		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -
130	SB006									1	1
131	SB022					1	1	1	1	2	1
132	SB026									1	1
133	SB036									7	7
134	SB037									1	
135	SB044									1	1
136	SJ062					60	60	40	40	60	60
137	SM012					10		10			
138	SM013						1		1	1	1
139	SM021					2	1	2	1	1	1
140	SM022						3		3	3	3
146	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
147		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -
148	ED050			PACS				32		32	
149	ED053			Other Formula				14		13	
150	EF031			Other Formula		7	20		15		25
151	EL015			Highly Technical						24	
152	EQ250			Highly Technical		7	20	29	15		25

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2022

Cognitive Behavioral Therapy Monitoring – Tab 12

In October 2020, the CPT Editorial Panel created five new CPT codes (98975, 98976, 98977, 98980, 98981) to report remote therapeutic monitoring (RTM) services. Remote therapeutic monitoring treatment management services are provided when a physician or a licensed qualified health care professional (QHP), and/or clinical staff use the results of remote therapeutic monitoring to manage a patient under a specific treatment plan. This family of RTM codes was established to monitor services (e.g., musculoskeletal system status, respiratory system status, therapy adherence, and therapy response) that represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. The RUC reviewed these five services at the January 2021 meeting, and CMS implemented the services for the 2022 Medicare Physician Payment Schedule.

In October 2021, the CPT Editorial Panel replaced Category III codes 0702T *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days* and 0703T *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month*) with Category I code 989X6 *Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, cognitive behavioral therapy, therapy adherence, therapy response); initial set-up and patient education on use of equipment; device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days.* The CPT Editorial Panel created 989X6 for 2023. Codes 0702T and 0703T have been deleted.

989X6 *Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days*
CPT code 989X6 is a practice expense only code. The specialty societies indicated that the technology for this service is still evolving. The RUC agreed that due to its emerging and varying technology, CPT code 989X6 should be contactor priced to accommodate the wide variability in supplies, equipment and conditions monitored. **The RUC recommends that CPT code 989X6 be contractor priced.**

Affirmation of RUC Recommendations
The RUC reviewed the specialty societies' request to affirm the RUC valuations for the recently reviewed CPT codes 98975, 98976, 98977, 98980 and 98981. In October 2021, the CPT Editorial Panel revised the code descriptors for 98975, 98976 and 98977 to include "cognitive behavioral therapy" and created 989X6 to report this service. The RUC confirmed that this editorial revision would not change the typical patient most commonly receiving these procedures, which would continue to be patients requiring respiratory and musculoskeletal monitoring. The RUC agreed with the specialty societies that the changes to 98975, 98976, and 98977 are editorial only and do not result in a change in work or the typical patient most commonly receiving these procedures. Additionally, AMA Staff have noted a point of confusion in in regard to the "eg" parenthetical in the parent code 98975 as it impacts all subsequent codes (i.e., 98976, 98977, and 989X6). Any potential change is editorial and

does not require a change in work but would provide clarity for reporting purposes. These codes are part of the additional items for review from the September 2021 CPT Panel meeting at the February 2022 CPT Panel meeting.

The RUC recommends affirming the following recent RUC recommendations:

0.00 for CPT code 98975 (PE only)
0.00 for CPT code 98976 (PE only)
0.00 for CPT code 98977 (PE only)
0.62 for CPT code 98980
0.61 for CPT code 98981

Practice Expense
The PE Subcommittee reviewed the practice expense recommendations for this code and affirmed the inputs from the January 2021 RUC meeting. However, the spreadsheet required minor editorial updates to the CPT descriptors to represent the 2023 CPT approved coding changes. The PE Subcommittee agreed with the request to contractor price CPT code 989X6 and requested that the RUC place this service on the New Technology list to be re-reviewed in three years to ensure correct valuation and utilization assumptions.

The RUC requested that those that provide CPT code 98977 provide a paid invoice for the *Remote musculoskeletal therapy system* "device" cost. For 2022, CMS cross-walked this cost to the equipment cost for EQ392 *heart failure patient physiologic monitoring equip*, resulting in a Medicare national payment of $56 per month. However, the RUC understands that the monthly rental cost is estimated to be $25 per month and the CMS crosswalk is not based on the actual resource cost. The RUC notes that this problem is mirrored with CPT code 98976, where CMS used a crosswalk not based on resource cost as a proxy for the device equipment, rather than the invoice provided that illustrated the $25 per month rental cost. CMS should use the actual device cost to determine valuation for each of these codes.

New Technology/New Service
The RUC recommends that CPT codes 98975, 98976, 98977, 98980, and 98981 stay on the New Technology list and recommends that 989X6 will be added to the list.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Medicine
Non-Face-to-Face Nonphysician Services

Remote Therapeutic Monitoring Services

Remote therapeutic monitoring services (eg, musculoskeletal system status, respiratory system status, cognitive behavioral therapy, *therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.*

Codes 98976, 98977, 989X6 *are used to report Remote Therapeutic Monitoring Services during a 30-day period. To report 98975, 98976, 98977,* 989X6 *the service must be ordered by a physician, other qualified health care professional, or qualified nonphysician healthcare professional. Code 98975 may be used to report the set-up and patient education on use of any device(s) used for data collection. Codes 98976, 98977,* 989X6 *may be used to report supply of the device for daily recording or programmed alert transmissions. To report 98975, 98976, 98977,* 989X6 *the device used must be a medical device as defined by the FDA. Codes 98975, 98976, 98977,* 989X6 *are not reported if monitoring is less than 16 days. Do not report 98975, 98976, 98977,* 989X6 *with other physiologic monitoring services (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring or 99453, 99454 for remote monitoring of physiologic parameter(s)).*

Code 98975 is reported for each episode of care. For coding remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated, and ends with attainment of targeted treatment goals.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲98975	AA1	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status, cognitive behavioral therapy,~~ therapy adherence, therapy response); initial set-up and patient education on use of equipment (Do not report 98975 more than once per episode of care) (Do not report 98975 for monitoring of less than 16 days)	XXX	0.00 (PE Only) Affirmed January 2021 RUC Recommendation 0.00

▲98976	AA2	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX	0.00 (PE Only) Affirmed January 2021 RUC Recommendation
▲98977	AA3	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	XXX	0.00 (PE Only) Affirmed January 2021 RUC Recommendation
●989X6	AA4	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days (Do not report 98975, 98976, 98977, 989X6 in conjunction with codes for more specific physiologic parameters [93296, 94760, 99453, 99454]) (Do not report 98976, 98977, 989X6 for monitoring of less than 16 days) (For therapeutic monitoring treatment management services, use 98980) (For remote physiologic monitoring, see 99453, 99454) (For physiologic monitoring treatment management services, use 99457) (For self-measured blood pressure monitoring, see 99473, 99474)	XXX	Contractor Price (PE Only)
(f)98980	AA5	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes (Report 98980 once each 30 days, regardless of the number of therapeutic parameters monitored)	XXX	0.62 (Affirmed January 2021 RUC recommendation)

		(Do not report 98980 for services of less than 20 minutes) (Do not report 98980 in conjunction with 93264, 99091, 99457, 99458) (Do not report 98980 in the same calendar month as 99473, 99474)		
+(f)98981	AA6	each additional 20 minutes (List separately in addition to code for primary procedure) (Use 98981 in conjunction with 98980) (Do not report 98981 for services of less than an additional increment of 20 minutes)	ZZZ	0.61 (Affirmed January 2021 RUC recommendation)

Remote Therapeutic Monitoring Treatment Management Services

Remote therapeutic monitoring treatment management services are provided when a physician or other qualified health care professional uses the results of remote therapeutic monitoring to manage a patient under a specific treatment plan. To report remote therapeutic monitoring, the service must be ordered by a physician or other qualified health care professional. To report 98980, 98981, any device used must be a medical device as defined by the FDA. Do not use 98980, 98981 for time that can be reported using codes for more specific monitoring services. Codes 98980, 98981 may be reported during the same service period as chronic care management services (99439, 99487, 99489, 99490, 99491), transitional care management services (99495, 99496), principal care management services (99424, 99425, 99426, 99427), and behavioral health integration services (99484), and psychiatric collaborative care services (99492, 99493, 99494). *However, time spent performing these services should remain separate and no time should be counted toward the required time for both services in a single month. Codes 98980, 98981 require at least one interactive communication with the patient or caregiver. The interactive communication contributes to the total time, but it does not need to represent the entire cumulative reported time of the treatment management service. For the first completed 20 minutes of physician or other qualified health care professional time in a calendar month report 98980, and report 98981 for each additional completed 20 minutes. Do not report 98980, 98981 for services of less than 20 minutes. Report 98980 once regardless of the number of therapeutic monitoring modalities performed in a given calendar month.*

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services [99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215], domiciliary, ~~rest home services [99324, 99325, 99326, 99327, 99328~~, ~~99334, 99335, 99336, 99337~~], home services [99341, 99342, ~~99343~~, 99344, 99345, 99347, 99348, 99349, 99350], inpatient services [99221, 99222, 99223, 99231, 99232, 99233, ~~99251~~, 99252, 99253, 99254, 99255]).

Do not count any time related to other reported services (eg, psychotherapy services [90832, 90833, 90834, 90836, 90837, 90838], interrogation device evaluation services [93290], anticoagulant management services [93793], respiratory monitoring services [94774, 94775, 94776, 94777], health behavior assessment and intervention services [96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171], therapeutic interventions that focus on cognitive function services [97129, 97130], adaptive behavior treatment services [97153, 97154, 97155, 97156, 97157, 97158], therapeutic procedures [97110, 97112, 97116, 97530, 97535], tests and measurements [97750, 97755], physical therapy evaluation services [97161, 97162, 97163, 97164], occupational therapy evaluations [97165, 97166, 97167, 97168], orthotic management and training and prosthetic training services [97760, 97661, 97763], medical nutrition therapy services [97802, 97803,

97804], medication therapy management services [99605, 99606, 99607], critical care services [99291, 99292], principal care management services [99424, 99425, 99426, 99427]) in the cumulative time of the remote therapeutic monitoring treatment management service during the calendar month of reporting.

Category III Codes

~~●*0702T Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days*~~

~~●*0703T management services by physician or other qualified health care professional, per calendar month*~~

~~(Do not report 0702T, 0703T in conjunction with 96158, 96159, *98975, 98976, 98977,* 99091, *99424, 99425, 99426, 99427, 99437,* 99453, 99454, 99457, 99458, 99484, 99492, 99493, 99494)~~

(0702T, 0703T have been deleted)

(For remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program, use 989X6)

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	AQ	AR	AS	AT	AU
3	**ISSUE:** Cognitive Behavioral Therapy Monitoring																										
4	**TAB:** 12																										
5								RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
6	Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
7	1st REF	99457	XXX	Remote physiologic monitoring treatment management	12	0.031	0.031			0.61			20						20								
8	2nd REF 2020 value	99442	XXX	Telephone evaluation and management service by a	12	0.037	0.032			0.97			30	5					20			5					
9	CURRENT	98980	XXX	Remote therapeutic monitoring treatment, physician or other qualified health care		0.031	0.031			0.62			20						20								
10	AFFIRM	98980	XXX	Remote therapeutic monitoring treatment, physician or other qualified health care		0.031	0.031			0.62			20						20								
11																											
12																											
13								RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
14	Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
15	1st REF	99458	ZZZ	Remote physiologic monitoring treatment management	28	0.031	0.031			0.61			20						20								
16	2nd REF	G0506	ZZZ	Comprehensive assessment of and care planning for patients	12	0.037	0.031			0.87			28.5	5					16			7.5					
17	CURRENT	98981	ZZZ	Remote therapeutic monitoring treatment, physician or other qualified health care		0.031	0.031			0.61			20						20								
18	AFFIRM	98981	ZZZ	Remote therapeutic monitoring treatment, physician or other qualified health care		0.031	0.031			0.61			20						20								

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 98975, 98976, 98977, 989X6, 98980 & 98981
SPECIALTY SOCIETY(IES): APA (Psychology) and APA (Psychiatry)
PRESENTER(S): Stephen Gillaspy, PhD and Ronald Burd, MD

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Meeting Date: January 2022

CPT Code	Long Descriptor	Global Period
98975	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status, cognitive behavioral therapy,~~ therapy adherence, therapy response); initial set-up and patient education on use of equipment (Do not report 98975 more than once per episode of care) (Do not report 98975 for monitoring of less than 16 days)	XXX
98976	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX
98977	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	XXX
989X6	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days (Do not report 98975, 98976, 98977, 989X6 in conjunction with codes for more specific physiologic parameters [93296, 94760, 99453, 99454]) (Do not report 98976, 98977, 989X6 for monitoring of less than 16 days) (For therapeutic monitoring treatment management services, use 989X4) (For remote physiologic monitoring, see 99453, 99454) (For physiologic monitoring treatment management services, use 99457) (For self-measured blood pressure monitoring, see 99473, 99474)	XXX
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	XXX
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
98975	A 65-year-old male presents to the physician's or other qualified health care professional's office with exacerbation of a chronic condition. Following the visit, the

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	physician initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management.
98976	An 8-year-old female presents to the physician's or other qualified health care professional's office with cough and wheezing. She is diagnosed with a respiratory condition exacerbated by environmental factors. Following the visit, the physician or other qualified health care professional initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management of her respiratory condition.
98977	A 66-year-old female who has limited mobility caused by osteoarthritis of her knees is enrolled in a remote therapeutic monitoring program to enable data collection and monitoring to support treatment management of her musculoskeletal condition.
989X6	A 43-year-old female presents to the physician's or other qualified health care professional's office and is diagnosed with substance use disorder. Following the visit, the physician or other qualified health care professional initiates a cognitive behavioral therapy-based digital remote therapeutic monitoring program as an adjunct to outpatient treatment for a specified duration to enable data collection, monitoring, and support therapeutic management of her behavioral condition.
98980	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring.
98981	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring. Note: This is an add-on service. Only consider the additional work related to the additional physician or QHP staff time beyond the 20 minutes reported with 98980.

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:

APA-Psychology and APA-Psychiatry expressed interest in the Cognitive Behavioral Therapy Monitoring (98975, 98976, 98977, 989X6, 98980, 98981) Tab (12). Level 1 interest to developing practice expense (PE) recommendations for CPT code 989X6 and Level 2 interest to reaffirm the values for the existing remote therapy monitoring (RTM) family of codes (98975, 98976, 98977, 98980, 98981). The societies conducted several interviews with industry representatives as well as current CBT providers to better understand how the service is currently rendered.

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 989X6 – N/A

CPT Code 98975 used CPT Code 99453 *Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment* as the Reference Service Code

CPT Codes 98976 & 98977 used CPT Code 99454 *Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days* as the Reference Service Code

CPT Code 98980 used CPT Code 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 first month; first 20 minutes* as a Reference Service Code

CPT Code 98981 used CPT Code 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 first month; each additional 20 minutes* as a Reference Service 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)

   New code

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   New code

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   Not applicable

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:

   Not applicable

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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:

Not applicable

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:

From January 2021 RUC Submission to CMS: Not applicable as vital signs are not taken for this code.

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):

From January 2021 RUC Submission to CMS: 98975 - Clinical staff greets the patient and reviews medical records to confirm service. Clinical staff conducts set up of the technology and educates the patient regarding its use. 98980 and 98981 – Clinical staff reviews therapeutic monitoring data with the physician. Data outside of expected norms

   c. Post-service period:

From January 2021 RUC Submission to CMS: 98975 - Clinical staff contacts the patient following the encounter to ensure the technology is working and that the patient is on track to complete their daily tasks related to therapeutic monitoring. 98980 and 98981 – Clinical staff conducts patient communications throughout the month to improve therapy adherence, address lack of improvement/control of condition, and resolve any technology or data transmission concerns.

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:*

From January 2021 RUC Submission to CMS: 98975 - Clinical staff walks the patient through set up of the therapeutic monitoring technology. The patient is educated regarding how to use the technology and related daily tasks. For respiratory therapy monitoring, this includes introduction to the device as well as mobile app. For musculoskeletal therapy monitoring, this includes set up of the device, review of the 3D

motion capture technology, and review of the specific exercises as prescribed by the physician/QHP. The patient is given the opportunity to ask questions.

98980 and 98981 – Clinical staff reviews the therapeutic monitoring data with the physician/QHP. Areas in which data reflects poor control of condition or deviation from expected treatment adherence are identified. This data review is typically done on a weekly basis throughout the 30 days.

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.
Not applicable.

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*):
Not applicable.

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.
Not applicable

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:
From January 2021 RUC Submission to CMS:
Propeller Health invoice for $300 documenting the leasing of the Bluetooth sensors (2 provided in each rental) placed on top of the patient's inhalers (typically 1 daily use inhaler and 1 rescue inhaler) as well as use of the app technology for tracking. This is included in line 102 of the spreadsheet as a monthly rental price of $25. The useful life of this technology is 1 year as the sensors are replaced after 1 year.

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.

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From January 2021 RUC Submission to CMS:
The only supply used is the new supply described in question 16.

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:

As of February 2022:
Invoice not submitted for Remote musculoskeletal therapy system

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

From January 2021 RUC Submission to CMS:
Line 113 – Remote musculoskeletal therapy system uses the monitoring equipment formula, however no staff time is associated with this code.

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

At the October 2020 CPT Editorial Panel meeting the Panel accepted as part of Tab 12 five CPT codes (98975-98981) to report remote monitoring of non-physiologic parameters. These codes were created to be analogous to the remote physiologic monitoring (RPM) codes 99453, 99454, 99457, 99458. The new remote therapeutic monitoring (RTM) codes (98975-98981) are intended to monitor services (eg, musculoskeletal system status, respiratory system status, therapy adherence, therapy response) representing the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response.

In May 2021, as part of tabs 47, Cat III - Validated Digital Behavioral Therapy for Substance Use and 48, Cat III - Remote Cognitive Behavioral Therapy Services, the Panel accepted the addition of two new Category III codes. The first code, 0702T; *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days*, is intended to be reported for the supply and technical support for each 30 days, and the second child code, 0703T; *Remote therapeutic monitoring of a standardized online digital cognitive*

behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month, for reporting the management services by physician or other qualified health care professional per calendar month.

The services described by 0702T and 0703T represent online computer-based cognitive behavioral therapy that can be used for a range of disorders, including substance use. This coding structure was designed as a parent/child approach, such that both the technical supply, as well as the clinician monitoring work component must relate to the overriding defining clinical service specific to online remote cognitive behavioral therapy.

In October 2021, a proposal was submitted to replace those recently created Category III codes (0702T and 0703T) with a Category I code 989X6; *Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with daily recording(s) or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days*, *added* to the RTM code set. The application noted that the professional work described by Category III codes 0702T, 0703T was not distinguishable from the recently added Category I code family for Remote Therapeutic Monitoring and Remote Therapeutic Monitoring Treatment Management Services. The CPT Editorial Panel accepted the proposal to create a practice expense only CPT code (989X6) and deleted the category III codes 0702T and 0703T.

This code represents new and evolving technology. The resource costs associated with CBT products vary under current distribution models depending on how these products are accessed and used by patients. The attached document includes highlights from the interviews conducted to gather resource cost information. During the interviews, it became apparent that CBT products might fit better as separately payable supplies or in a different benefit category. In addition, modifications to the coding structure should also be considered to more appropriately capture the expenses associated with CBT. Based on the information gathered, APA-Psychology and APA-Psychiatry recommend Carrier Pricing for CPT 989X6, which will accommodate the wide variability in practice patterns and pricing.

Also important to note, in the CMS Final Rule for 2022, CMS established values for 98975 by crosswalking to the PE RVU for RPM code 99453 upon which the new RTM code was based. CMS established values for 98976 and 98976 by crosswalking to the PE RVU for RPM code 99454, a code that includes payment for the medical device used to collect and transmit data. CMS noted that the only input to CPT code 98976 was a monthly fee of $25, which would not be paid as a direct cost under the PFS. Historically, they have considered most computer software and associated licensing fees to be indirect costs. However, as CMS noted in section II.B. of the CY2022 final rule (the PE section), stakeholders routinely expressed concern with this policy, especially for evolving technologies that rely primarily on software and licensing

fees with minimal costs in equipment or hardware. As noted in that section of this rule, CMS continues to consider how best to reflect such costs under our current PE methodology.

Finally, CMS hopes to continue to engage in dialogue with stakeholders, including the AMA CPT, in the immediate future on how best to refine the coding for the RTM services to address some of the specific concerns raised by stakeholders. CMS noted that as general medicine codes, these codes can be billed by physicians and other qualified health care professionals. They also note that the five RTM codes will be designated as "sometimes therapy" codes, which means that the services can be billed outside a therapy plan of care by a physician and certain NPPs, but only when appropriate. While therapists' services must always be provided under therapy plans of care, RTM services that relate to devices specific to therapy services, such as the ARIA Physical Therapy device (CPT code 98977), should always be furnished under a therapy plan of care. CMS also clarified that the two device codes, CPT codes 98976 and 98977, are not subject to the de minimis standard that establishes the threshold for the statutorily required payment adjustment that applies to therapy services provided in whole or in part by therapy assistants. However, the initial set-up and patient education services represented by CPT code 98975 is subject to the de minimis policy.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

CPT Code 989X6 – N/A (Carrier Pricing)

From January 2021 RUC Submission to CMS:
Crosswalk for 98975 is 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment

Crosswalk for 98976 and 98977 is 99454 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

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	K	L	N	O	P	Q	R	S	U	V	W	X	Z	AA	AB	AC	AD	AE
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		AFFIRM January 2021 RUC Recommendation		REFERENCE CODE		AFFIRM January 2021 RUC Recommendation		AFFIRM January 2021 RUC Recommendation		REFERENCE CODE		AFFIRM January 2021 RUC Recommendation		REFERENCE CODE		AFFIRM January 2021 RUC Recommendation		Contractor Price	
2						CPT Code 99453		CPT Code 98975		CPT Code 99454		CPT Code 98976		CPT Code 98977		CPT Code 99457		CPT Code 98980		CPT Code 99458		CPT Code 98981		CPT Code 989X6	
3		*RUC Collaboration Website*																							
4	Clinical Activity Code	Meeting Date: January 2021, January 2022 Revision Date (if applicable): Tab: 24, 12 Specialty: AAP, AAPM&R, ANA, APTA	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment		Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment		Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days		Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes		Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes		Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes		Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	
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	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ -	$ -	$ -	$ -	$ -	$ -	$ 25.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	L037D			33.0	0.0	48.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0	0.0	40.0	0.0	20.0	0.0	20.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D			30.0	0.0	38.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	10.0	0.0	10.0	0.0	10.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D			3.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.0	0.0	30.0	0.0	10.0	0.0	10.0	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		L037D																						
16	CA002		L037D																						
17	CA003		L037D																						
18	CA004		L037D																						
19	CA005		L037D																						
20	CA006		L037D																						
21	CA007		L037D																						
22	CA008		L037D																						
23			L037D																						
26		*Other activity: please include short clinical description here and type new in*	L037D																						
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		L037D			3		3																	
34	CA010		L037D																						
35	CA011		L037D																						
36	CA012		L037D																						
37	CA013		L037D																						
38	CA014		L037D																						
39	CA015		L037D																						
40	CA016		L037D																						
41	CA017		L037D																						
42			L037D																						
45		*Other activity: please include short clinical description here and type new in*	L037D																						
48		Intra-service (of service period)																							
49	CA018		L037D																						
50	CA019		L037D																						
51	CA020		L037D																						
52	CA021		L037D			27		35								10		10		10		10			
55			L037D																						
56		*Other activity: please include short clinical description here and type new in*	L037D																						
59		Post-Service (of service period)																							
60	CA022		L037D																						
61	CA023		L037D																						
62	CA024		L037D																						
63	CA025		L037D																						
64	CA026		L037D																						
65	CA027		L037D																						
66	CA028		L037D																						
67	CA029		L037D																						
68	CA030		L037D																						
69	CA031		L037D																						
70	CA032		L037D																						
71	CA033		L037D																						
72	CA034		L037D																						
73	CA035		L037D																						
74	CA036		L037D			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
75			L037D																						
78		*Other activity: please include short clinical description here and type new in*	L037D																						
81		End: Patient leaves office/facility																							
82		POST-SERVICE PERIOD																							
83		Start: Patient leaves office/facility																							
84	CA037		L037D			3		10								30		30		10		10			
85	CA038		L037D																						
86		*Office visits: List Number and Level of Office Visits*	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
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		L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
93			L037D																						
96		*Other activity: please include short clinical description here and type new in*	L037D																						
99		End: with last office visit before end of global period																							

	A	B	D	E	F	G	H	K	L	N	O	P	Q	R	S	U	V	W	X	Z	AA	AB	AC	AD	AE
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**AFFIRM January 2021 RUC Recommendation**		**REFERENCE CODE**		**AFFIRM January 2021 RUC Recommendation**		**AFFIRM January 2021 RUC Recommendation**		**REFERENCE CODE**		**AFFIRM January 2021 RUC Recommendation**		**REFERENCE CODE**		**AFFIRM January 2021 RUC Recommendation**		**Contractor Price**	
2						**CPT Code 99453**		**CPT Code 98975**		**CPT Code 99454**		**CPT Code 98976**		**CPT Code 98977**		**CPT Code 99457**		**CPT Code 98980**		**CPT Code 99458**		**CPT Code 98981**		**CPT Code 989X6**	
3		***RUC Collaboration Website***																							
4	**Clinical Activity Code**	**Meeting Date: January 2021, January 2022** **Revision Date (if applicable):** **Tab: 24, 12** **Specialty: AAP, AAPM&R, ANA, APTA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment		Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment		Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days		Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes		Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes		Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes		Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes		Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	
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**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -	$ -	$ 25.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	L037D			**33.0**	**0.0**	**48.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**40.0**	**0.0**	**40.0**	**0.0**	**20.0**	**0.0**	**20.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**30.0**	**0.0**	**38.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**0.0**	**30.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**																					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -	$ 25.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102	New	Remote respiratory therapy system	25	monthly rental								1													
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	EQ392									43200															
113	New	Remote musculoskeletal therapy system - *Invoice not submitted*	0.00	Monitoring										43200											
114																									
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.*																							

December 14, 2021

Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885
sent via email: Sherry.Smith@ama-assn.org

Re: Tab 12 Cognitive Behavioral Therapy Monitoring

Dear Dr. Silva:

APA-Psychology and APA-Psychiatry expressed interest in the Cognitive Behavioral Therapy Monitoring (98975, 98976, 98977, 989X6, 98980, 98981) Tab (12) for the upcoming January 2022 RUC meeting. Level 1 interest to developing practice expense (PE) recommendations for CPT code 989X6 and Level 2 interest to reaffirm the values for the existing remote therapy monitoring (RTM) family of codes (98975, 98976, 98977, 98980, 98981). The societies conducted several interviews with industry representatives as well as current CBT providers to better understand how the service is currently rendered.

Background

At the October 2020 CPT Editorial Panel meeting the Panel accepted as part of Tab 12 five CPT codes (98975-98981) to report remote monitoring of non-physiologic parameters. These codes were created to be analogous to the remote physiologic monitoring (RPM) codes 99453, 99454, 99457, 99458. The new remote therapeutic monitoring (RTM) codes (98975-98981) are intended to monitor services (e.g., musculoskeletal system status, respiratory system status, therapy adherence, therapy response) representing the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response.

In May 2021, as part of tabs 47, Cat III - Validated Digital Behavioral Therapy for Substance Use and 48, Cat III - Remote Cognitive Behavioral Therapy Services, the Panel accepted the addition of two new Category III codes. The first code, 0702T; *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days*, is intended to be reported for the supply and technical support for each 30 days, and the second child code, 0703T; *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month*, for reporting the management services by physician or other qualified health care professional per calendar month.

The services described by 0702T and 0703T represent online computer-based cognitive behavioral therapy that can be used for a range of disorders, including substance use. This coding structure was designed as a parent/child approach, such that both the technical supply, as well as the clinician monitoring work component must relate to the overriding defining clinical service specific to online remote cognitive behavioral therapy.

In October 2021, a proposal was submitted to replace those recently created Category III codes (0702T and 0703T) with a Category I code 989X6; *Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, cognitive behavioral therapy, therapy adherence, therapy response); device(s) supply with daily recording(s) or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days*, added to the RTM code set. The application noted that the professional work described by Category III codes 0702T, 0703T was not distinguishable from the recently added Category I code family for Remote Therapeutic Monitoring and Remote Therapeutic Monitoring Treatment Management Services. The CPT Editorial Panel accepted the proposal to create a practice expense only CPT code (989X6) and deleted the category III codes 0702T and 0703T.

Recommendations

This code represents new and evolving technology. The resource costs associated with CBT products vary under current distribution models depending on how these products are accessed and used by patients. The attached document includes highlights from the interviews conducted to gather resource cost information. During the interviews, it became apparent that CBT products might fit better as separately payable supplies or in a different benefit category. In addition, modifications to the coding structure should also be considered to more appropriately capture the expenses associated with CBT. Based on the information gathered, APA-Psychology and APA-Psychiatry recommend Carrier Pricing for CPT 989X6, which will accommodate the wide variability in practice patterns and pricing.

Also included in Tab 12 are the recently reviewed remote therapeutic monitoring (RTM) codes (98975-98981). APA-Psychology and APA-Psychiatry request reaffirmation of the January 2021 RUC and Practice Expense recommendations. Please see attached.

We look forward to being part of future discussions on this issue. We thank you in advance for your time and consideration of our comments. Should you have questions or require additional information, please contact our CPT and RUC Staff, Meghann Dugan-Haas, APA-Psychology at mdugan-haas@apa.org and Becky Yowell, APA-Psychiatry at byowell@psych.org.

Sincerely,

Stephen Gillaspy, PhD
American Psychological Association (APA)

Ronald Burd, MD
American Psychiatric Association (APA)

Attachments

cc: Neil Pliskin, PhD, APA-Psychology Advisor, AMA CPT Editorial Panel
Jeremy Musher, MD, APA-Psychiatry Advisor, AMA CPT Editorial Panel and AMA RUC
Becky Yowell, APA-Psychiatry CPT and RUC Staff
Meghann Dugan-Haas, APA-Psychology CPT and RUC Staff
Trisha Crishock, APA-Psychology Consultant
Denise Merlino, APA-Psychiatry Consultant

			Responded to RFI
M-Health Index & Navigation Database https://mindapps.org/Apps (MIND is an interactive database of mental health and brain apps. List filtered for CBT APPs)	App	Company	
	MEDITATION BY MT – SELF HELP, STRESS RELIEF	Meditation & Life improvement	No
	CBT-i Coach	US Dept of Veterans Affairs	
	ACT iCoach: Acceptance Commitment Therapy	Resiliens, Inc	Yes
	feel better - Mood & CBT therapy to manifest goals	Media Local	
	InnerHour Self-Care Therapy: Anxiety & Depression	InnerHour	No
	myStrength	myStrength, Inc.	No
	SURE Recovery	Mindwave Ventures	No
	iCouch CBT	iCouch Inc.	
	Memorado - Brain Games	Memorado GMBH	
	Aura: Meditations, Sleep & Mindfulness	Aura Health - Mindfulness, Sleep, Meditation	Yes
	Bloom: CBT Therapy & Self-Care	Meemo Media Inc.	Yes
	COVID Coach	US Department of Veterans Affairs (VA)	
	Calm - Meditate, Sleep, Relax	Calm.com, Inc	Yes
	Breethe - Meditation & Sleep App	Breethe	Yes
	Sleep Meditation for Calm Sleep by Wysa	Touchkin	No
	Simple Habit: Meditation, Sleep	Simple Habit, Inc.	Yes
	Insomnia Coach	US Department of Veterans Affairs (VA)	
	Sleep Sounds - Relax & Sleep, Relaxing Sounds	Craftsman Spirit	No
	Insomnia - Cognitive Research	CogniFit Inc	Yes
	Sanvello: Anxiety & Depression	Sanvello Health Ltd	No
	Patronus: Mental Health Guide	CM MentalGrowth Ltd	
	Serenity: Guided Meditation & Mindfulness	Olson Meditation and Mindfulness Apps	
	Rootd - Panic Attack & Anxiety Relief	Simply Rooted Media	Yes
	Headspace: Meditation & Sleep	Headspace for Meditation, Mindfulness	Yes
	AbilitiCBT	Morneau Shepell Ltd	
	21-Day Meditation Experience	Chopra Enterprises LLC	No
	BedTyme	BedTyme, LLC	Yes
	Relax Melodies: Sleep Sounds, Meditation	Ipnos Software	Yes
	Panic Diary: A Axiety Tracker	Body & Mind Meditation	No
	Happy Boost, Depression Help	Hypnosis & Subliminal	
	Moshi: Sleep and Meditation	Mind Candy Ltd	No
	Relaxed - Sleep Well, Relieve Stress & Insomnia	Game Mavericks	No
	Insomnia - Breathe & Fall Asleep Under 60 Seconds	Pink Paradise Health	
	Sweet Sleep : Relax, Meditation, Insomnia, Yoga	Pinkaide	
	Sleep Restore	Mark Grant	No
Other (general web search)	Sanvello	Sanvello	Yes
	Moodpath	Moodpath	Yes
	MoodTools	Moodtools	No
	What's Up	What's Up	Yes
	Mood Kit	Thriveport	Yes
	CBTI - SHUTi: Sleep Healthy Using the Internet	CBTI - SHUTi: Sleep Healthy Using the Internet	Yes
CBT4 CBT	CBT4CBT	Clients/purchasers are varied and are primarily state/local governments, health plans, behavioral health facilities.	Yes
PEAR Connect TM	reSET reSET-O	Pear's current products are not sold or distributed in a way where the physician practice is incurring a charge.	Yes

			Responded to RFI
Orexo	VORVIDA ® DEPREXIS ®	There is a great deal of variability in the level and type of interaction between the DTx and the clinician, with some DTx relying solely on communication between the clinician and the patient to convey information on treatment adherence and response, and others offering options for patient to enable clinician access to information on DTx use. CBT DTx can be offered in relatively simple, linear formats with patient progression through modules in a manner similar to moving through the chapters of an e-book. The patient gains the benefit of the information presented, but the DTx cannot generate data or present information that responds to the patient or their therapeutic response. Orexo´s digital therapies build on the artificial intelligence (AI) software broca® and simulates interaction between the patient and an empathetic physician or therapist. CPT Code 989X6 would include devices that offer "tracking" for clinician monitoring purposes and "therapeutic" devices. There is, therefore, no single payment amount that would appropriately capture the cost associated with use of the divergent set of devices that fit within the language of the code descriptor.	Yes
BigHealth	Sleepio Daylight	The coding structure does not fully or clearly describe the CBT products offered by BigHealth. As drafted, code 989XX describes only the supply of device(s) to monitor cognitive behavioral therapy and does not explain how the supply of the cognitive behavioral therapy program itself would be coded--i.e., whether it would be included under the code or reported separately (e.g., using a supply code). The CBT software as a medical device products offered by BigHealth are currently under enforcement discretion by FDA related to the Public Health Emergency. Big Health intends to pursue the appropriate FDA premarket review pathway following the PHE pursuant to pending transition guidance from FDA. The resource costs associated with the BigHealth products vary under current distribution models depending on how these products are accessed and used by patients. The BigHealth products might fit better as separately payable supplies associated with a healthcare practitioner service or in different benefit category.	Yes

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Remote Therapeutic Monitoring – Tab 24

In October 2020, the CPT Editorial Panel created five new CPT codes to report remote therapeutic monitoring services. Remote physiologic monitoring treatment management services are provided when a physician or qualified health care professional (QHP) and/or clinical staff use the results of remote physiological monitoring to manage a patient under a specific treatment plan.

98980 ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes***
The RUC reviewed the survey results from 50 physicians and qualified health care professionals (QHPs) for CPT code 98980 and determined that the survey 25th percentile work RVU of 0.62 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC noted that a physician/QHP would not be permitted to report this code if that physician/QHP spent less than 20 minutes performing these services across a given calendar month and that this work would include 2-3 minutes of data review every few days and an interactive communication with the patient once per month. The RUC also discussed the vignette and the fact that the typical patient is an 8-year-old with asthma. The specialty societies noted that only 46 percent of survey respondents found the vignette to be typical. The respondents and the specialty noted the typical patient to be older and have complex medical conditions and co-morbidities, particularly following surgical procedures after which these treatment/monitoring devices would be provided.

The RUC compared CPT code 98980 to the top key reference service CPT code 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* (work RVU = 0.61, 20 minutes total time) and determined that both services require nearly identical physician work, time and intensity, which supports the RUC recommended work RVU valuation of 98980. The RUC also compared 98980 to CPT code 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* (work RVU = 0.50, 15 minutes total time) and noted that 98980 requires 5 minutes of additional time because there is considerably more data review and collection associated with 98980 across a period of 30 days, compared with a period of 7 days for 99422. **The RUC recommends a work RVU of 0.62 for CPT code 98980.**

98981 ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 physicians and qualified health care professionals (QHPs) for CPT code 98981 and determined that the survey 25th percentile work RVU of 0.61 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC compared CPT code 98981 to the top key reference service CPT code 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, total time 20 minutes) and determined that both services require the same physician work, time and intensity.

The RUC discussed the valuation of key reference services 99457 (work RVU = 0.61) and 99458 (work RVU =0.61) and noted that these key reference services have identical work RVU values. This supports the same relativity between CPT codes 98980 and 98981 being nearly identical. The specialty societies also noted that a typical patient for 98981 is inherently complex and needs additional evaluation and information gathering and that the work associated with this would essentially be identical to that of the base code. **The RUC recommends a work RVU of 0.61 for CPT code 98981.**

New Technology/New Services
CPT codes 98975, 98976, 98977, 98980 and 98981 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee adjusted the CA021 clinical staff time to reflect the typical musculoskeletal patient for CPT code 98975; discussed the leasing/rental fee for the new supply item associated with CPT code 98976; and noted the need for the specialty societies to obtain a paid invoice for the new equipment item for CPT code 98977. **The RUC recommends the direct practice expense inputs as modified** by the Practice Expense Subcommittee. The RUC notes that the specialty societies were unable to obtain a paid invoice for the new equipment item by the date of submission and **recommends that CMS work directly with the specialty societies and others to determine the acquisition costs for the new equipment item *Remote musculoskeletal therapy 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Non-Face-to-Face Services** **Digitally Stored Data Services/Remote Physiologic Monitoring** *Codes 99453 and 99454 are used to report remote physiologic monitoring services (eg, weight, blood pressure, pulse oximetry) during a 30-day period. To report 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Code 99453 may be used to report the setup and patient education on use of the device(s). Code 99454 may be used to report supply of the device for daily recording or programmed alert transmissions. Codes 99453, 99454 are not reported if monitoring is less than 16 days. Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring).* *Code 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.* *If the services described by 99091 or 99474 are provided on the same day the patient presents for an evaluation and management (E/M) service to the same provider, these services should be considered part of the E/M service and not reported separately.* *Do not report 99091 for time in the same calendar month when used to meet the criteria for care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), remote physiologic monitoring services (99457, 99458), or personally performed chronic or principal care management (99491, 99437, 99424, 99425,99426, 99427). Do not report 99091 if other more specific codes exist (eg, 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.* *Code 99453 is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals.* *#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*				

(Do not report 99453 more than once per episode of care)

(Do not report 99453 for monitoring of less than 16 days)

#99454 *device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*

(For physiologic monitoring treatment management services, use 99457)

(Do not report 99454 for monitoring of less than 16 days)

(Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])

(For self-measured blood pressure monitoring, see 99473, 99474)

(For remote therapeutic monitoring, see 98975, 98976, 98977)

#99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*

(Do not report 99091 in conjunction with 99457, 99458)

(Do not report 99091 ~~if it occurs within 30 days of~~ for time in a calendar month when used to meet the criteria for 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99457, 99487, 99491, 99437, 99424, 99425)

Remote Physiologic Monitoring Treatment Management Services

Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Do not use 99457, 99458 for time that can be reported using more specific monitoring services ~~(eg, for the patient that requires reevaluation of medication regimen and/or changes in treatment)~~. Codes 99457, 99458 may be reported during the same service period as chronic care management services (99437, 99439, 99487, 99489, 99490, 99491), principal care management services (99424, 99425, 99426, 99427), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494)~~;~~, ~~h~~However, time spent performing these services should remain separate and no time should be counted twice toward the required time for any~~both~~ services in a single month. Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. For the first completed 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes. Do not report 99457, 99458 for services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

To report remote therapeutic monitoring treatment management services provided by physician/other qualified health care professional, see 98980, 98981.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255). Do not count any time related to other reported services (eg, 93290, 93793, 99291, 99292).

#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*

(Report 99457 once each 30 days, regardless of the number of parameters monitored)

(Do not report 99457 for services of less than 20 minutes)

(Do not report 99457 in conjunction with 93264, 99091)

(Do not report 99457 in the same month as 99473, 99474)

+#99458 *each additional 20 minutes (List separately in addition to code for primary procedure)*

(Use 99458 in conjunction with 99457)

(For remote therapeutic monitoring treatment management services, see 98980, 98981)

~~*(Report only 99457 if you have not completed 20 minutes of additional treatment regardless of time spent)*~~

(Do not report 99458 for services of less than an additional increment of 20 minutes)

Medicine
Non-Face-to-Face Nonphysician Services
Qualified Nonphysician Health Care Professional Online Digital Assessment and Management Service

Qualified nonphysician health care professional online digital assessment and management services are…

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*

98971 *11-20 minutes*

98972 *21 or more minutes*

(Report 98970, 98971, 98972 once per 7-day period)

(Do not report online digital E/M services for cumulative visit time less than 5 minutes)

(Do not count 98970, 98971, 98972 time otherwise reported with other services)

(Do not report 98970, 98971, 98972 for home and outpatient INR monitoring when reporting 93792, 93793)

(Do not report 98970, 98971, 98972 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99490, 99491, 99426, 99427 for the same communication[s])

Remote Therapeutic Monitoring Services

Remote therapeutic monitoring services (eg, musculoskeletal system status, respiratory system status, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.

Codes 98975, 98976, 98977 are used to report remote therapeutic monitoring services during a 30-day period. To report 98975, 98976, 98977 the service must be ordered by a physician or other qualified health care professional. Code 98975 may be used to report the set-up and patient education on use of any device(s) used for therapeutic data collection. Codes 98976, 98977 may be used to report supply of the device for scheduled (eg, daily) recording(s) and/or programmed alert(s) transmissions. To report 98975, 98976, 98977, the device used must be a medical device as defined by the FDA. Codes 98975, 98976, 98977 are not reported if monitoring is less than 16 days. Do not report 98975, 98976, 98977 with other physiologic monitoring services (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring or 99453, 99454 for remote monitoring of physiologic parameter[s]).

Code 98975 is reported for each episode of care. For reporting remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals.

● 98975	AA1	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment (Do not report 98975 more than once per episode of care) (Do not report 98975 for monitoring of less than 16 days)	XXX	0.00 (PE Only)
● 98976	AA2	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX	0.00 (PE Only)
● 98977	AA3	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days (For therapeutic monitoring treatment management services, use 98980) (For physiologic monitoring treatment management services, use 99457) (Do not report 98976, 98977 for monitoring of less than 16 days) (Do not report 98975, 98976, 98977 in conjunction with codes for more specific physiologic parameters [93296, 94760, 99453, 99454]) (For remote physiologic monitoring, see 99453, 99454) (For self-measured blood pressure monitoring, see 99473, 99474)	XXX	0.00 (PE Only)

Remote Therapeutic Monitoring Treatment Management Services

Remote therapeutic monitoring treatment management services are provided when a physician/other qualified health care professional uses the results of remote therapeutic monitoring to manage a patient under a specific treatment plan. To report remote therapeutic monitoring, the service must be ordered by a physician or other qualified health care professional. To report 98980, 98981, any device used must be a medical device as defined by the FDA. Do not use 98980, 98981 for time that can be reported using more specific monitoring services. Codes 98980, 98981 may be reported during the same service period as chronic care management services (99439, 99487, 99489, 99490, 99491), transitional care management services (99495, 99496), *principal care management services (99424, 99425, 99426, 99427)* and behavioral health integration services (99484, 99492, 99493, 99494); however, time spent performing these services should remain separate and no time should

be counted toward the required time for both services in a single month. Codes 98980, 98981 require at least one interactive communication with the patient/caregiver. The interactive communication contributes to the total time but need not represent cumulative reported time of the treatment management service. For the first completed 20 minutes of physician/other qualified health care professional time in a calendar month report 98980, and report 98981 for each additional completed 20 minutes. Do not report 98980, 98981 for services of less than 20 minutes. Report 98980 one time regardless of the number of therapeutic monitoring modalities performed in a given calendar month.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255).

Do not count any time related to other reported services (eg, psychotherapy services 90832, 90833, 90834, 90836, 90837, 90838, interrogation device evaluation services 93290, anticoagulant management services 93793, respiratory monitoring services 94774, 94775, 94776, 94777, health behavior assessment and intervention services 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96160, 96161, 96170, 96171, therapeutic interventions that focus on cognitive function services 97129, 97130, adaptive behavior treatment services 97153, 97154, 97155, 97156, 97157, 97158, therapeutic activities 97530, physical therapy evaluation services 97161, 97162, 97163, 97164, occupational therapy evaluations 97165, 97166, 97167, 97168, orthotic management and training and prosthetic training services 97760, 97661, 97763, medical nutrition therapy services 97802, 97803, 97804, medication therapy management services 99605, 99606, 99607, critical care services 99291, 99292, *principal care management services 99424, 99425, 99426, 99427*) in the cumulative time of the remote therapeutic monitoring treatment management service during the calendar month of reporting.

● 98980	AA4	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes (Report 98980 once each 30 days, regardless of the number of therapeutic parameters monitored) (Do not report 98980 for services of less than 20 minutes) (Do not report 98980 in conjunction with 93264, 99091, 99457, 99458) (Do not report 98980 in the same calendar month as 99473, 99474)	XXX	0.62
✚● 98981	AA5	each additional 20 minutes (List separately in addition to code for primary procedure)	ZZZ	0.61

		(Use 98981 in conjunction with 98980) (Do not report 98981 for services of less than an additional increment of 20 minutes)		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98980 Tracking Number AA4 Original Specialty Recommended RVU: **0.62**
Presented Recommended RVU: **0.62**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.62**

CPT Descriptor: Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

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: Physician or QHP analyzes and interprets the data. Based on the interpreted data, the physician/QHP uses medical/clinical decision making to assess the patient's condition, communicate with the patient, and oversee, coordinate, and/or modify the patient's care through shared decision making in order to achieve established outcomes/goals of care.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD		
Specialty Society(ies):	AAPM&R; ANA; APTA; AAP		
CPT Code:	98980		
Sample Size:	7314	**Resp N:**	50
Description of Sample:	Each society selected a random sample of US physician or QHP members: AAPM&R (1,000), AAP (1,000), APTA (4,343), and AAN (971).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	10.00	1200.00
Survey RVW:	0.48	0.62	**0.97**	1.00	65.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	15.00	**20.00**	20.00	35.00

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:	98980	**Recommended Physician Work RVU: 0.62**		
		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)

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? 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
99457	XXX	0.61	**RUC Time**

CPT Descriptor 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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99442	XXX	0.97	**RUC Time**

CPT Descriptor 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 (Note: the Work RVU listed is the 2020 Work RVU value).

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
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 1 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	10,729,531

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: 12 **% of respondents:** 24.0 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 24.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 98980	Top Key Reference CPT Code: 99457	2nd Key Reference CPT Code: 99442
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	20.00	20.00	20.00
Median Immediate Post-service Time	0.00	0.00	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	**20.00**	**20.00**	**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%	0%	58%	42%	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		67%	33%
Physical effort required	8%	67%	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	8%	58%	34%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	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	42%	33%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	59%	33%
Physical effort required	33%	50%	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%	58%	42%

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.

An expert panel of providers from each of the participating specialty societies (ie, AAPM&R, ANA, APTA, AAP) reviewed and discussed survey results for the Remote Therapeutic Monitoring (RTM) codes (98980 and 98981).

98980
We are recommending the **median intraservice time** (20 minutes). This code is reported for the first completed 20 minutes of physician/other qualified health care professional time in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99457 (20 minutes) which was one of the two key reference services.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.62. This value places this code in proper rank order to 99457 as well as to the key reference services.

98981
We are recommending the **median intraservice time** (20 minutes). This code is reported for each additional completed 20 minutes in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99458 (20 minutes) which was the top key reference service.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.61. This value places this code in proper rank order to 99458 as well as to the key reference services.

While the median Service Performance Rate for this code was zero, we believe that the number of responses received and the data for both codes was sufficient to support making a recommendation to the RUC.

Key Reference Services
Service Performance Rates

KRS #1: 99458
Low: 0
25th: 0
Median: 12
75th: 47
High: 1200

KRS #2: G0506
Low: 0
25th: 0
Median: 1
75th: 18
High: 1200

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) N/A This is a new service

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 Physical Medicine & Rehabilitation How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Specialty Physical Therapy How often? Sometimes

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. Based on 2019 Medicare claims for 99457

Specialty Physical Medicine & Rehabilitation Frequency 20000 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 20000 Percentage 33.33 %

Specialty Physical Therapy Frequency 20000 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50,000 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 claims for 99457

Specialty Physical Medicine & Rehabilitation Frequency 16500 Percentage 33.00 %

Specialty Nurse Practitioner Frequency 16500 Percentage 33.00 %

Specialty Physical Therapy Frequency 16500 Percentage 33.00 %

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:
Tests

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20553

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98981 Tracking Number AA5 Original Specialty Recommended RVU: **0.61**
Presented Recommended RVU: **0.61**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **0.61**

CPT Descriptor: Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month;each additional 20 minutes (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring. Note: This is an add-on service. Only consider the additional work related to the additional physician or QHP staff time beyond the 20 minutes reported with 98980.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

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: Physician or QHP analyzes and interprets the data. Based on the interpreted data, the physician/QHP uses medical/clinical decision making to assess the patient's condition, communicate with the patient, and oversee, coordinate, and/or modify the patient's care through shared decision making in order to achieve established outcomes/goals of care. Additional time is needed due to the specific needs of the patient's medical condition(s).

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD					
Specialty Society(ies):	AAPM&R; ANA; APTA; AAP					
CPT Code:	98981					
Sample Size:	7314	**Resp N:**	46			
Description of Sample:	Each society selected a random sample of US physician or QHP members: AAPM&R (1,000), AAP (1,000), APTA (4,343), and AAN (971).					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	10.00	1200.00
Survey RVW:	0.50	0.61	**0.73**	0.97	23.00
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	14.00	**20.00**	24.00	45.00

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:	98981	**Recommended Physician Work RVU: 0.61**		
		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
99458	ZZZ	0.61	**RUC Time**

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0506	ZZZ	0.87	**CMS Time File**

CPT Descriptor Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management 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
20552	000	0.66	**RUC Time**	350,677

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77002	ZZZ	0.54	**RUC Time**	528,759

CPT Descriptor 2 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (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: 28 **% of respondents:** 60.8 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 26.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 98981	Top Key Reference CPT Code: 99458	2nd Key Reference CPT Code: G0506
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	20.00	20.00	16.00
Median Immediate Post-service Time	0.00	0.00	7.50
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**	**20.00**	**28.50**
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%	64%	29%	3%

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	14%	50%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	68%	21%
Physical effort required	29%	57%	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	11%	53%	36%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	42%	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	8%	42%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	50%	42%
Physical effort required	33%	50%	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	8%	33%	59%

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.

An expert panel of providers from each of the participating specialty societies (ie, AAPM&R, ANA, APTA, AAP) reviewed and discussed survey results for the Remote Therapeutic Monitoring (RTM) codes (989 and 98981).

98980
We are recommending the **median intraservice time** (20 minutes). This code is reported for the first completed 20 minutes of physician/other qualified health care professional time in a calendar month. The expert panel agreed that the

median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99457 (20 minutes) which was one of the two key reference services.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.62. This value places this code in proper rank order to 99457 as well as to the key reference services.

98981
We are recommending the **median intraservice time** (20 minutes). This code is reported for each additional completed 20 minutes in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99458 (20 minutes) which was the top key reference service.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.61. This value places this code in proper rank order to 99458 as well as to the key reference services.

While the median Service Performance Rate for this code was zero, we believe that the number of responses received and the data for both codes was sufficient to support making a recommendation to the RUC.

Key Reference Services
Service Performance Rates

KRS #1: 99458
Low: 0
25th: 0
Median: 12
75th: 47
High: 1200

KRS #2: G0506
Low: 0
25th: 0
Median: 1
75th: 18
High: 1200

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 This is a new service

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 Physical Medicine & Rehabilitation How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 40000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Two-thirds of the estimate for 98980

Specialty Physical Medicine & Rehabilitation Frequency 13333 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 13333 Percentage 33.33 %

Specialty Physical Therapy Frequency 13333 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Two-thirds of the estimate for 98980

Specialty Physical Medicine & Rehabilitation Frequency 11000 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 11000 Percentage 33.33 %

Specialty Physical Therapy Frequency 11000 Percentage 33.33 %

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:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

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. 20553

SS Rec Summary

ISSUE: Remote Therapeutic Monitoring

TAB: 24

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	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	99457	XXX	Remote physiologic monitoring treatment management	12	0.031	0.031			0.61			20						20								
2nd REF 2020	99442	XXX	Telephone evaluation and management service by a	12	0.037	0.032			0.97			30	5					20			5					
SVY	98980	XXX	Remote therapeutic monitoring treatment, physician/other	50	0.049	0.049	0.48	0.62	0.97	1.00	65.00	20				1	15	20	20	35		0	0	1	10	1200
REC	98980	XXX	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar		0.031	0.031			0.62			20						20								

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	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	99458	ZZZ	Remote physiologic monitoring treatment management	28	0.031	0.031			0.61			20						20								
2nd REF	G0506	ZZZ	Comprehensive assessment of and care planning for patients	12	0.037	0.031			0.87			28.5	5					16			7.5					
SPR More Than Zero	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	22	0.037	0.037	0.50	0.61	0.73	0.99	20.00	20				8	15	20	26	45		1	5	10	20	1200
SPR Zero	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	24	0.038	0.038	0.50	0.61	0.73	0.97	23.00	19				5	12	19	21	30		0	0	0	0	0
SVY	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	46	0.037	0.037	0.50	0.61	0.73	0.97	23.00	20				5	14	20	24	45		0	0	0	10	1200
REC	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)		0.031	0.031			0.61			20						20								

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 98975**

SPECIALTY SOCIETY(IES):_AAP, AAPM&R, ANA, APTA

PRESENTER(S):_Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	XXX
98976	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	XXX
98980	Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	XXX
98981	Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
98975	A 65-year-old male presents to the physician's or other qualified health care professional's office with exacerbation of a chronic condition. Following the visit, the physician initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management.
98976	An 8-year-old female presents to the physician's or other qualified health care professional's office with cough and wheezing. She is diagnosed with a respiratory condition exacerbated by environmental factors. Following the visit, the physician or other qualified health care professional initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management of her respiratory condition.
98977	A 66-year-old female who has limited mobility caused by osteoarthritis of her knees is enrolled in a remote therapeutic monitoring program to enable data collection and monitoring to support treatment management of her musculoskeletal condition.
98980	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 98975**

SPECIALTY SOCIETY(IES):_AAP, AAPM&R, ANA, APTA

PRESENTER(S):_Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

98981	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring. Note: This is an add-on service. Only consider the additional work related to the additional physician or QHP staff time beyond the 20 minutes reported with 98980.

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 98975 were determined through 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 the remote physiological monitoring codes (99453, 99454, 99457 and 99458). Further, the societies contacted representatives from two remote therapeutic monitoring technology companies: specifically, Aria (formerly VERA), which produces a musculoskeletal system monitoring device and Propeller Health which produces a respiratory system monitoring device. Both companies provided receipt information as well as insights into staff time related to their technologies. This information was taken into consideration as recommendations were developed.

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 for 98975 - 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment

Reference for 98976 and 98977 – Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Reference for 98980 – Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

Reference for 98981 – Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes

The remote physiologic monitoring (RPM) code family was used as a reference in the development of our recommendations for this code family. This was due to the remote therapeutic codes being modeled, with some variations, after the RPM codes in structure. The RPM codes are reflective of similar staff work though the specific equipment is different.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   New code

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   New code

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   Not applicable

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:

   Not applicable

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:

   Not applicable

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:

   Not applicable as vital signs are not taken for this code.

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):

   98975 - Clinical staff greets the patient and reviews medical records to confirm service. Clinical staff conducts set up of the technology and educates the patient regarding its use.

   98980 and 98981 – Clinical staff reviews therapeutic monitoring data with the physician. Data outside of expected norms

   c. Post-service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

98975 - Clinical staff contacts the patient following the encounter to ensure the technology is working and that the patient is on track to complete their daily tasks related to therapeutic monitoring.

98980 and 98981 – Clinical staff conducts patient communications throughout the month to improve therapy adherence, address lack of improvement/control of condition, and resolve any technology or data transmission concerns.

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:*

98975 - Clinical staff walks the patient through set up of the therapeutic monitoring technology. The patient is educated regarding how to use the technology and related daily tasks. For respiratory therapy monitoring, this includes introduction to the device as well as mobile app. For musculoskeletal therapy monitoring, this includes set up of the device, review of the 3D motion capture technology, and review of the specific exercises as prescribed by the physician/QHP. The patient is given the opportunity to ask questions.

98980 and 98981 – Clinical staff reviews the therapeutic monitoring data with the physician/QHP. Areas in which data reflects poor control of condition or deviation from expected treatment adherence are identified. This data review is typically done on a weekly basis throughout the 30 days.

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.

Not applicable.

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*):

Not applicable.

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.

Not applicable

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?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

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:

Propeller Health invoice for $300 documenting the leasing of the Bluetooth sensors (2 provided in each rental) placed on top of the patient's inhalers (typically 1 daily use inhaler and 1 rescue inhaler) as well as use of the app technology for tracking. This is included in line 102 of the spreadsheet as a monthly rental price of $25. The useful life of this technology is 1 year as the sensors are replaced after 1 year.

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.

The only supply used is the new supply described in question 16.

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:

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Line 113 – remote musculoskeletal therapy system uses the monitoring equipment formula, however no staff time is associated with this code.

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Crosswalk for 98975 is 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment

Crosswalk for 98976 and 98977 is 99454 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

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	K	L	N	O	P	Q	R	S	U	V	W	X	Z	AA	AB	AC
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		RECOMMENDED		REFERENCE CODE		RECOMMENDED		RECOMMENDED		REFERENCE CODE		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2						CPT Code 99453		CPT Code 98975		CPT Code 99454		CPT Code 98976		CPT Code 98977		CPT Code 99457		CPT Code 98980		CPT Code 99458		CPT Code 98981	
3		*RUC Collaboration Website*																					
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: 24 Specialty: AAP, AAPM&R, ANA, APTA	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Remote monitoring of physiologic parameter(s) (eg, weight, blood		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote monitoring of physiologic parameter(s) (eg, weight, blood		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy		Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health care		Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health care	
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	Non Fac	Facility
6		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 12.21	$ -	$ 17.76	$ -	$ 48.85	$ -	$ 25.00	$ -	$ -	$ -	$ 14.80	$ -	$ 14.80	$ -	$ 7.40	$ -	$ 7.40	$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	33.0	0.0	48.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0	0.0	40.0	0.0	20.0	0.0	20.0	0.0
9		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	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	L037D	RN/LPN/MTA	0.37	30.0	0.0	38.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	10.0	0.0	10.0	0.0	10.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.0	0.0	30.0	0.0	10.0	0.0	10.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ 12.21	$ -	$ 17.76	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14.80	$ -	$ 14.80	$ -	$ 7.40	$ -	$ 7.40	$ -
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*	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															
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 related	L037D	RN/LPN/MTA	0.37																		
50	CA019	Assist physician or other qualified healthcare professional---directly related	L037D	RN/LPN/MTA	0.37																		
51	CA020	Assist physician or other qualified healthcare professional---directly related	L037D	RN/LPN/MTA	0.37																		
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	27		35								10		10		10		10	
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, and	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		n/a		n/a		n/a		n/a		n/a		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	3		10								30		30		10		10	
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	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# 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)	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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																					
100	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT																			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ -	$ -	$ -	$ -	$ -	$ -	$ 25.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102	New	Remote respiratory therapy system	25	monthly rental								1											
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				$ -	$ -	$ -	$ -	$ 48.85	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
112	EQ392	heart failure patient physiologic monitoring equipment package	1000		0.001130764					43200													
113	New	Remote musculoskeletal therapy system		Monitoring										43200									
114																							
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.*																					

American Occupational Therapy Association

December 21, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update committee
Relative Value Systems, American Medical Association
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611

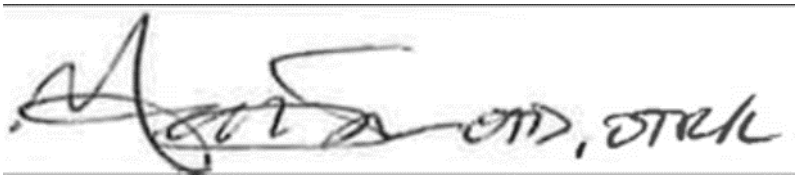
Dear Dr. Smith,

The American Occupational Therapy Association is interested in the new CPT codes for remote therapeutic monitoring as it was surveyed by a related specialty and has relevance to our membership. AOTA's RUC advisors met, reviewed the recommendation, and respectfully submit the following comments.

AOTA is generally supportive of the Remote Therapeutic Monitoring submission. We agree with the selection of key reference services used in the survey. AOTA agrees with the practice expense inputs, but wonders if a valid purchase invoice should be submitted. AOTA noticed that respondents appeared to be lacking experience with the service.

Thank you for the opportunity to comment.

Sincerely,



Katie Jordan, OTD, OTR/L, FAOTA
Primary RUC Advisor

ASHA
American
Speech-Language-Hearing
Association

January 4, 2021

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update Committee Relative Value Systems
American Medical Association
330 N. Wabash Ave.
Suite 39300
Chicago, IL 60611

Re: Tab 24 – Remote Therapeutic Monitoring (98975, 98980, and 98981)

Dear Dr. Smith:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the specialty society recommendations for codes **98975**, *remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment***; 98980**, *remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes*; and **98981**, *each additional 20 minutes.*

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

A small subset of audiologists and speech-language pathologists may report codes 98975, 98980, and 98981, to remotely monitor the progress of treatment for certain hearing, communication, and swallowing disorders, such as tinnitus and dysphagia. As such, ASHA's advisors and Health Care Economics Committee reviewed the recommendations put forth by the submitting specialty societies. For codes **98980 and 98981,** we agree the 25th percentile work RVU and median intra-service times are appropriate and align well with the key reference service codes. ASHA also agrees with the practice expense inputs for **98975**, **98980, and 98981**. The recommended clinical staff times align with the remote physiologic monitoring reference codes, which were also used as a model for the structure of the new codes. **Therefore, ASHA fully supports the work and practice expense recommendations for codes 98975, 98980, and 98981**

Thank you for the opportunity to offer comments on the recommendations for remote therapeutic monitoring. If you or AMA staff have any questions, please contact Neela Swanson, ASHA's director of health care policy for coding and reimbursement, at nswanson@ash.org.

Sincerely,

Leisha R Eiten

Leisha R. Eiten, AuD, CCC-A
ASHA RUC HCPAC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Inpatient and Observation Care Services – Tab 13

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making (MDM). Most of the utilization for each service is expected to be inpatient and not observation.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore the survey respondents may not have captured the correct total time on the date of encounter. The specialty societies revised their survey instrument by working with the Research Subcommittee. The RUC reviewed the inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2022 RUC meeting.

COMPELLING EVIDENCE

The specialty societies presented three points for compelling evidence that the work of providing inpatient hospital and observation care visits for the evaluation and management of patients may have changed. First, a change in the patient population, the distillation down to sicker patients who are in the hospital for a shorter period; second, a change in technology due to the widespread implementation of institutional electronic health records (EHR), which are data intensive and therefore more intense for the patient encounters; and third, a change in the providers of these services with the recent emergence of hospitalists and intensivists.

Change in Patient Population

The number of diagnoses that appear in the Medicare claims for inpatient visits (based on the 5% Medicare claims file) has increased in the last 16 years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006, the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%. Physicians are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a skilled nursing facility.

Data from the Chronic Conditions Data Warehouse also support the assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Technology

EHRs have significantly changed since 2006. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags in the EHR are frequent, as they are put in place for safety reasons, however, these flags require the physician/QHP rather than clinical staff to review and override any modifications to treatment, such as a medication change, before the clinical staff can continue with care of the patient. The American Hospital Association reported that in 2017[1] 95% of hospitals had some form of EHR implemented. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Change in Provider

Hospitalists are a new and growing specialty that were not fully organized as a specialty in 2006 when the codes were last surveyed. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[2] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified

[1] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.
Note: The sample consists of 3,599 non-federal acute care hospitals. “There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data.” ONC Data Brief No. 46 April 2019

[2] Wachter RM, Goldman L. The emerging role of “hospitalists” in the American health care system. N Engl J Med. 1996;335(7):514–517.

using a 90% threshold of Medicare billing claims associated with hospitalizations.[3] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[4] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[5] As the field grows, the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the typical model of outpatient primary care (e.g., rounding in the hospital on their patients) in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[6] Shift-based coverage makes at least one handoff between physicians during a 24-hour period, a ubiquitous practice. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[7] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[8]

The RUC acknowledges that the existing Medicare data attributes a much smaller proportion of claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) using a Medicare specialty billing code (C6) that was just recently established in 2017. The Medicare claims data greatly underrepresent the proportion of hospitalists who perform these services. Given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today.

The RUC agrees that there is compelling evidence based on a change in patient population, change in technology, and change in the provider of these services.

[3] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[4] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[5] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data shows an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[6] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[7] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[8] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

SURVEY PROCESS AND DATA ANALYSIS

The customized survey, vignettes and reference service lists (RSL) were developed and approved by the Research Subcommittee in conjunction with the CPT/RUC Workgroup on E/M and input from medical specialties. The RSLs were specifically developed in an objective manner to represent relativity within the Medicare Physician Payment Schedule (MFS). The Research Subcommittee considered requests from the surveying specialties to add or remove codes from the initial lists originally developed by the Workgroup. The vignettes were developed by the CPT/RUC Workgroup on E/M and approved by the CPT Editorial Panel and the RUC's Research Subcommittee. Approximately 90 percent of respondents agreed that the vignettes described their typical patient.

The survey was the concerted effort of 24 specialty societies and other health care professional organizations. The RUC analyzed the responses and noted that the number of survey responses received per specialty correlated with those who perform inpatient hospital and observation care visits in the MFS. These data were summarized by categories of specialties (hospital, surgical, primary care and medicine/other). The number of respondents by category were also representative of Medicare allowed charges for inpatient hospital and observation care visits for those same categories.

To ensure that survey respondents understood the new CPT guidelines and descriptors and the impact that these changes may have on their work, the RUC asked that each respondent carefully read the new descriptors/guidelines and attest that they had read the information. The survey respondents understood that code selection will be based on either MDM or time on the date of the patient encounter. While the history and physical is no longer required for purposes of documentation, it is expected that a clinically appropriate history and physical exam is performed during the visit.

For the initial and subsequent hospital inpatient or observation care codes (CPT codes 99221-99233) all time is on the date of encounter, thus intra-service time only. The survey instrument was revised to specify that "unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the "unit/floor". The survey asked about the different components of time to ensure that the respondents considered all appropriate time for these services before floor time, floor time and after floor time. The respondents then needed to confirm that the summed time of the components was the accurate total time on the date of encounter for each service to proceed with the survey. Additional details on the survey tool questions and responses are provided in the letter from the specialty societies.

The hospital inpatient or observation services with admission and discharge on the same date (CPT codes 99234-99236) and the discharge management services (99238 and 99239) include **post-service time** because these services include discharge activities where there is contact with the patient and/or family member or further work after the patient had left the hospital. Post-service activities do not occur in the initial or subsequent hospital inpatient or observation care codes because these will be captured when discharged, using CPT codes 99238 and 99239. CPT codes 99234-99236 are based upon total time on the date of encounter if selecting a code level based upon time. The discharge management services are time-based codes only; 30 minutes or less or more than 30 minutes.

INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE

99221 ***Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.***

The RUC reviewed the survey results from 230 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.63, which is lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that both services require similar medical decision making, intensity/complexity, time and physician work to perform. Additionally, of the survey respondents who chose 99203 as the key reference service, 64% indicated that CPT code 99221 is somewhat more to much more intense. Thus, the work RVU of 1.63 is appropriate.

For additional support, the RUC referenced MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92 and 47 minutes total time) and determined that 99221 requires a lower level of medical decision making, is slightly less intense/complex and requires less physician time and work to perform. Therefore, supports a lower work RVU for 99221 compared to CPT code 99204.

The RUC also referenced CPT code 99395 *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years* (work RVU = 1.75 and 45 minutes total time), which requires similar physician time and work to perform as CPT code 99221. **The RUC recommends a work RVU of 1.63 for CPT code 99221.**

99222 ***Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.***

The RUC reviewed the survey results from 250 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 55 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that both services require the same level of medical decision making, similar physician time and the same physician work.

The RUC also compared the surveyed code to the second top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes of total time) and determined that CPT code 99222 is appropriately valued lower as it requires a lower level of medical decision making and less physician time. **The RUC recommends a work RVU of 2.60 for CPT code 99222.**

99223 ***Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.***

The RUC reviewed the survey results from 257 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 74 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that both services require the same level of medical decision making and the same physician work. The RUC noted that of the survey respondents who chose 99205 as the key reference service, 82% indicated that CPT code 99223 is somewhat more to much more intense.

The RUC compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 70 minutes of total time) and determined that 99223 is less intense, thus valued lower than CPT code 99291.

For additional support the RUC referenced CPT code 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)* (work RVU = 3.86 and 75 minutes total time). **The RUC recommends a work RVU of 3.50 for CPT code 99223.**

SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE

99231 ***Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.***

The RUC reviewed the survey results from 234 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of intra-service/total time, an increase from the current time.

The RUC compared the surveyed code to the top key reference services 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes of total time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70 and 16 minutes of total time) and determined that the medical decision making, intensity/complexity, physician time and physician work for 99231 are appropriately bracketed by these two services.

For additional support, the RUC referenced MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.* (work RVU = 0.93 and 20 minutes of total time), which requires only straightforward medical decision making for a new patient and slightly less physician work and time to perform than 99231. **The RUC recommends a work RVU of 1.00 for CPT code 99231.**

99232 ***Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.***

The RUC reviewed the survey results from 252 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.59 appropriately accounts for the work required to perform this service. The RUC recommends 36 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total

time) and determined that 99232 is slightly more intense/complex but requires less physician time and work to perform. Additionally, of the survey respondents who chose 99214 as the key reference service, 64% indicated that CPT code 99232 is somewhat more to much more intense. Therefore, supports a lower work RVU for 99232 compared to CPT code 99214.

The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes of total time) and determined CPT code 99232 requires a higher level of medical decision making, is slightly more intense and complex and requires more physician time and work to perform. Additionally, of the survey respondents who chose 99213 as the key reference service, 62% indicated that CPT code 99232 is somewhat more to much more intense.

The RUC noted that the recommended work RVU for 99232 maintains the appropriate relativity with the initial inpatient hospital visit with straightforward or low MDM recommendation 99221 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (recommended work RVU = 1.63 and 40 minutes intra-service time).

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time), which requires similar physician work and time to perform. **The RUC recommends a work RVU of 1.59 for CPT code 99232.**

99233 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.*

The RUC reviewed the survey results from 258 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC recommends 52 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that CPT code 99233 requires the same level of medical decision making but less physician time and work to perform. Additionally, of the survey respondents who chose 99215 as the key reference service, 76% indicated that CPT code 99233 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that CPT code 99233 requires a higher level of medical decision making, is more intense/complex, and requires more physician time and work to perform. Additionally, of the survey respondents who chose 99214 as the key reference service, 81% indicated that CPT code 99233 is somewhat more to much more intense. **The RUC recommends a work RVU of 2.40 for CPT code 99233.**

ADMISSION AND DISCHARGE ON THE SAME DATE

99234 ***Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.-When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***

The RUC reviewed the survey results from 58 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.00 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that CPT code 99234 has a lower level of medical decision making, is slightly less intense and requires less physician work and time to perform.

The RUC also compared the surveyed code to the second top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60 and 35 minutes total time) and determined that CPT code 99234 requires more physician work and time to perform. Additionally, of the survey respondents who chose 99203 as the key reference service, 71% indicated that CPT code 99234 is somewhat more to much more intense. **The RUC recommends a work RVU of 2.00 for CPT code 99234.**

99235 ***Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate of medical decision making.-When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.***

The RUC reviewed the survey results from 59 physicians and other qualified healthcare professionals and determined that the current work RVU of 3.24 appropriately accounts for the work required to perform this service. The RUC recommends 68 minutes of intra-service and 8 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that CPT code 99235 requires a lower level of medical decision making, and less physician work and time to perform. However, of the survey respondents who chose 99205 as the key reference service, 71% indicated that CPT code 99235 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that CPT code 99235 requires more physician work and time to perform. Given the higher intensity of the hospital care and the added work of discharge, the RUC agreed that the current value of 3.24 places 99235 in proper rank order to the key reference services. Additionally, of the survey respondents who chose 99204 as the key reference service, 84% indicated that CPT code 99235 is somewhat more to much more intense. **The RUC recommends a work RVU of 3.24 for CPT code 99235.**

99236 ***Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making.-When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.***

The RUC reviewed the survey results from 59 physicians and other qualified healthcare professionals and determined that the survey median work RVU of 4.30 appropriately accounts for the work required to perform this service. The RUC recommends 85 minutes of intra-service and 12 minutes post-service time. The RUC noted that the total time has increased slightly, since this survey captured total time on the date of encounter, which is all indicated in the intra-service time. The RUC noted this was a reallocation of time but not necessarily an increase of 30 minutes intra-service time from what it was previously.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that although both codes require the same level of medical decision making, CPT code 99236 is more intense and complex and requires more physician time and work to perform. Additionally, of the survey respondents who chose 99205 as the key reference service, 85% indicated that CPT code 99236 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 70 minutes total time) and determined that although CPT code 99236 requires more time to perform, it is much less intense. **The RUC recommends a work RVU of 4.30 for CPT code 99236.**

DISCHARGE DAY MANAGEMENT

99238 ***Hospital inpatient or observation discharge day management; 30 minutes or less***
The RUC reviewed the survey results from 167 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 28 minutes of intra-service and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference services 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that since 99238 is a time-based code that it is appropriately valued higher than 99213 since it requires more physician time and work and is appropriately valued lower than 99214 since it requires less physician time and work. Additionally, of the survey respondents who chose 99213 as the key reference service, 75% indicated that CPT code 99238 is somewhat more to much more intense and for those who chose 99214 as the second top key reference service, 69% indicated that CPT code 99238 is somewhat more to much more intense.

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) since it requires similar physician work and time to perform. **The RUC recommends a work RVU of 1.50 for CPT code 99238.**

99239 ***Hospital inpatient or observation discharge day management; more than 30 minutes***
The RUC reviewed the survey results from 171 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.15 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and 19 minutes post-service time.

The RUC compared the surveyed code to the top key reference services 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter*. (work RVU = 2.80 and 70 minutes total time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that since 99239 is a time-based code that it is appropriately valued higher than 99214 since it requires more physician time and work and is appropriately valued lower than 99215 since it requires less physician time and work. Additionally, of the survey respondents who chose 99215 as the key reference service, 76% indicated that CPT code 99238 is somewhat more to much more intense.

For additional support, the RUC referenced MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes intra-service time, 66.5 minutes total time). **The RUC recommends a work RVU of 2.15 for CPT code 99239.**

CPT DESCRIPTOR TIME

The RUC recommends the following times for the CPT descriptors based on the survey medians. The time in the CPT descriptors is rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code	Descriptor	Time on the Date of Encounter Rec to CPT
99221	Initial hospital inpatient or observation care per day, straightforward or low MDM	**40**
99222	Initial hospital inpatient or observation care per day, moderate MDM	**55**
99223	Initial hospital inpatient or observation care per day, high MDM	**75**
99231	Subsequent hospital inpatient or observation care per day, straightforward or low MDM	**25**
99232	Subsequent hospital inpatient or observation care per day, moderate MDM	**35**
99233	Subsequent hospital inpatient or observation care per day, high MDM	**50**
99234	Hospital inpatient or observation care, admission and discharge on the same date, straightforward or low MDM	**45**
99235	Hospital inpatient or observation care, admission and discharge on the same date, moderate MDM	**70**
99236	Hospital inpatient or observation care, admission and discharge on the same date, high MDM	**85**

PRACTICE EXPENSE

The Practice Expense (PE) Subcommittee affirmed the PE recommendations for CPT codes 99238 and 99239 as approved without modification in October 2021. The other inpatient and observation care codes are facility-only and have no direct PE inputs. The only direct practice expense inputs are for CA036 *Discharge Day Management*, with 12 minutes for CPT code 99238 and 15 minutes for CPT code 99239. The RUC noted that the discharge services have always included and continue to include these clinical activities. Time is allocated for office clinical staff to perform coordination of care activities during a hospitalization including phone calls that office based clinical staff have with family members who have clinical questions regarding care about a hospitalized patient and phone calls with hospital clinical staff to exchange clinical data between the office and the hospital. These could be calls initiated by the hospital staff or by the office staff. These activities are in support of hospitalized patients and are necessary to provide patient care. In addition to time for clinical staff work during a hospitalization, there are clinical staff activities associated with discharge day management services. Typically, there will be discharge management related calls to the patient/family/pharmacy/other providers. This work has not changed. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

GLOBAL SURGICAL PERIOD

The RUC recommends that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239) be incorporated into the surgical global periods for each CPT code with a global of 010-day, 090-day, MMM (maternity) codes and other codes that have hospital visits included in the valuation. The RUC recommends that the practice expense inputs should be modified for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239) within the global periods. The RUC agrees that inpatient hospital and observation care work is equivalent and a crosswalk of 100% of the inpatient hospital and observation care visit valuations should be bundled into the codes with global periods of 010-days, 090-days, MMM and other codes that have hospital visits included in the valuation. A spreadsheet itemizing these changes is included in the attached supporting material.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Evaluation and Management

Office or Other Outpatient Services

Established Patient

▲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~~

Hospital Observation Services

~~The following codes are used to report evaluation and management services provided to patients designated/ admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.~~

~~If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.~~

~~For definitions of key components and commonly used terms, please see **Evaluation and Management Services Guidelines.**~~

~~***Coding Tip***~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~

Observation Care Discharge Services

~~Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.~~

~~99217~~	-	~~**Observation care discharge** day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])~~ (99217 has been deleted. To report observation care discharge services, see 99238, 99239)	~~XXX~~	~~N/A~~

Initial Observation Care
New or Established Patient

~~The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.~~

~~To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care (page 15). For observation care services on other than the initial or discharge date, see subsequent observation services codes (99224-99226). For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate initial hospital care code (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with a hospital admission (99221-99223).~~

~~When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician or other qualified health care professional should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting.~~

~~Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281- 99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324- 99337), home services (99341-99350), and preventive medicine services (99381-99429) on the same date related to the admission to "observation status" should not be reported separately.~~

~~These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical "package." These codes apply to all evaluation and management services that are provided on the same date of initiating "observation status."~~

~~99218~~	-	~~**Initial observation care**, per day, for the evaluation and management of a patient which requires these 3 key components:~~ ~~• **A detailed or comprehensive history;**~~ ~~• **A detailed or comprehensive examination; and**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~
~~99219~~	-	~~**Initial observation care**, per day, for the evaluation and management of a patient which requires these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~

~~99220~~	-	~~**Initial observation care**, per day, for the evaluation and management of a patient which requires these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99218, 99219, 99220 have been deleted. To report initial observation care, new or established patient, see 99221, 99222, 99223)	~~XXX~~	~~N/A~~
Subsequent Observation Care ~~All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment.~~				
~~99224~~	-	~~**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ ~~• **Problem focused interval history;**~~ ~~• **Problem focused examination;**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~

~~99225~~	-	~~**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ ~~• **An expanded problem focused interval history;**~~ ~~• **An expanded problem focused examination;**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~
~~99226~~	-	~~**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ ~~• **A detailed interval history;**~~ ~~• **A detailed examination;**~~ ~~• **Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99224, 99225, 99226 have been deleted. To report subsequent observation care, see 99231, 99232, 99233)	~~XXX~~	~~N/A~~

Hospital Inpatient and Observation Care Services

The following codes are used to report initial and subsequent evaluation and management services provided to hospital inpatients and to patients designated as hospital outpatient "observation status". ~~Hospital inpatient services include those services provided to patients in a "partial hospital" setting.~~ Hospital inpatient or observation care codes are to be used to report partial hospitalization services. ~~For definition of partial hospitalization, see **Psychiatry** [90785-90899]. These are to be used to report these partial hospitalization services. See also **psychiatry** notes in the full text of the CPT code set~~.

For patients designated/admitted as "observation status" in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc), these codes may be utilized if the patient is placed in such an area.

~~For definitions of key components and commonly used terms, see **Evaluation and Management Services Guidelines.** For Hospital Observation Services, see 99218-99220, 99224-99226.~~ For a patient admitted and discharged from ~~observation or~~ hospital inpatient or observation status on the same calendar date, ~~the services should be~~ reported ~~with codes~~ 99234, 99235, 99236 as appropriate.

~~**Coding Tip**~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~

Total time on the date of the encounter is by calendar date. When using MDM or time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one date. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service.

Initial Hospital Inpatient or Observation Care
New or Established Patient

The following codes are used to report the first hospital inpatient or observation status encounter with the patient ~~by the admitting physician~~.

~~For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.~~

An initial service may be reported when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician.

For admission services…

When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, ~~observation status in a hospital,~~ office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same calendar date. ~~all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.~~

In the case when the services in a separate site are reported and the initial inpatient or observation care service is a consultation service, do not report 99221, 99222, 99223, 99252, 99253, 99254, or 99255. The consultant reports the subsequent hospital inpatient or observation care codes 99231, 99232, 99233 for the second service on the same calendar date.

~~Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99397) on the same date related to the admission to "observation status" should **not** be reported separately.~~

~~For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.~~

If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233). This instruction applies whether the consultation occurred on the date of the admission or a date previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

For a patient admitted and discharged from hospital inpatient or observation ~~or inpatient~~ status on the same calendar date, report 99234, 99235, 99236 as appropriate.

For the purposes of reporting an initial hospital or observation care service a transition from observation level to inpatient does not constitute a new stay.

▲99221	F1	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. ~~these 3 key components:~~ • ~~**A detailed or comprehensive history;**~~ • ~~**A detailed or comprehensive examination; and**~~ • ~~**Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	XXX	1.63
▲99222	F2	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	XXX	2.60

▲99223	F3	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded. (For services of 90 minutes or longer, use prolonged services code 993X0)	XXX	3.50

Subsequent Hospital Inpatient or Observation Care ~~All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition and response to management) since the last assessment.~~				
▲99231	F4	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused interval history;**~~ • ~~**A problem focused examination;**~~ • ~~**Medical decision making that is straight forward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	XXX	1.00

▲99232	F5	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	XXX	1.59
▲99233	F6	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded. (For services of 65 minutes or longer, use prolonged services code 993X0)	XXX	2.40

Hospital Inpatient or Observation ~~or Inpatient~~ Care Services (Including Admission and Discharge Services)

The following codes are used to report ~~observation or inpatient~~ hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.

~~When a patient is admitted to the hospital from observation status on the same date, only the initial hospital care code should be reported. The initial hospital care code reported by the admitting physician or other qualified health care professional should include the services related to the observation status services he/she provided on the same date of inpatient admission.~~

~~When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same individual.~~

For patients admitted to hospital inpatient or observation ~~or inpatient~~ care and discharged on a different date, see ~~codes 99217, 99218-99220, 99224-99226, or~~ 99221, 99222, ~~-~~99223, 99231, 99232, 99233, 99238, ~~and~~ 99239.

Codes 99234, 99235, 99236 require two or more encounters on the same calendar date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter. For a patient admitted and discharged at the same encounter, see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed ~~at~~ on the same calendar date.

(For discharge services provided to newborns admitted and discharged on the same calendar date, use 99463)

▲99234	F7	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~these 3 key components:~~ • ~~**A detailed or comprehensive history;**~~ • ~~**A detailed or comprehensive examination; and**~~ • ~~**Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~	XXX	2.00

		~~Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.		
▲99235	F8	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.	XXX	3.24
▲99236	F9	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~	XXX	4.30

		~~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) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded. (For services of 100 minutes or longer, use prolonged services code 993X0)		
Hospital Inpatient or Observation Discharge Services The hospital inpatient or observation discharge day management codes are to be used to report the total duration of time on the date of the encounter spent by a physician or other qualified health care professional for final hospital or observation discharge of a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, ~~even if the time spent by the physician on that date is not continuous,~~ instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. For a patient admitted and discharged from hospital inpatient or observation ~~or inpatient~~ status on the same calendar date, ~~the services should be~~ report~~ed with codes~~ 99234, 99235, -99236 as appropriate. Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family and coordination of post discharge services may be reported with 99231, 99232, 99233.				
▲99238	F10	**Hospital inpatient or observation discharge day management;** 30 minutes or less on the date of the encounter	XXX	1.50
▲99239	F11	more than 30 minutes on the date of the encounter ~~(These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. To report services to a patient who is admitted as an inpatient and discharged on the same date, see codes 99234, 99235, 99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by an individual other than the physician or qualified health care professional performing the~~	XXX	2.15

		~~discharge day management service, use subsequent hospital care codes [99231-99233] on the day of discharge.)~~ ~~(For Observation Care Discharge, use 99217)~~ (For hospital inpatient or observation ~~or inpatient hospital~~ care including the admission and discharge of the patient on the same calendar date, see 99234-99236) ~~(For Nursing Facility Care Discharge, see 99315, 99316)~~ (For discharge services provided to newborns admitted and discharged on the same calendar date, use 99463)		

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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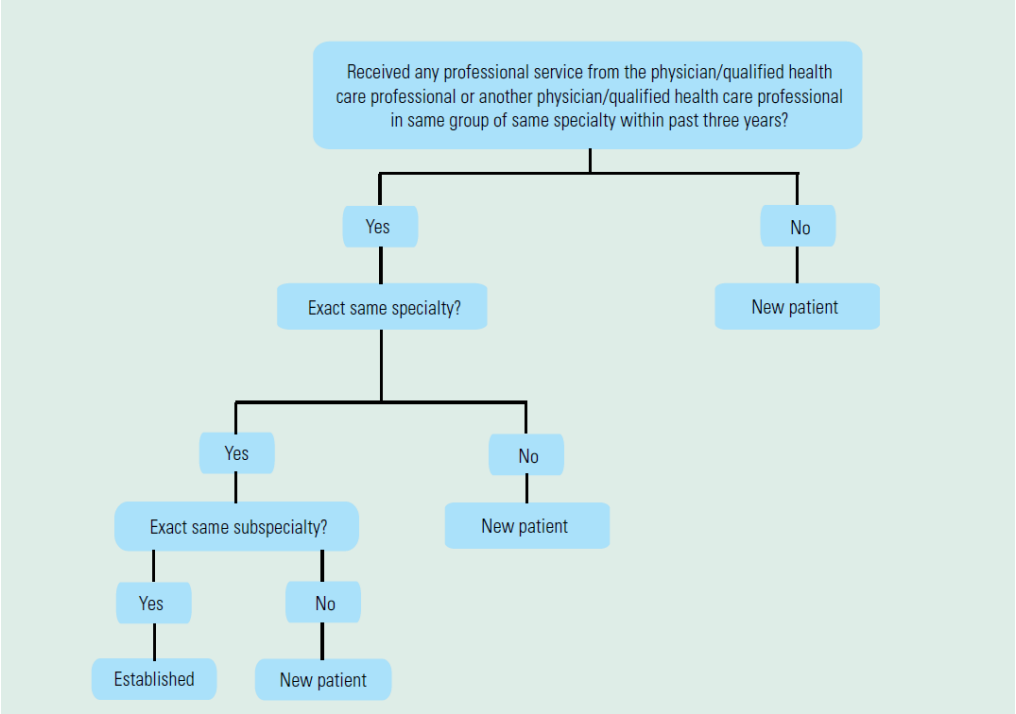
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

December 14, 2021

To: Ezequiel Silva III, MD
Chair, AMA/Specialty Society RVU Update Committee (RUC)

From: Surveying Societies for Inpatient-Obs Codes 99221-99239

Re: Tab 13, Supplemental Information

When compared with the prior October 2021 survey, additional text and questions were added to the survey instrument by the Research Subcommittee. On behalf of the surveying societies, a discussion of these survey revisions and additional questions is provided below, along with additional survey statistic for information.

Supplemental Information 1: *(The 11 surveyed codes have this additional information for Tab 13.)*

A new question (highlighted in red below) was added by the Research Subcommittee following the question about whether the vignette describes a typical patient. This is the first time that this question has been included in an E/M survey. The statistics from this survey question are presented below for informational purposes. We do not believe, however, that any conclusion can be drawn from these data because this question was placed after the "typical patient" question and not in the context of total time on the date of encounter (ie, Question 2B). It is possible that some respondents may have interpreted this question to ask if only one physician/QHP is responsible for the typical patient on a given day, independent of the specialty. Said another way, the question does not specify whether the response should be reflective of more than one physician/QHP in a group that is reporting a single code on a date.

On a single calendar day, will there typically (ie, more than 50% of the time) be more than one physician/QHP who spends time providing CPT code <auto populate> for the typical patient described above?

	99221		99222		99223		99231		99232		99233	
Yes	83	36%	165	66%	205	80%	95	41%	179	71%	200	78%
No	147	64%	85	34%	52	20%	139	59%	73	29%	58	22%
	99234		99235		99236				99238		99239	
Yes	24	41%	38	64%	39	66%			77	46%	86	50%
No	34	59%	21	36%	20	34%			90	54%	85	50%

Supplemental Information 2: *(The 99221-99236 have this additional information for Tab 13.)*

When compared with the prior survey, additional text was added to the general background information to make it clear that: the code changes will not be effective until 2023; the codes will include both inpatient and observation services; and all time on the date of encounter is included—not just unit/floor time.

Background for Question 2 **[Revised text highlighted in red]**

Physician/other qualified health care professional time includes the following activities, when performed, whether on or off the unit/floor:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

DO NOT include time for work related to another service, procedure, or evaluation and management code that is separately reportable.

"Physician work" does not include the services provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical assistants, receptionists, or technicians; these services are included in the practice expense relative values, a different component of the Resource-Based Relative Value Scale (RBRVS).

When total time on the date of encounter is used to select the appropriate level of an inpatient and observation care service code, both the face-to-face and non-face-to-face time personally spent by the physician or QHP and other physicians or QHPs in the same group and same subspecialty that is reporting the single inpatient/observation consultation are summed to select the appropriate code. Please consider all the time spent on the service for a full calendar day.

"Unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the unit /floor.

Hospital Inpatient/Observation Services

Services PRIOR to work on the unit/floor ON THE DATE OF THE ENCOUNTER:
This includes services that are not performed on the patient's hospital unit or floor, including: communications with other professionals and the patient's family; obtaining and/or reviewing the results of diagnostic and other studies; and written and telephone reports.

Services ON the unit/floor ON THE DATE OF THE ENCOUNTER:
This includes the services provided while you are present on the patient's hospital unit or floor, including: reviewing the patient's chart; seeing the patient, writing orders or performing documentation, and communicating with other professionals and the patient's family.

Services AFTER work on the unit/floor ON THE DATE OF THE ENCOUNTER:
This includes services that are not provided on the patient's hospital unit or floor, including:

communicating further with other professionals and the patient's family; obtaining and/or reviewing the results of diagnostic and other studies; writing orders or performing documentation and other written or telephone reports.

- Question 2 was expanded to include Question 2A to be used as a "worksheet" for considering time based on the definitions of time. This was followed by Question 2B which automatically populated the total time based on Question 2A, requesting that the survey respondent confirm the total time was accurate (or go back and adjust times in Question 2A. Question 2B was meant to establish a total time for the revised codes as arrayed, with confirmation by the respondent prior to proceeding with the survey.

  The statistics for Question 2A are shown below—for information. There is not a way to calculate the median based on medians of subsets of the whole and still be statistically accurate. It is statistically incorrect to sum the median statistic of individual components for the same day of service and call that sum the median of total time. This is because each respondent "arranged" their day of service time based on their particular experience. In Question 2B the respondents were asked to focus on total time and confirm that total time was accurate. The goal of the survey time question was to collect total time. As comparison, it is also incorrect to sum the minimum or maximum statistic and state the sum is the minimum or maximum of total time. For example, considering code 99221, no respondent indicated 4 minutes for total time; the minimum total time for any respondent was 9 minutes.

TIME	Before Floor 99221	On Floor 99221	After Floor 99221	2B Sum Total 99221	Before Floor 99222	On Floor 99222	After Floor 99222	2B Sum Total 99222	Before Floor 99223	On Floor 99223	After Floor 99223	2B Sum Total 99223
Min	0	4	0	4	0	5	2	7	4	8	2	14
25th	7	13	6	26	10	18	10	38	15	25	15	55
Median	10	16	10	36	15	25	15	55	20	30	20	70
75th	15	25	15	55	20	30	20	70	25	40	25	90
Max	40	60	60	160	50	85	60	195	60	115	70	245
TIME	Before Floor 99231	On Floor 99231	After Floor 99231	2B Sum Total 99231	Before Floor 99232	On Floor 99232	After Floor 99232	2B Sum Total 99232	Before Floor 99233	On Floor 99233	After Floor 99233	2B Sum Total 99233
Min	0	3	0	3	0	3	0	3	0	4	2	6
25th	5	7	5	17	6	11	8	25	10	15	10	35
Median	5	10	7	22	10	15	10	35	12	20	15	47
75th	10	15	10	35	12	20	15	47	18	30	20	68
Max	30	45	35	110	35	60	40	135	45	90	60	195

TIME	Before Floor 99234	On Floor 99234	After Floor 99234	2B Sum Total 99234	Before Floor 99235	On Floor 99235	After Floor 99235	2B Sum Total 99235	Before Floor 99236	On Floor 99236	After Floor 99236	2B Sum Total 99236
Min	3	5	0	8	5	10	5	20	5	10	10	25
25th	7	16	10	33	10	24	14	48	14	30	20	64
Median	10	20	12	42	15	30	15	60	20	40	20	80
75th	15	30	17	62	20	41	30	91	25	60	38	123
Max	40	50	60	150	40	75	70	185	60	100	160	320

Question 2 text revisions are highlighted in red

Question 2A

How much physician/QHP time on the date of encounter is required per patient treated for each of the following steps in patient care related to the survey code(s)? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Type in your answers (in minutes) in each box below. If no time is typically spent on a listed time period, please enter 0 minutes. It is important that you list all the time on a calendar date and, if more than one physician/QHP is performing the single service, to sum the time spent on the date.

Please refer to the definitions of physician time above.

~~IMPORTANT: Beginning in 2023, when total time on the date of encounter is used to select the appropriate level of a Inpatient or Observation Consultation Service code, both the face-to-face and non-face-to-face time personally spent by the physician and/or QHP are summed to select the appropriate code.~~

DO NOT include the time provided by clinical staff, such as RNs, LPNs, MAs and technicians, as their time is measured separately from this survey and do not include time for services that are separately reported.

	Place your time (in minutes) below
✶ Physician/QHP time on date of encounter PRIOR to work on the unit/floor (in minutes)	
Physician/QHP time on date of encounter ON the unit/floor (in minutes)	
Physician/QHP time on Date of Encounter AFTER work on the unit/floor (in minutes)	

Question 2B

Below is the TOTAL physician/QHP time you estimated that is typically performed on the date of encounter (this is the aggregate of your responses for each code in the previous question). "Unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the unit/floor. Also, these estimated times should not include time for services that are separately reported and also should NOT include the time provided by clinical staff, such as RNs, LPNs, MAs and technicians, as their time is measured separately from this survey.

CPT Code	Descriptor	TOTAL Physician/QHP time on Date of Encounter from Your Estimate
<auto populate>	<auto populate>	<auto populate>

Please confirm that the above Total Time estimates, which aggregated your responses to the previous survey question, represent the total physician/QHP time on the date of encounter that is required per patient treated for each of the following steps in patient care related to the survey code(s). If you wish to adjust any of your time estimates after reviewing the Total Time, click the BACK button below, and update your estimates as needed.

○ I confirm that I have reviewed the above Total Time estimates and they appropriately reflect the total physician/QHP time on the date of encounter.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99221 Tracking Number F1 Original Specialty Recommended RVU: **1.92**
Presented Recommended RVU: **1.92**
Global Period: XXX Current Work RVU: **1.92** RUC Recommended RVU: **1.63**

CPT Descriptor: Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services.

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: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring straightforward or low medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS					
CPT Code:	99221					
Sample Size:	52732	**Resp N:**	230			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**12.00**	49.00	500.00
Survey RVW:	0.20	1.63	**1.95**	2.50	45.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	9.00	30.00	**40.00**	50.00	125.00

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:	99221	**Recommended Physician Work RVU: 1.63**		
		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:		**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)

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? 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
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter..

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
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

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: 94 **% of respondents:** 40.8 **%**

Number of respondents who choose 2nd Key Reference Code: 33 **% of respondents:** 14.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99221	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99204**
Median Pre-Service Time	0.00	5.00	10.00
Median Intra-Service Time	40.00	25.00	40.00
Median Immediate Post-service Time	0.00	5.00	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	**40.00**	**35.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	30%	61%	3%

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%	31%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	71%	25%
Physical effort required	7%	54%	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	5%	32%	63%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	15%	33%	52%	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	15%	45%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	15%	64%	21%
Physical effort required	15%	36%	49%

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	12%	30%	58%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total

times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

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[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the

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[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.

[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.

[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480

[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99221 Review and Recommendations

There were 230 respondents of whom 87% found the vignette to be typical. The survey times and median RVW were 0/40/0/40/1.95 and the 25th percentile RVW was 1.63.

The previous data was: 265 respondents of whom 88% found the vignette to be typical. The survey times and median work RVU were 0/30/0/30/1.8 and the 25th percentile work RVU was 1.50.

The current times and work RVU are 10/30/50/90/1.92.

The two key reference services were 99203, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter*, with times and work RVU of 5/25/5/35/1.60, and 99204, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter*, with times and work RVU of 10/40/10/60/2.60 .

These were the same key reference services as for the previous survey.

99221 can be reported for SF or low-level MDM. The total time of 40 minutes on day of encounter is the same as the day of encounter intra time for 99204 and 15 minutes more intra than the day of encounter time for 99203.

The expert panel agreed that the vast majority of patients will require low level MDM and that the survey time of 40 minutes and greater intensity of inpatient visits support the current value of 1.92. The 25th percentile RVW of 1.63 is too low as it does not reflect the time of 99221 and the added intensity of hospital work.

Therefore, the expert panel recommends 40 minutes of intra-service / total time and maintaining the current RVW of 1.92.

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) 99221, 99218

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Commonly
Specialty Nurse Practitioner	How often? Commonly
Specialty General Surgery	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5740020
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine	Frequency 771639	Percentage 13.44 %
Specialty Nurse Practitioner	Frequency 453967	Percentage 7.90 %
Specialty General Surgery	Frequency 427574	Percentage 7.44 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,913,340 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine	Frequency 257213	Percentage 13.44 %
Specialty Nurse Practitioner	Frequency 151322	Percentage 7.90 %
Specialty General Surgery	Frequency 142525	Percentage 7.44 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Initial

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 99221

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:99222 Tracking Number F2 Original Specialty Recommended RVU: **2.61**
Presented Recommended RVU: **2.60**
Global Period: XXX Current Work RVU: **2.61** RUC Recommended RVU: **2.60**

CPT Descriptor: Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an acute illness with systemic symptoms or acute complicated injury is admitted for either initial inpatient or observation care services.

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: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring moderate medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS					
CPT Code:	99222					
Sample Size:	52732	**Resp N:**	250			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**40.00**	100.00	1200.00
Survey RVW:	0.40	2.60	**2.81**	3.44	55.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	14.00	45.00	**55.00**	70.00	150.00

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:	99222	**Recommended Physician Work RVU: 2.60**		
		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:		**55.00**		

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? 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
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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

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: 122 **% of respondents:** 48.8 **%**

Number of respondents who choose 2nd Key Reference Code: 46 **% of respondents:** 18.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 99222	Top Key Reference CPT Code: 99204	2nd Key Reference CPT Code: **99205**
Median Pre-Service Time	0.00	10.00	14.00
Median Intra-Service Time	55.00	40.00	59.00
Median Immediate Post-service Time	0.00	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	**55.00**	**60.00**	**88.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	29%	52%	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%	29%	68%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	65%	34%
Physical effort required	3%	55%	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	2%	23%	75%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	26%	46%	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	7%	35%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	59%	37%
Physical effort required	4%	43%	53%

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%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99222 Review and Recommendations

There were 250 respondents of whom 96% found the vignette to be typical. The survey times and median RVW were 0/55/0/55/2.81 and the 25th percentile was 2.60.

The previous data was: 107 respondents of whom 93% found the vignette to be typical. The survey times and median work RVU were 0/45/0/45/2.80. The 25th percentile work RVU was 2.53.

The current times and work RVU are 15/40/20/75/2.61.

The key reference services were 99204, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter*, with times and work RVU of 10/40/10/60/2.60, and 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter*, with times and work RVU of 14/59/15/88/3.50.

The key reference services were the same for the previous survey.

The survey time of 55 minutes is five minutes less than the total time for 99204 which has the same level of MDM as 99222. The expert panel agreed that between the survey 25th and 50th percentile RVW of 2.61 places 99222 in proper rank order to 99204 because of the higher intensity of inpatient work. In addition, the survey time of 55 minutes is 50% higher than the survey time for 99221 (36 minutes) and the survey 25th percentile RVW of 2.61 is 60% higher than the recommended work RVU for 99221 (1.63). Finally, the 2.61 is the current value for 99222.

Therefore, the expert panel recommends the survey intra/total time of 55 minutes and maintaining the current RVW of 2.61.

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) 99222, 99219

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Cardiology How often? Commonly

Specialty Nephrology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 21403900
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 4353900 Percentage 20.34 %

Specialty Cardiology Frequency 1937822 Percentage 9.05 %

Specialty Nephrology Frequency 1337097 Percentage 6.24 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,134,401 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 1451300 Percentage 20.34 %

Specialty Cardiology Frequency 645941 Percentage 9.05 %

Specialty Nephrology Frequency 445699 Percentage 6.24 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Initial

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 99222

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:99223 Tracking Number F3 Original Specialty Recommended RVU: **3.86**
Presented Recommended RVU: **3.86**
Global Period: XXX Current Work RVU: **3.86** RUC Recommended RVU: **3.50**

CPT Descriptor: Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a chronic illness with severe exacerbation, or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring high medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022		
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)		
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS		
CPT Code:	99223		
Sample Size:	52732	**Resp N:**	257
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**60.00**	150.00	1800.00
Survey RVW:	0.60	3.50	**4.00**	4.25	75.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	60.00	**74.00**	90.00	190.00

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:	99223	**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:		**74.00**		

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? 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
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	5,905,780

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

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: 138 **% of respondents:** 53.6 **%**

Number of respondents who choose 2nd Key Reference Code: 58 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 99223	Top Key Reference CPT Code: 99205	2nd Key Reference CPT Code: 99291
Median Pre-Service Time	0.00	14.00	15.00
Median Intra-Service Time	74.00	59.00	40.00
Median Immediate Post-service Time	0.00	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	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	**74.00**	**88.00**	**70.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	1%	1%	16%	29%	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	2%	22%	76%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	52%	47%
Physical effort required	3%	41%	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	2%	11%	87%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	45%	21%	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	7%	57%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	29%	47%	24%
Physical effort required	22%	47%	31%

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	19%	33%	48%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99223 Review and Recommendations

There were 257 respondents of whom 99% found the vignette to be typical. The survey times and median RVW were 0/74/0/74/4.00 and the 25th percentile RVW was 3.50.

The previous survey data was: 302 respondents of whom 97% found the vignette to be typical. The survey times and median work RVU were 0/60/0/60/3.86. The survey 25th percentile was 3.50.

The current times and work RVU are 15/55/20/90/3.86.

The key reference services were, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter*, with times and work RVU of 14/59/15/88/3.5, and 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*, with times and work RVU of 15/40/15/70/4.50.

The key reference services from the previous survey were the same.

The survey time of 74 minutes is 14 minutes less than the total time of 99205 but 4 minutes longer than that of 99291. The expert panel agreed that the current RVW of 3.86 was appropriate and placed 99223 in proper rank order to 99205 because of the higher intensity of inpatient care. In addition, 3.86 places 99223 in proper rank order to 99291 which is of higher intensity but has lower intra-service time. The expert panel also noted that the survey time of 74 minutes is 34% more than the survey time for 99222 (55 minutes) and the current RVW of 3.86 is 48% more than the recommended work RVU for 99222 (2.60).

Therefore, the expert panel recommends the intra/total time of 74 minutes and maintain the current RVW of 3.86.

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) 99223, 99220

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Hospitalist How often? Commonly

Specialty Cardiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 36675741
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 11243794 Percentage 30.65 %

Specialty Hospitalist Frequency 3060532 Percentage 8.34 %

Specialty Cardiology Frequency 2677965 Percentage 7.30 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 12,225,247 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 3747931 Percentage 30.65 %

Specialty Hospitalist Frequency 1020177 Percentage 8.34 %

Specialty Cardiology Frequency 892655 Percentage 7.30 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Initial

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 99223

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:99231 Tracking Number F4 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: XXX Current Work RVU: **0.76** RUC Recommended RVU: **1.00**

CPT Descriptor: Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an acute illness or injury whose condition is improving or is stable receives subsequent hospital inpatient or observation care.

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:

Description of Intra-Service Work: If necessary, review interval correspondence, referral notes, and medical records generated since the last visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient as well as the prior clinical notes. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring straightforward or low medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS					
CPT Code:	99231					
Sample Size:	52732	**Resp N:**	234			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**38.00**	100.00	1000.00
Survey RVW:	0.10	1.00	**1.30**	1.50	45.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	9.00	19.00	**25.00**	30.00	100.00

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:	99231	**Recommended Physician Work RVU: 1.00**		
		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:		**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)

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? 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
99213	XXX	1.30	**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 low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**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 straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,490,658

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99213	XXX	1.30	**RUC Time**	92,217,549

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and 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.

Other Reference CPT Code	Global	Work RVU	Time Source
	XXX		**RUC Time**

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:** 45.7 **%**

Number of respondents who choose 2nd Key Reference Code: 51 **% of respondents:** 21.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99231	Top Key Reference CPT Code: 99213	2nd Key Reference CPT Code: **99212**
Median Pre-Service Time	0.00	5.00	2.00
Median Intra-Service Time	25.00	20.00	11.00
Median Immediate Post-service Time	0.00	5.00	3.00
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	**25.00**	**30.00**	**16.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	1%	5%	49%	42%	3%

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%	49%	41%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	70%	22%
Physical effort required	9%	54%	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%	46%	51%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	51%	41%	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	8%	55%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	74%	22%
Physical effort required	2%	69%	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	12%	47%	41%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99231 Review and Recommendations

There were 234 respondents of whom 91% found the vignette to be typical. The survey times and median RVW were 0/25/0/25/1.30 and the 25th percentile RVW was 1.0.

The previous survey data was: 283 respondents of whom 92% found the vignette to be typical. The survey times and median work RVU were 0/17/0/17/1.30. The 25th percentile work RVU was 1.00.

The current times and work RVU are 5/10/5/20/0.76.

The key reference services were 99213, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter*, with times and work RVU of 5/20/5/30/1.30, and 99212, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter*, with times and work RVU of 2/11/3/16/0.70.

These were the same key reference services as the previous survey.

The total time of 25 minutes is 5 minutes less than that of 99213 and 9 minutes more than that of 99212. 99231 can be reported for both SF and low-level MDM.

Therefore, the expert panel agreed that the 25th percentile work RVU of 1.00 places 99231 in correct rank order with 99212 and 99213. A work RVU of 1.00 also places 99231 in correct rank order with 99213 which requires low level MDM and has more time.

Therefore, the expert panel recommends the survey intra/total time of 25 minutes and the survey 25th percentile work RVU of 1.00.

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) 99231, 99224

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Psychiatry How often? Commonly

Specialty Nurse Practitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 20583189
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 3222209 Percentage 15.65 %

Specialty Psychiatry Frequency 2566776 Percentage 12.47 %

Specialty Nurse Practitioner Frequency 1960451 Percentage 9.52 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,861,063 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 1074070 Percentage 15.65 %

Specialty Psychiatry Frequency 855592 Percentage 12.47 %

Specialty Nurse Practitioner Frequency 653484 Percentage 9.52 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Subsequent

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 99231

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:99232 Tracking Number F5 Original Specialty Recommended RVU: **1.59**
Presented Recommended RVU: **1.59**
Global Period: XXX Current Work RVU: **1.39** RUC Recommended RVU: **1.59**

CPT Descriptor: Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an illness or acute injury that is progressing or requires ongoing diagnostic evaluation, medical management or potential surgical treatment receives subsequent hospital inpatient or observation care.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: If necessary, review interval correspondence, referral notes, and medical records generated since the last visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient as well as the prior clinical notes. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring moderate medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS
CPT Code:	99232
Sample Size: 52732	**Resp N:** 252
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	38.00	**100.00**	300.00	5000.00
Survey RVW:	0.20	1.59	**2.00**	2.46	55.00
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	30.00	**36.00**	45.00	115.00

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: 99232	**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:	**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:	**36.00**		

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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**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 low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.92	**RUC Time**	106,900,291

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and 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.

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: 121 **% of respondents:** 48.0 **%**

Number of respondents who choose 2nd Key Reference Code: 40 **% of respondents:** 15.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 99232	Top Key Reference CPT Code: 99214	2nd Key Reference CPT Code: **99213**
Median Pre-Service Time	0.00	7.00	5.00
Median Intra-Service Time	36.00	30.00	20.00
Median Immediate Post-service Time	0.00	10.00	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	**36.00**	**47.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	34%	53%	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	7%	34%	59%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	59%	36%
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	2%	25%	73%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	28%	57%	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	5%	33%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	63%	32%
Physical effort required	3%	50%	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	3%	32%	65%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99232 Review and Recommendations

There were 252 respondents of whom 97% found the vignette to be typical. The survey times and median RVW were 0/36/0/36/2.00 and the 25th percentile RVW was 1.59.

The previous survey data was: 108 respondents of whom 94% found the vignette to be typical. The survey times and median work RVU were 0/30/0/30/2.00. The 25th percentile work RVU was 1.80.

The current times and work RVU are 10/20/10/40/1.39.

The key reference services were 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter*, with times and work RVU of 7/30/10/47/1.92, and 99213, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter*, with times and work RVU of 5/20/5/30/1.30.

These were the same key reference services as the previous survey.

The expert panel noted that the survey total time of 36 minutes is 11 minutes less than the total time of 99214 which has the same level of MDM (moderate). In addition, the total time of 36 minutes is 6 minutes more than the total time of 99213. The expert panel decided that the 25th percentile RVW of 1.59 places 99232 in proper rank order with both key reference services given the higher intensity of inpatient care.

The panel then looked at its recommendation for 99231 and noted that the survey time for 99232 was 44% more than the survey time for 99231 (36 vs. 25) and that the 25th percentile work RVU of 1.59 is appropriately 60% higher than the recommendation for 99231 to account for increased intensity and complexity of work.

Therefore, the expert panel recommends the survey intra/total time of 36 minutes and the survey 25th percentile work RVU of 1.59.

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) 99232, 99225

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Nephrology How often? Commonly

Specialty Hospitalist How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 135888537
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 38511081 Percentage 28.34 %

Specialty Nephrology Frequency 11119387 Percentage 8.18 %

Specialty Hospitalist Frequency 9913671 Percentage 7.29 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 45,296,179 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 12837027 Percentage 28.34 %

Specialty Nephrology Frequency 3706462 Percentage 8.18 %

Specialty Hospitalist Frequency 3304557 Percentage 7.29 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Subsequent

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 99232

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:99233 Tracking Number F6 Original Specialty Recommended RVU: **2.40**
Presented Recommended RVU: **2.40**
Global Period: XXX Current Work RVU: **2.00** RUC Recommended RVU: **2.40**

CPT Descriptor: Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient who is unstable or has developed a significant complication or a significant new problem receives subsequent hospital inpatient or observation care encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: If necessary, review interval correspondence, referral notes, and medical records generated since the last visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient as well as the prior clinical notes. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring high medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day and respond to treatment failures.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS					
CPT Code:	99233					
Sample Size:	52732	**Resp N:**	258			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**100.00**	300.00	5600.00
Survey RVW:	0.30	2.40	**2.90**	3.24	75.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	11.00	41.00	**52.00**	60.00	165.00

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:	99233	**Recommended Physician Work RVU: 2.40**		
		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:		**52.00**		

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? 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
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.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.92	**RUC Time**	106,900,291

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

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: 129 **% of respondents:** 50.0 **%**

Number of respondents who choose 2nd Key Reference Code: 37 **% of respondents:** 14.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99233	Top Key Reference CPT Code: 99215	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	0.00	10.00	7.00
Median Intra-Service Time	52.00	45.00	30.00
Median Immediate Post-service Time	0.00	15.00	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	**52.00**	**70.00**	**47.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	22%	33%	43%

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%	30%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	52%	44%
Physical effort required	6%	45%	49%

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%	18%	80%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	16%	41%	40%

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	3%	49%	48%
Physical effort required	3%	30%	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	5%	8%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99233 Review and Recommendations

There were 258 respondents of whom 97% found the vignette to be typical. The survey times and median RVW were 0/52/0/52/2.90 and the 25th percentile RVW was 2.40.

The previous survey data was: 107 respondents (to the revised vignette) of whom 96% found the vignette to be typical. The survey times and median work RVU were 0/40/0/40/3.00. The survey 25th percentile work RVU was 2.66.

The current times and work RVU are 10/30/15/55/2.00.

The key reference services were 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter*, with times and work RVU of 10/45/15/70/2.80, and 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter*, with times and work RVU of 7/30/10/47/1.92.

The key reference services for the previous survey were 99215 and 99205.

The expert panel noted that the survey time of 52 minutes is 5 minutes more than the total time for 99214 but that the level of MDM for 99233 is high while that for 99214 is moderate. 99215 has the same level of MDM as 99233 (high) but has 18 more minutes of time.

Given the higher intensity of inpatient care, the expert panel agreed that the survey 25th percentile RVW of 2.40 placed 99233 in proper rank order to both key reference services.
The panel also noted that the survey time of 52 minutes is 44% higher than the survey time for 99232 and the 25th percentile work RVU of 2.40 is appropriately 50% higher than the recommended work RVU for 99232 (1.59).

Therefore, the expert panel recommends the survey intra/total time of 52 minutes and the survey 25th percentile work RVU of 2.40 to account for increased intensity and complexity of work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99233, 99226

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Hospitalist How often? Commonly

Specialty Pulmonary Disease How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 74874021
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 24051911 Percentage 32.12 %

Specialty Hospitalist Frequency 7899071 Percentage 10.54 %

Specialty Pulmonary Disease Frequency 5905847 Percentage 7.88 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 24,958,007 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 8017304 Percentage 32.12 %

Specialty Hospitalist Frequency 2633024 Percentage 10.54 %

Specialty Pulmonary Disease Frequency 1968616 Percentage 7.88 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Subsequent

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 99223

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:99234 Tracking Number F7 Original Specialty Recommended RVU: **2.56**
Presented Recommended RVU: **2.00**
Global Period: XXX Current Work RVU: **2.56** RUC Recommended RVU: **2.00**

CPT Descriptor: Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services. The patient is discharged later that same day.
(This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)

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:

Description of Intra-Service Work: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring straightforward or low medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Provide care coordination for the transition, including instructions to caregivers for aftercare. Arrange for post-discharge follow-up professional services and testing. Reconcile patient's medications with attention to pre-admission therapy, observation therapy, and outpatient formulary; write prescriptions as necessary. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day, prior to discharge, respond to treatment failures during the admission.

Description of Post-Service Work: Complete discharge records. Respond and attend to any treatment failures, negative outcomes, medication refill requests, or adverse medication reactions that may occur after discharge until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence,

including obtaining results pending at discharge, until the primary care physician assumes care. Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAFP, AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA ATS, CHEST, IDSA, NASS, SHM, STS					
CPT Code:	99234					
Sample Size:	41608	**Resp N:**	58			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	11.00	800.00
Survey RVW:	0.90	2.00	**2.60**	3.00	4.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	39.00	**45.00**	62.00	115.00

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:	99234	**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:		**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:	**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
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

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: 17 **% of respondents:** 29.3 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 99234	Top Key Reference CPT Code: 99204	2nd Key Reference CPT Code: **99203**
Median Pre-Service Time	0.00	10.00	5.00
Median Intra-Service Time	45.00	40.00	25.00
Median Immediate Post-service Time	5.00	10.00	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	**50.00**	**60.00**	**35.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	65%	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%	47%	35%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	88%	6%
Physical effort required	6%	59%	35%

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%	53%	41%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	22%	57%	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	7%	43%	50%
Physical effort required	7%	50%	43%

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

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99234 Review and Recommendations

There were 58 respondents of whom 90% found the vignette to be typical. The survey times and median RVW were 0/45/5/50/2.6 and the 25th percentile RVW was 2.00
The previous survey data was: 74 respondents of whom 92% found the vignette to be typical. The survey times and work RVU were 0/34/0/34/1.92. The 25th percentile work RVU was 1.56.

The current times and work RVU are 14/40/15/69/2.56

The key reference services were 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/25/5/35/1.60, and 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/40/10/2.60.

These were the same key reference services as the previous survey.

The expert panel noted that the survey time for 99234 (50) is 15 minutes more than that of 99203 (42% more) and that time difference is best reflected by the current RVW which is 60% more than that of 99203.

Because 99234 includes the work of admission and discharge, the expert panel agreed that the current RVW of 2.56 placed it in proper rank order with the key reference services. It reflects the higher intensity of hospital care and the added work of the discharge.

The expert panel noted that with respect to 99204, the survey time for 99234 is only 10 minutes less and that because hospital care is more intense the survey 25th percentile of 2.00 is too low and would create a rank order anomaly.

Therefore, the expert panel recommends the survey intra 45 minutes, post time 5 minutes /total time of 50 minutes and the current RVW of 2.56.

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) 99234

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Specialty Emergency Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 101271
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 29976 Percentage 29.59 %

Specialty Family Medicine Frequency 12963 Percentage 12.80 %

Specialty Emergency Medicine Frequency 7798 Percentage 7.70 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,757
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 9992 Percentage 29.59 %

Specialty Family Medicine Frequency 4321 Percentage 12.80 %

Specialty Emergency Medicine Frequency 2599 Percentage 7.69 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:

Initial

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 99234

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:99235 Tracking Number F8 Original Specialty Recommended RVU: **3.24**
Presented Recommended RVU: **3.24**
Global Period: XXX Current Work RVU: **3.24** RUC Recommended RVU: **3.24**

CPT Descriptor: Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with an acute illness with systemic symptoms or a patient with an acute complicated injury that requires medical management or potential surgical treatment is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)

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:

Description of Intra-Service Work: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring moderate medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Provide care coordination for the transition, including instructions to caregivers for aftercare. Arrange for post-discharge follow-up professional services and testing. Reconcile patient's medications with attention to pre-admission therapy, observation therapy, and outpatient formulary; write prescriptions as necessary. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day, prior to discharge, respond to treatment failures during the admission

Description of Post-Service Work: Complete discharge records. Respond and attend to any treatment failures, negative outcomes, medication refill requests, or adverse medication reactions that may occur after discharge until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assistance, and other

necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence, including obtaining results pending at discharge, until the primary care physician assumes care. Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAFP, AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA ATS, CHEST, IDSA, NASS, SHM, STS					
CPT Code:	99235					
Sample Size:	41608	**Resp N:**	59			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	26.00	400.00
Survey RVW:	1.00	2.88	**3.50**	3.83	60.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	28.00	50.00	**68.00**	80.00	155.00

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:	99235	**Recommended Physician Work RVU: 3.24**		
		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:		**68.00**		

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
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter

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
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

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: 22 **% of respondents:** 37.2 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 32.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99235	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99204**
Median Pre-Service Time	0.00	14.00	10.00
Median Intra-Service Time	68.00	59.00	40.00
Median Immediate Post-service Time	8.00	15.00	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	**76.00**	**88.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	23%	59%	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%	32%	59%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	68%	27%
Physical effort required	0%	36%	64%

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%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	5%	0%	11%	58%	26%

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	21%	21%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	37%	58%
Physical effort required	5%	47%	48%

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.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total

times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

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[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the

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[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.

[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.

[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480

[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99235 Review and Recommendations

There were 59 respondents of whom 92% found the vignette to be typical. The survey times and median RVW were 0/68/8/76/3.50 and the 25th percentile RVW was 2.88.

The previous survey data were: 79 respondents of whom 92% found the vignette typical. The survey times and median work RVU were 0/45/0/45/2.75. The 25th percentile work RVU was 2.10.

The current times and work RVU are 14/50/19.5/83.5/3.24.

The key reference services were 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/40/10/60/2.60, and 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and work RVU of 14/59/15/88/3.50.

These are the same key reference services as for the previous survey.

The time of 76 minutes is 16 minutes more than that of key reference service 99204 which has the same level of MDM (moderate). Further, the survey 25th percentile RVW of 2.88 does not reflect the increased time of 99235 and would create a rank order anomaly.

Given the higher intensity of hospital care and the added work of discharge, the expert panel agreed that the current RVW of 3.24 places 99235 in proper rank order to the key reference services.

It also ranks 99235 in proper order to 99234. 99235 has 52% more time (76 vs. 50) and the current RVW of 3.24 is 26% more than the current RVW for 99234.

Therefore, the expert panel recommends the survey intra 68 minutes, post time 8 minutes/total time of 76 minutes and the current RVW of 3.24.

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) 99235

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Specialty Hospitalist How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 271197
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 113360 Percentage 41.79 %

Specialty Family Medicine Frequency 45019 Percentage 16.60 %

Specialty Hospitalist Frequency 32272 Percentage 11.89 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 90,399
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 37787 Percentage 41.80 %

Specialty Family Medicine Frequency 15006 Percentage 16.59 %

Specialty Hospitalist Frequency 10757 Percentage 11.89 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Initial

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 99235

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:99236 Tracking Number F9 Original Specialty Recommended RVU: **4.30**
Presented Recommended RVU: **4.30**
Global Period: XXX Current Work RVU: **4.20** RUC Recommended RVU: **4.30**

CPT Descriptor: Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a severe exacerbation of a chronic illness or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Review available prior medical records and data, place requests for other records and data as necessary for the new patient visit/obs/admission service. Coordinate with other members of the health care team regarding the obs/admission service. Visit patient location (e.g., floor, observation area, unit) confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan (requiring high medical decision making [MDM]). Consider discharge needs of patient. Discuss the treatment plan with patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write and/or review observation or inpatient admission orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Document the encounters throughout the calendar day in the medical record. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family and/or caregivers throughout the calendar day. Provide care coordination for the transition, including instructions to caregivers for aftercare. Arrange for post-discharge follow-up professional services and testing. Reconcile patient's medications with attention to pre-admission therapy, observation therapy, and outpatient formulary; write prescriptions as necessary. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver that may occur within the calendar day, prior to discharge, respond to treatment failures during the admission

Description of Post-Service Work: Complete discharge records. Respond and attend to any treatment failures, negative outcomes, medication refill requests, or adverse medication reactions that may occur after discharge until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence,

including obtaining results pending at discharge, until the primary care physician assumes care. Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAFP, AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA ATS, CHEST, IDSA, NASS, SHM, STS					
CPT Code:	99236					
Sample Size:	41608	**Resp N:**	59			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**7.00**	23.00	400.00
Survey RVW:	1.50	3.55	**4.30**	4.58	7.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	37.00	68.00	**85.00**	105.00	260.00

Immediate Post Service-Time:	**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 **0.00** 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:	99236	**Recommended Physician Work RVU: 4.30**		
		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:		**85.00**		

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:	**12.00**	**0.00**	**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? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	5,905,780

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

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: 26 **% of respondents:** 44.0 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 28.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 99236	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99291**
Median Pre-Service Time	0.00	14.00	15.00
Median Intra-Service Time	85.00	59.00	40.00
Median Immediate Post-service Time	12.00	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	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	**97.00**	**88.00**	**70.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	4%	0%	11%	27%	58%

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%	27%	69%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	35%	61%

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%	23%	77%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	12%	53%	23%	12%

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%	47%	35%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	24%	47%	29%
Physical effort required	6%	59%	35%

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	12%	41%	47%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

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[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99236 Review and Recommendations

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[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.

[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.

[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480

[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

There were 59 respondents of whom 86% found the vignette to be typical. The survey times and median RVW were 0/85/12/97/4.30 and the 25th percentile RVW was 3.55.

The previous survey data was: 75 respondents of whom 91% found the vignette to be typical. The survey times and median work RVU were 0/60/0/60/3.60 and the 25th percentile work RVU was 2.85.

The current times and work RVU are 19/55/20/94/4.20.

The key reference services were 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and work RVU of 14/59/15/88/3.50, and 99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, with times and RVW of 15/40/15/70/4.50.

The key reference services for the previous survey were 99205 and 99215.

For reference: 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80.

The expert panel noted that the time of 97 minutes is 3 minutes more than the current time and 9 minutes more than the total time for 99205, the main key reference service. It is also 10 minutes more than that of 99291 but the intensity is less.

The expert panel agreed that because of the higher intensity of hospital care and the 9 minute time differential with 99205, the 25th percentile work RVU of 3.55 was too low and would create a rank order anomaly. On the other hand, the survey median work RVW of 4.30 reflects the increased time and would place 99236 in proper rank order to both key reference services.

The expert panel noted that the time for 99236 is 27% higher than the time for 99235 and the survey median RVW of 4.3 is 32% more than the current RVW for 99235.

Therefore, the expert panel recommends the survey intra 85 minutes, post time 12 minutes /total time of 97 minutes and the survey median RVW of 4.30.

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) 99236

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Hospitalist How often? Commonly

Specialty Family Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 4811919
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 177819 Percentage 3.69 %

Specialty Hospitalist Frequency 56257 Percentage 1.16 %

Specialty Family Medicine Frequency 42881 Percentage 0.89 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
131,135 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 4839 Percentage 3.69 %

Specialty Hospitalist Frequency 1522 Percentage 1.16 %

Specialty Family Medicine Frequency 1168 Percentage 0.89 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
Initial

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 99236

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:99238 Tracking Number F10 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.28** RUC Recommended RVU: **1.50**

CPT Descriptor: Hospital inpatient or observation discharge day management; 30 minutes or less.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient receives hospital inpatient or observation discharge day management services requiring 30 minutes or less of total time.

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: Review medical records and other available data. Obtain an interval history and perform a physical examination. Formulate and/or revise diagnosis and treatment plan(s), including making the decision for discharge. Review information regarding availability, safety, and adequacy of post-discharge support systems. Discuss aftercare treatment with patient, family and/or caregivers and other health care professionals. Provide care coordination for transition that includes instructions to patient/caregivers for aftercare. Write orders for post-discharge follow-up professional services and testing as necessary. Reconcile patient's medications with attention to pre-admission therapy, inpatient/observation therapy, and outpatient formulary. Write prescriptions as necessary. Complete discharge and aftercare forms. Inform referring physician of discharge plans. Complete medical record documentation.

Description of Post-Service Work: Review and sign off all discharge records. Respond to patient/caregiver and other healthcare provider post-discharge questions related to facility stay until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence, including obtaining results pending at discharge, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS
CPT Code:	99238
Sample Size: 47536	**Resp N:** 167
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**35.00**	100.00	700.00
Survey RVW:	0.18	1.50	**1.90**	2.50	60.00
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	24.00	**28.00**	31.00	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)

XXX Global Code

CPT Code:	99238	**Recommended Physician Work RVU: 1.50**		
		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:		**28.00**		

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:	**10.00**	**0.00**	**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 **0.0** 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
99213	XXX	1.30	**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 low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,490,658

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

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: 44 **% of respondents:** 26.3 **%**

Number of respondents who choose 2nd Key Reference Code: 39 **% of respondents:** 23.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99238	Top Key Reference CPT Code: 99213	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	0.00	5.00	7.00
Median Intra-Service Time	28.00	20.00	30.00
Median Immediate Post-service Time	10.00	5.00	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	**38.00**	**30.00**	**47.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	25%	73%	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	5%	41%	54%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	68%	27%
Physical effort required	9%	48%	43%

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%	32%	61%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	31%	61%	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	3%	41%	56%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	82%	18%
Physical effort required	0%	62%	38%

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%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99238 Review and Recommendations

There were 167 respondents of whom 89% found the vignette to be typical. The survey times and median RVW were 0/28/10/38/1.90 and the 25th percentile RVW was 1.50.

The previous survey data was: 215 respondents of whom 89% found the vignette to be typical. The median times and work RVU were 0/26/0/26/1.75 and the 25th percentile work RVU was 1.40.

The current times and work RVU are 8/20/10/38/1.28.

The key reference services were 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/20/5/30/1.30, and 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVU of 7/30/10/47/1.92.

These are the same key reference services as for the previous survey.

Because this is a time-based code, the expert panel focused on comparing the survey times to the existing times and reference service times. The expert panel noted that the time of 38 minutes is identical to the current total time. It is also 8 minutes high than 99213 which has an RVW of 1.30 and 9 minutes less than 99214 which has an RVW of 1.92.

Based on this information, the expert panel agreed that the 25th percentile RVW of 1.5 placed 99238 in proper rank order to both key reference services.

Therefore, the expert panel recommends the survey intra 28, post time 10/total time of 38 minutes and the 25th percentile RVW of 1.50.

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) 99238, 99217

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Family Medicine How often? Commonly

Specialty Hospitalist How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 7651503
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 3305449 Percentage 43.19 %

Specialty Family Medicine Frequency 1086513 Percentage 14.19 %

Specialty Hospitalist Frequency 788105 Percentage 10.30 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,036,538 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 1311481 Percentage 43.19 %

Specialty Family Medicine Frequency 430885 Percentage 14.19 %

Specialty Hosptialist Frequency 312764 Percentage 10.30 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99238

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:99239 Tracking Number F11 Original Specialty Recommended RVU: **2.15**
Presented Recommended RVU: **2.15**
Global Period: XXX Current Work RVU: **1.90** RUC Recommended RVU: **2.15**

CPT Descriptor: Hospital inpatient or observation discharge day management; more than 30 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient receives hospital inpatient or observation discharge day management services requiring greater than 30 minutes of total time

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: Review medical records and other available data. Obtain an interval history and perform a physical examination. Formulate and/or revise diagnosis and treatment plan(s), including making the decision for discharge. Review information regarding availability, safety, and adequacy of post-discharge support systems. Discuss aftercare treatment with patient, family and/or caregivers and other health care professionals. Provide care coordination for transition that includes instructions to patient/caregivers for aftercare. Write orders for post-discharge follow-up professional services and testing as necessary. Reconcile patient's medications with attention to pre-admission therapy, inpatient/observation therapy, and outpatient formulary. Write prescriptions as necessary. Complete discharge and aftercare forms. Inform referring physician of discharge plans. Complete medical record documentation.

Description of Post-Service Work: Review and sign off all discharge records. Respond to patient/caregiver and other healthcare provider post-discharge questions related to facility stay until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence, including obtaining results pending at discharge, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Charles Hamori, MD, FACP (ACP); Guy Orangio, MD, FACS (ASCRS); Michael Perskin, MD (AGS, AAHCM); Don Selzer, MD, FACS (ACS); Korinne Van Keuren, DNP,MS, RN, CPNP-AC, APRN-BC, RFNA (ANA); Richard Wright, MD (ACC); Rob Zipper, MD (SHM)					
Specialty Society(ies):	AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SAGES, SHM, STS, SVS					
CPT Code:	99239					
Sample Size:	47536	**Resp N:**	171			
Description of Sample:	Each society selected a random sample from their US physician or QHP members. We have a separate spreadsheet with the total from each society available as a PDF.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**50.00**	105.00	1200.00
Survey RVW:	0.30	2.15	**2.90**	3.50	75.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	40.00	**45.00**	55.00	90.00

Immediate Post Service-Time:	**19.00**	
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:	99239	**Recommended Physician Work RVU: 2.15**		
		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:	**19.00**	**0.00**	**19.00**

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
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.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	090	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	272,131

CPT Descriptor 2 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.

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: 45 **% of respondents:** 26.3 **%**

Number of respondents who choose 2nd Key Reference Code: 40 **% of respondents:** 23.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99239	Top Key Reference CPT Code: 99215	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	0.00	10.00	7.00
Median Intra-Service Time	45.00	45.00	30.00
Median Immediate Post-service Time	19.00	15.00	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	**64.00**	**70.00**	**47.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	22%	51%	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	2%	31%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	62%	34%
Physical effort required	4%	51%	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	7%	24%	69%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	10%	70%	12%

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%	25%	65%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	55%	32%
Physical effort required	15%	30%	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	10%	18%	72%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visit codes, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date. All the codes were surveyed in June/July and discussed at length for the October 2021 RUC meeting as well as several pre facilitation meetings.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services.

The Inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) were surveyed again by the specialty societies with the research approved revised survey tool. The survey societies sent out the survey randomly to members in November 2021 for presentation at the January 2022 RUC meeting.

The surveying societies were:
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Association of Neurological Surgeons/Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association for Thoracic Surgery
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American Thoracic Society
Infectious Diseases Society of America
North American Spine Society
Society of Hospital Medicine
Society of Thoracic Surgeons
Society for Vascular Surgery

Details of the Research Approved Revised Survey Tool for inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2021 RUC meeting

As discussed at the October 2021 RUC meeting, the specialty societies believed that the intraservice time data was flawed. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation E/M services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. This total time confirmation is important because the joint societies believe the correct analysis is to use the total time as confirmed by the survey respondent. Both survey tools are included in the RUC materials. We note that the total time presented in our SoRs and in our RUC summary materials are the statistics of the total time as calculated in the survey tool and verified by the survey respondent. For full transparency, additional details on the survey tool questions and responses is provided in a separate informational file.

Compelling Evidence

We believe we meet several compelling evidence criteria

1.) Documentation by "Other reliable data" for change in physician work
   a. *Change in patient population*
   b. *Change in length of hospital stay*
   c. *Change in Technology*
   d. *Change in Knowledge (new provider type)*

Documentation by Other reliable data

Our compelling evidence is based on four types of changes: a.) patient population; b.) reduced length of stay; c.) change in technology (inpatient EHRs); and d.) change in knowledge (new provider type). We believe each of these meet the criteria for "***other reliable data.***"

Change in patient population

The number of diagnoses that appear in the Medicare claims for Inpatient Visits (based on the 5% file) has increased over the years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006 the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%.

Our experts are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a SNF. The chart below supports the fact that patients at higher level codes have more indications to consider in decision making and physicians/QHP caring for these patients are being asked to move those patients along to the next level of care and shorter LOS.

CPT Code	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Percentage Change
99221	2.46	2.61	2.76	2.83	2.31	2.39	2.48	2.55	2.64	2.76	2.92	3.06	3.18	3.26	**24%**
99222	2.65	2.75	2.86	2.93	2.57	2.62	2.69	2.75	2.86	2.95	3.13	3.30	3.43	3.55	**25%**
99223	2.80	2.92	3.04	3.11	2.82	2.90	2.98	3.05	3.18	3.31	3.53	3.74	3.92	4.06	**31%**
99231	2.28	2.34	2.40	2.44	2.47	2.49	2.58	2.62	2.73	2.82	2.95	3.12	3.25	3.30	**31%**
99232	2.55	2.63	2.72	2.78	2.85	2.92	3.02	3.09	3.23	3.35	3.58	3.79	3.96	4.10	**38%**
99233	2.70	2.79	2.89	2.95	3.03	3.13	3.25	3.35	3.51	3.67	3.96	4.18	4.39	4.54	**41%**
99234	2.28	2.33	2.38	2.49	2.51	2.56	2.58	2.73	2.79	2.89	3.05	3.13	3.39	3.45	**34%**
99235	2.47	2.54	2.62	2.70	2.75	2.84	2.87	2.92	2.99	3.11	3.30	3.51	3.58	3.83	**36%**
99236	2.64	2.67	2.74	2.81	2.88	2.94	3.04	3.03	3.16	3.23	3.48	3.64	3.73	3.80	**31%**
99238	2.67	2.78	2.89	2.96	3.04	3.12	3.23	3.32	3.46	3.61	3.85	4.04	4.21	4.38	**39%**
99239	2.91	3.04	3.17	3.24	3.34	3.44	3.53	3.61	3.79	3.92	4.16	4.36	4.53	4.66	**38%**

The demographics of hospitalized patients continue to change over time, particularly as payors and patients apply pressure to provide care in the lowest, safest acuity setting. Medicare and Medicaid patients continue to grow as a proportion of inpatient stays. In 1999, Medicare patients made up 35.9% of inpatients and Medicaid patients, 16.6%. By 2018, these proportions increased significantly: Medicare (40.9%) and Medicaid (22.7%).[1] This shift was almost entirely accounted for by decrease in inpatients with private insurance, while overall number of hospitalizations nationwide remained relatively constant. Over the

[1] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

same 1999-2018 period, average length of stay for Medicare patients declined from 6.0 days to 5.2 days and Medicaid patients stayed similar (4.5 days to 4.6 days).[2]

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

CMS LDS Acute Hospitalization Summary	Fiscal Year 2013*	2014	2015	2016	2017	2018	2019	2020	2021**
Surgical									
Total Acute Care Hospitalizations	1,980,907	2,578,950	2,573,113	2,696,289	2,604,555	2,638,175	2,594,572	2,179,122	517,738
Average CMI	2.74	2.81	2.84	2.87	2.90	2.96	2.98	3.07	3.15
Average Length of Stay	5.70	5.67	5.61	5.55	5.38	5.38	5.31	5.42	5.59
Medical									
Total Acute Care Hospitalizations	5,058,297	6,419,001	6,600,547	6,405,577	6,539,043	6,449,708	6,220,061	5,406,587	1,363,405
Average CMI	1.18	1.18	1.20	1.20	1.22	1.25	1.27	1.33	1.44
Average Length of Stay	4.76	4.76	4.74	4.62	4.62	4.59	4.62	4.84	5.19
Total Total Acute Care Hospitalizations	**7,039,204**	**8,997,951**	**9,173,660**	**9,101,866**	**9,143,598**	**9,087,883**	**8,814,633**	**7,585,709**	**1,881,143**
Total Average CMI	**1.62**	**1.65**	**1.66**	**1.70**	**1.70**	**1.75**	**1.77**	**1.83**	**1.91**
Total Average Length of Stay	**5.02**	**5.02**	**4.98**	**4.89**	**4.84**	**4.82**	**4.83**	**5.01**	**5.30**

*Includes only 1/1/2013 - 9/30/2013
**Includes only 10/1/2020 - 12/31/2020

Change in length of hospital stay

Case-Mix Index (CMI) data (from the CMS Limited Data Set) using 100% of the Medicare Fee for Service population also bear out the assertions that the severity of illness and risk of adverse outcome of hospitalized patients continues to increase over time, while average length of stay for acute care hospitalizations trends downwards, excepting the impact of the COVID-19 pandemic in 2020 and 2021.

In addition, a published report from the OIG has documented significant decreases in length of stay and that hospitals are billing the highest severity DRGs more frequently.

The OIG stated:
"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same."

While this OIG article suggests that providers may be upcoding, the expert panels' experience suggest that the trend supports the fact that physicians/QHPs are caring for patients who have many more contributing conditions and increased pressure to get the patient on to the next level of care outside the acute care setting of the inpatient stay. This requires more intense and complex work in a shorter period of time.

Change in Technology

Outpatient EHRs are significantly different from inpatient EHRs. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags are frequently popping up as they are put in place for safety reasons, however, these flags require physician/QHP rather than clinical staff to review and override after decisions for treatments have been modified and thus requires the physician/QHP to go back to the EHR before the clinical staff can continue with care of the patient such as a medication change.

The American Hospital Association reported that in 2017[3] 95% of hospitals had some form of EHR implemented. This is significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

[2] Agency for Healthcare Research and Quality (AHRQ). HCUP Fast Stats—Trends in Inpatient Stays. Accessed November 29, 2021, via https://www.hcup-us.ahrq.gov/faststats/NationalTrendsServlet/

[3] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Data from the Chronic Conditions Data Warehouse also support our assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%) and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Knowledge (new HOSPITALIST specialty provider type)

Hospitalists are a new specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed and is a specialty that continues to grow. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[4] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[5] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[6] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[7] This shows that the field continues to grow and the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the model of outpatient primary care rounding in the hospital on their patients in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[8] Shift-based coverage makes at least one handoff between physicians during a 24-hour period ubiquitous. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[9] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all of the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[10]

We concede that the existing data in the RUC database attributes a much smaller proportion of billing claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in PECOS using a recently established Medicare specialty billing code (C6). However, given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today. Therefore we believe this meets the CE criteria for shift to another specialty with different knowledge base.

Survey Analysis

The specialty societies discussed that the work RVUs for the initial inpatient/observation codes, the discharge codes, and the same day admission/discharge codes must be in proper rank order to each other (and to the office visit codes). Similarly, the subsequent inpatient/observation visit codes must be in proper rank order to the initial visit codes and comparable office visit codes.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief ■ No. 46■ April 2019

[4] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.
[5] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.
[6] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480
[7] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.
[8] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[9] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.
[10] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

As a threshold matter, the expert panel reviewed the intensity/complexity measures for all the codes. For virtually all the codes, well over 50% of respondents reported that the intensity and complexity of these services was somewhat, or much more than the reference services which were mostly office visits. This confirmed the panel's understanding that inpatient visits are more intense the outpatient office visits.

99239 Review and Recommendations

There were 171 respondents of whom 95% found the vignette to be typical. The survey times and median RVW were 0/45/19/64/2.90 and the 25th percentile RVW was 2.15.

The previous survey data was: 204 respondents of whom 93% found the vignette to be typical. The survey times and median work RVU were 0/45/0/45/2.75 and the 25th percentile work RVU was 2.00.

The current times and work RVU are 10/30/15/55/1.90.

The key reference services were 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80, and 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVU of 7/30/10/47/1.92.

These are the same key reference services as the previous survey.

Because this is a time-based code, the expert panel focused on comparing the survey times to the existing times and reference service times. The survey time for 99239 is 6 minutes less than the total time for 99215 (RVW of 2.80), 17 minutes higher than the total time for 99214 (RVW of 1.92), and 9 minutes higher than the current time.

Therefore, the expert panel agreed that the 25th percentile RVW of 2.15 placed 99239 in proper rank order with both key reference services and reflects the increased time as compared to the current time.

The expert panel then compared the survey data to the recommendations for 99238. The survey time for 99239 is 68% higher than the time for 99238 and the 25th percentile RVW is 43% higher than the recommended RVW for 99238 (1.50).

Therefore, the expert panel recommends the survey intra 45, post time 19/total time of 64 minutes and the survey 25th percentile work RVU of 2.15.

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) 99239, 99217

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Hospitalist How often? Commonly

Specialty Family Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 15569490
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Internal Medicine Frequency 8049426 Percentage 51.69 %

Specialty Hospitalist Frequency 3300732 Percentage 21.20 %

Specialty Family Medicine Frequency 1463532 Percentage 9.39 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,176,631 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Internal Medicine Frequency 3192701 Percentage 51.69 %

Specialty Hospitalist Frequency 1309446 Percentage 21.20 %

Specialty Family Medicine Frequency 579996 Percentage 9.39 %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99239

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: Inpatient and Observation Care Services (99291-99233)

TAB: 13

Source	RUC Year	CPT	DESC	Global	Resp	CPT Time	MDM	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX	% Typical	Medicare Utilization
1st REF	2019	99203	Office or other outpatient visit for th	XXX	94	30-44	Low	0.046	0.046			1.60			35	5			25			5							11,452,897
2nd REF	2019	99204	Office or other outpatient visit for th	XXX	33	45-59	Mod	0.043	0.043			2.60			60	10			40			10							10,714,246
Current	2006	99221	Initial hospital care, per day, for the	XXX		30	SF or low	0.049	0.038			1.92			50	10			30			10							1,759,562
Current (D)	2010	99218	Initial observation care, per day, for	XXX		30	SF or low	0.049	0.038			1.92			50	10			30			10							153,778
SVY	Jan-22	99221	Initial hospital inpatient or observat	XXX	230		SF or low	0.049	0.049	0.20	1.63	1.95	2.50	45.00	40		9	30	40	50	125		0	4	12	49	500	87%	
REC	Jan-22	99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a	XXX		40	SF or Low	0.041	0.041			1.63			40				40										
Hospital	Jan-22	99221	KRS 1 = 99203	XXX	43					0.20	1.80	2.00	2.53	4.40	41		15	30	41	50	110		0	1	5	20	130	86%	
Medicine	Jan-22	99221	KRS 1 = 99203	XXX	57					0.20	1.60	1.92	2.20	45.00	36		9	27	36	45	125		0	5	10	30	250	86%	
Surgery	Jan-22	99221	KRS 1 = 99203	XXX	88					0.93	1.60	1.90	2.50	4.30	40		19	30	40	50	105		0	10	25	50	500	89%	
Primary Care	Jan-22	99221	KRS 1 = 99203	XXX	42					0.93	1.75	2.00	2.55	4.00	43		18	33	43	55	90		0	1	9	19	100	86%	
1st REF	2019	99204	Office or other outpatient visit for th	XXX	122	45-59	Mod	0.043	0.043			2.60			60	10			40			10							10,714,246
2nd REF	2019	99205	Office or other outpatient visit for th	XXX	46	60-74	High	0.040	0.040			3.50			88	14			59			15							2,923,626
Current	2006	99222	Initial hospital care, per day, for the	XXX		50	Mod	0.046	0.035			2.61			75	15			40			20							6,459,408
Current (D)	2010	99219	Initial observation care, per day, for	XXX		50	Mod	0.051	0.040			2.60			65	10			40			15							674,993
SVY	Jan-22	99222	Initial hospital inpatient or observat	XXX	250		Mod	0.051	0.051	0.40	2.60	2.81	3.44	55.00	55		14	45	55	70	150		0	20	40	100	1200	96%	
REC	Jan-22	99222	Initial hospital inpatient or observation care, per day, for the	XXX		55	Mod	0.047	0.047			2.60			55				55										
Hospital	Jan-22	99222	KRS 1 = 99204	XXX	43					1.45	2.78	2.90	3.46	4.70	55		20	50	55	70	130		0	21	45	100	500	95%	
Medicine	Jan-22	99222	KRS 1 = 99204	XXX	70					0.40	2.60	2.81	3.20	55.00	54		14	40	54	64	135		0	20	55	200	1200	96%	
Surgery	Jan-22	99222	KRS 1 = 99204	XXX	91					1.10	2.50	2.80	3.35	5.74	55		20	45	55	70	150		0	20	30	60	750	96%	
Primary Care	Jan-22	99222	KRS 1 = 99204	XXX	46					1.50	2.71	2.90	3.50	4.50	60		27	45	60	70	110		0	24	50	101	350	96%	
1st REF	2019	99205	Office or other outpatient visit for th	XXX	138	60-74	HIGH	0.040	0.040			3.50			88	14			59			15							2,923,626
2nd REF	2005	99291	Critical care, evaluation and manag	XXX	58	30-74	HIGH	0.096	0.064			4.50			70	15			40			15							5,905,780
Current	2006	99223	Initial hospital care, per day, for the	XXX		70	High	0.056	0.043			3.86			90	15			55			20							10,626,847
Current (D)	2010	99220	Initial observation care, per day, for	XXX		70	High	0.064	0.047			3.56			75	15			45			15							1,598,400
SVY	Jan-22	99223	Initial hospital inpatient or observat	XXX	257		High	0.054	0.054	0.60	3.50	4.00	4.25	75.00	74		15	60	74	90	190		0	25	60	150	1800	99%	
REC	Jan-22	99223	Initial hospital inpatient or observation care, per day, for the	XXX		75	HIGH	0.047	0.047			3.50			74				74										
MPC	2019	99205	Office or other outpatient visit for th	XXX		60-74	HIGH	0.048	0.040			3.50			88	14			59			15							
MPC	2005	99291	Critical care, evaluation and manag	XXX		30-74	HIGH	0.096	0.064			4.50			70	15			40			15							
Hospital	Jan-22	99223	KRS 1 = 99205	XXX	45					1.95	3.60	3.95	4.20	5.80	74		25	65	74	90	150		0	58	120	243	1800	98%	
Medicine	Jan-22	99223	KRS 1 = 99205	XXX	73					0.60	3.50	4.00	4.50	75.00	72		15	58	72	90	155		3	43	99	195	1000	100%	
Surgery	Jan-22	99223	KRS 1 = 99205	XXX	93					0.93	3.50	4.00	4.50	6.45	72		20	60	72	85	190		0	15	40	70	1000	99%	
Primary Care	Jan-22	99223	KRS 1 = 99205	XXX	46					1.60	3.70	4.00	4.00	6.00	75		36	65	75	90	160		0	40	75	193	566	98%	

											RVW					Total	PRE	INTRA-TIME					POST	SURVEY EXPERIENCE						Medicare
	Source	RUC Year	CPT	DESC	Global	Resp	CPT Time	MDM	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	PRE	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX	% Typical	Utilization
	ISSUE:	Inpatient and Observation Care Services (99291-99233)																												
	TAB:	13																												
46	1st REF	2019	99213	Office or other outpatient visit for th	XXX	107	20-29	LOW	0.043	0.043			1.30			30	5			20			5							92,217,549
47	2nd REF	2019	99212	Office or other outpatient visit for th	XXX	51	10-19	SF	0.044	0.044			0.70			16	2			11			3							10,729,531
48	Current	2006	99231	Subsequent hospital care, per day,	XXX		15	SF or Low	0.054	0.038			0.76			20	5			10			5							6,736,945
49	Current (D)	2009	99224	Subsequent observation care, per d	XXX		15	SF or Low	0.054	0.038			0.76			20	5			10			5							124,118
50	SVY	Jan-22	99231	Subsequent hospital inpatient or ob	XXX	234		SF or low	0.052	0.052	0.10	1.00	1.30	1.50	45.00	25		9	19	25	30	100		0	10	38	100	1000	91%	
51	REC	Jan-22	99231	Subsequent hospital inpatient or observation care, per day, for the	XXX		25	SF or Low	0.040	0.040			1.00			25				25										
53	MPC	2019	99202	Office or other outpatient visit for th	XXX		15-29	SF	0.055	0.047			0.93			20	2			15			3							
54	Hospital	Jan-22	99231	KRS 1 = 99213	XXX	42					0.34	1.00	1.30	1.53	4.00	24		10	18	24	30	80		0	10	25	120	400	90%	
55	Medicine	Jan-22	99231	KRS 1 = 99213	XXX	62					0.10	1.00	1.30	1.50	45.00	23		9	16	23	30	75		0	10	39	100	1000	87%	
56	Surgery	Jan-22	99231	KRS 1 = 99213	XXX	88					0.18	0.89	1.30	1.50	7.12	25		12	20	25	35	100		0	20	50	100	750	95%	
57	Primary Care	Jan-22	99231	KRS 1 = 99213	XXX	42					0.70	1.00	1.33	1.60	4.00	25		14	20	25	30	65		0	4	28	53	150	86%	
58																														
59	1st REF	2019	99214	Office or other outpatient visit for th	XXX	121	30-39	MOD	0.041	0.041			1.92			47	7			30			10							106,900,291
60	2nd REF	2019	99213	Office or other outpatient visit for th	XXX	40	20-29	LOW	0.043	0.043			1.30			30	5			20			5							92,217,549
61	Current	2006	99232	Subsequent hospital care, per day,	XXX		25	Mod	0.047	0.035			1.39			40	10			20			10							44,656,174
62	Current (D)	2009	99225	Subsequent observation care, per d	XXX		25	Mod	0.047	0.035			1.39			40	10			20			10							640,005
63	SVY	Jan-22	99232	Subsequent hospital inpatient or ob	XXX	252		Mod	0.056	0.056	0.20	1.59	2.00	2.46	55.00	36		10	30	36	45	115		0	38	100	300	5000	97%	
64	REC	Jan-22	99232	Subsequent hospital inpatient or observation care, per day, for the	XXX		35	Mod	0.044	0.044			1.59			36				36										
66	MPC	2019	99203	Office or other outpatient visit for th	XXX		30-44	LOW	0.055	0.046			1.60			35	5			25			5							
67	Hospital	Jan-22	99232	KRS 1 = 99214	XXX	42					1.30	1.71	2.00	2.19	5.00	35		15	32	35	44	100		0	145	350	900	2500	98%	
68	Medicine	Jan-22	99232	KRS 1 = 99214	XXX	75					0.20	1.56	2.00	2.50	55.00	35		10	28	35	43	90		4	68	200	400	5000	96%	
69	Surgery	Jan-22	99232	KRS 1 = 99214	XXX	88					0.31	1.50	1.99	2.46	8.00	40		19	30	40	50	113		0	24	48	100	1250	98%	
70	Primary Care	Jan-22	99232	KRS 1 = 99214	XXX	47					1.30	1.79	2.00	2.40	4.00	36		22	30	36	41	115		0	50	100	234	1000	98%	
71																														
72	1st REF	2019	99215	Office or other outpatient visit for th	XXX	129	40-54	HIGH	0.040	0.040			2.80			70	10			45			15							10,388,878
73	2nd REF	2019	99214	Office or other outpatient visit for th	XXX	37	30-39	MOD	0.041	0.041			1.92			47	7			30			10							106,900,291
74	Current	2006	99233	Subsequent hospital care, per day,	XXX		35	High	0.048	0.036			2.00			55	10			30			15							24,607,697
75	Current (D)	2009	99226	Subsequent observation care, per d	XXX		35	High	0.048	0.036			2.00			55	10			30			15							350,310
76	SVY	Jan-22	99233	Subsequent hospital inpatient or ob	XXX	258		High	0.056	0.056	0.30	2.40	2.90	3.24	75.00	52		11	41	52	60	165		0	25	100	300	5600	97%	
77	REC	Jan-22	99233	Subsequent hospital inpatient or observation care, per day, for the	XXX		50	HIGH	0.046	0.046			2.40			52				52										
80	Hospital	Jan-22	99233	KRS 1 = 99215	XXX	44					1.70	2.50	2.99	3.25	6.00	52		20	45	52	60	120		0	110	300	678	2100	95%	
81	Medicine	Jan-22	99233	KRS 1 = 99215	XXX	77					0.30	2.25	2.90	3.30	75.00	47		11	40	47	60	120		7	50	120	300	5600	96%	
82	Surgery	Jan-22	99233	KRS 1 = 99215	XXX	91					1.50	2.25	2.90	3.20	8.50	57		30	43	57	65	150		0	14	30	100	1500	98%	
83	Primary Care	Jan-22	99233	KRS 1 = 99215	XXX	46					1.74	2.50	2.90	3.41	5.00	51		30	43	51	60	165		0	36	80	321	2600	98%	
84																														

ISSUE: Inpatient and Observation Care Services (99234-99236)

TAB: 13

Source	RUC Year	CPT	DESC	Global	Resp	CPT Time	MDM	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX	% Typical	Medicare Utilization
1st REF	2019	99204	Office or other outpatient visit fo	XXX	17	45-59	Mod	0.043	0.043			2.60			60	10			40			10							10,714,246
1st REF	2019	99203	Office or other outpatient visit fo	XXX	14	30-44	Low	0.046	0.046			1.60			35	5			25			5							11,452,897
CURRENT	2011	99234	Observation or inpatient hospita	XXX		40	SF or Low	0.048	0.037			2.56			69	14			40			15							33,757
SVY	Jan-22	99234	Hospital inpatient or observatio	XXX	58		SF or low	0.055	0.052	0.90	2.00	2.60	3.00	4.50	50		15	39	45	62	115	5	0	0	5	11	800	90%	
REC	Jan-22	99234	Hospital inpatient or observation care, for the	XXX			SF or low	0.042	0.040			2.00			50				45			5							
Hospital	Jan-22	99234	KRS 1 = 99204	XXX	9					1.80	2.30	2.70	3.00	3.30	40		15	39	40	51	70	0	0	0	1	2	10	100%	
Medicine	Jan-22	99234	KRS 1 = 99203	XXX	20					1.30	1.92	2.45	2.89	4.50	50		30	38	40	59	80	10	0	0	7	10	120	90%	
Surgery	Jan-22	99234	KRS 1 = 99204	XXX	16					0.90	2.36	2.60	3.13	4.50	51		24	35	43	63	100	8	0	2	10	21	800	88%	
Primary Care	Jan-22	99234	KRS 1 = 99215	XXX	13					1.20	2.20	2.60	3.15	4.00	55		22	45	55	62	115	0	0	0	3	15	50	85%	
1st REF	2019	99205	Office or other outpatient visit fo	XXX	22	60-74	High	0.040	0.040			3.50			88	14			59			15							2,923,626
1st REF	2019	99204	Office or other outpatient visit fo	XXX	19	45-59	Mod	0.043	0.043			2.60			60	10			40			10							10,714,246
CURRENT	2011	99235	Observation or inpatient hospita	XXX		50	Mod	0.049	0.038			3.24			85	15			50			20							90,399
SVY	Jan-22	99235	Hospital inpatient or observatio	XXX	59		Mod	0.049	0.046	1.00	2.88	3.50	3.83	60.00	76		28	50	68	80	155	8	0	2	10	26	400	92%	
REC	Jan-22	99235	Hospital inpatient or observation care, for the	XXX			MOD	0.045	0.043			3.24			76				68			8							
Hospital	Jan-22	99235	KRS 1 = 99204	XXX	9					2.80	3.00	3.22	3.70	3.80	60		30	47	60	68	100	0	0	2	3	5	144	100%	
Medicine	Jan-22	99235	KRS 1 = 99205	XXX	21					1.80	2.80	3.25	3.75	60.00	75		44	50	60	76	110	15	0	0	12	25	100	95%	
Surgery	Jan-22	99235	KRS 1 = 99205	XXX	16					1.00	3.33	3.55	4.00	6.00	83		32	47	70	86	150	13	0	3	10	38	400	81%	
Primary Care	Jan-22	99235	KRS 1 = 99205	XXX	13					2.00	3.00	3.50	3.70	5.50	84		28	70	80	82	155	4	0	10	20	45	150	92%	
1st REF	2019	99205	Office or other outpatient visit fo	XXX	26	60-74	High	0.040	0.040			3.50			88	14			59			15							2,923,626
1st REF	2005	99291	Critical care, evaluation and mar	XXX	17	30-74	High	0.096	0.064			4.50			70	15			40			15							5,905,780
CURRENT	2011	99236	Observation or inpatient hospita	XXX		55	High	0.060	0.045			4.20			94	19			55			20							131,135
SVY	Jan-22	99236	Hospital inpatient or observatio	XXX	59		High	0.047	0.044	1.50	3.55	4.30	4.58	7.00	97		37	66	85	105	260	12	0	0	7	23	400	86%	
REC	Jan-22	99236	Hospital inpatient or observation care, for the	XXX			HIGH	0.047	0.044			4.30			97				85			12							
Hospital	Jan-22	99236	KRS 1 = 99205	XXX	10					3.20	3.53	3.80	4.30	4.60	79		40	62	79	85	120	0	0	3	8	13	50	100%	
Medicine	Jan-22	99236	KRS 1 = 99205	XXX	22					2.50	3.63	4.35	4.50	7.00	105		60	70	85	100	260	20	0	0	5	20	400	91%	
Surgery	Jan-22	99236	KRS 1 = 99291	XXX	13					1.50	3.50	4.50	5.00	7.00	115		45	60	90	105	240	25	0	0	5	40	300	69%	
Primary Care	Jan-22	99236	KRS 1 = 99291	XXX	14					2.85	3.74	4.38	4.68	6.50	114		37	90	105	121	225	9	0	2	20	34	130	86%	

ISSUE: Inpatient and Observation Care Services (99234-99236)

TAB: 13

Source	RUC Year	CPT	DESC	Global	Resp	CPT Time	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	INTRA-TIME PRE	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	INTRA-TIME POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX	% Typical	Medicare Utilization
1st REF	2019	99213	Office or other outpatient visit for the	XXX	44	20-29	0.043	0.043			1.30			30	5			20			5							92,217,549
2nd REF	2019	99214	Office or other outpatient visit for the	XXX	39	30-39	0.041	0.041			1.92			47	7			30			10							106,900,291
Current	2006	99238	Hospital discharge day management	XXX		30 or less	0.044	0.034			1.28			38	8			20			10							2,550,501
Current (D)	1993	99217	Observation care discharge day man	XXX		30 or less	0.024	0.023			1.28			55	10			30			15							1,472,838
SVY	Jan-22	99238	Hospital inpatient or observation	XXX	167	30 or less	0.060	0.050	0.18	1.50	1.90	2.50	60.00	38		10	24	28	31	60	10	0	10	35	100	700	89%	
REC	Jan-22	99238	Hospital inpatient or observation discharge day management; 30 minutes or less	XXX		30 or less	0.046	0.039			1.50			38				28			10							
MPC	2019	99202	Office or other outpatient visit for the	XXX		15-29	0.055	0.047			0.93			20	2			15			3							
MPC	2019	99203	Office or other outpatient visit for the	XXX		30-44	0.055	0.046			1.60			35	5			25			5							
Hospital	Jan-22	99238	KRS 1 = 99214	XXX	21				0.50	1.50	1.70	2.01	52.00	33		15	25	28	34	60	5	0	14	55	103	341	90%	
Medicine	Jan-22	99238	KRS 1 = 99213	XXX	37				0.93	1.50	2.00	2.80	60.00	40		15	22	25	30	50	15	0	10	20	70	500	81%	
Surgery	Jan-22	99238	KRS 1 = 99213	XXX	78				0.18	1.50	1.87	2.43	15.00	44		10	25	29	34	60	15	0	16	48	100	700	91%	
Primary Care	Jan-22	99238	KRS 1 = 99214	XXX	31				0.20	1.53	1.80	2.25	20.00	33		15	22	28	30	55	5	0	5	30	88	500	90%	
1st REF	2019	99215	Office or other outpatient visit for the	XXX	45	40-54	0.040	0.040			2.80			70	10			45			15							10,388,878
2nd REF	2019	99214	Office or other outpatient visit for the	XXX	40	30-39	0.041	0.041			1.92			47	7			30			10							106,900,291
Current	2006	99239	Hospital discharge day management	XXX		> 30	0.045	0.035			1.90			55	10			30			15							5,189,830
SVY	Jan-22	99239	Hospital inpatient or observation dis	XXX	171	>30	0.055	0.045	0.30	2.15	2.90	3.50	75.00	64		20	40	45	55	90	19	0	10	50	105	1200	95%	
REC	Jan-22	99239	Hospital inpatient or observation discharge day management; more than 30 minutes	XXX		>30	0.038	0.034			2.15			64				45			19							
MPC	2019	99203	Office or other outpatient visit for the	XXX		30-44	0.055	0.046			1.60			35	5			25			5							
MPC	2010	95810	Polysomnography; age 6 years or old	XXX		N/A	0.050	0.038			2.50			67	15			37			15							
Hospital	Jan-22	99239	KRS 1 = 99215	XXX	21	2010			1.70	2.10	2.80	3.50	67.00	54		30	43	45	49	90	9	0	44	100	218	1200	100%	
Medicine	Jan-22	99239	KRS 1 = 99205	XXX	37				1.60	2.50	3.00	3.70	75.00	60		20	35	40	60	90	20	0	10	50	100	500	97%	
Surgery	Jan-22	99239	KRS 1 = 99214	XXX	81				0.30	2.20	2.90	3.50	30.00	70		30	42	45	55	90	25	0	10	28	75	900	93%	
Primary Care	Jan-22	99239	KRS 1 = 99215	XXX	32				0.40	2.00	2.80	3.08	35.00	53		27	37	45	50	70	8	0	10	70	188	650	97%	

SOURCE	Review Year	CPT	DESC	MDM	CPT TIME	wput	Rec RVW	stat	25th	RVW MED	75th	Total Time	PRE	intra	POST
RUC-2019	2019	99212	Office or other outpatient visit for the evaluatio	SF	10-19	0.044	0.70	xwalk	0.50	0.75	1.00	16	2	11	3
RUC-2021	2021	99307	Subsequent nursing facility care, per day, for	SF	10	0.050	0.70	25th	0.70	0.80	1.30	14	1	12	1
RUC-2021	2021	99347	Home or residence visit for the evaluation and	SF	20	0.030	0.90	25th	0.90	1.30	1.91	30	5	20	5
RUC-2019	2019	99202	Office or other outpatient visit for the evaluatio	SF	15-29	0.047	0.93	current	0.71	1.00	1.45	20	2	15	3
RUC-2021	2021	99341	Home or residence visit for the evaluation and	SF	15	0.037	1.00	25th	1.00	1.50	1.80	27	6	15	6
SVY	2022	99231	Subsequent hospital inpatient or observation	SF or LOW	25	0.040	1.00	25th	1.00	1.30	1.50	25		25	
SVY	2021	99242	Office or other outpatient consultation for a ne	SF	20	0.036	1.08	med	0.93	1.08	1.49	30	5	20	5
RUC-2019	2019	99213	Office or other outpatient visit for the evaluatio	LOW	20-29	0.043	1.30	med	1.00	1.30	1.75	30	5	20	5
RUC-2021	2021	99308	Subsequent nursing facility care, per day, for	LOW	15	0.048	1.30	25th	1.30	1.44	1.85	27	5	18	4
SVY	2022	99252	Inpatient or observation consultation for a new	SF	35	0.043	1.50	med	1.00	1.50	2.00	35		35	
RUC-2021	2021	99304	Initial nursing facility care, per day, for the eva	SF or LOW	25	0.042	1.50	25th	1.50	1.70	2.00	36	6	25	5
RUC-2021	2021	99348	Home or residence visit for the evaluation and	LOW	30	0.033	1.50	25th	1.50	1.92	2.13	46	7	29	9.5
SVY	2022	99232	Subsequent hospital inpatient or observation	MOD	35	0.044	1.59	25th	1.59	2.00	2.46	36		36	
RUC-2019	2019	99203	Office or other outpatient visit for the evaluatio	LOW	30-44	0.046	1.60	med	1.25	1.60	2.20	35	5	25	5
SVY	2022	99221	Initial hospital inpatient or observation care, p	SF or LOW	40	0.048	1.63	25th	1.63	1.95	2.50	40		40	
RUC-2021	2021	99342	Home or residence visit for the evaluation and	LOW	30	0.032	1.65	25th	1.65	2.00	2.60	52	10	32	10
SVY	2021	99243	Office or other outpatient consultation for a ne	LOW	30	0.041	1.80	med	1.60	1.80	2.00	44	7	30	7
RUC-2019	2019	99214	Office or other outpatient visit for the evaluatio	MOD	30-39	0.041	1.92	xwalk	1.50	2.00	2.56	47	7	30	10
RUC-2021	2021	99309	Subsequent nursing facility care, per day, for	MOD	30	0.041	1.92	25th	1.92	2.09	2.60	47	7	30	10
SVY	2022	99234	Hospital inpatient or observation care, for the	SF or LOW	45	0.051	2.00	25th	2.00	2.60	3.00	50		45	5
SVY	2022	99253	Inpatient or observation consultation for a new	LOW	45	0.044	2.00	med	1.60	2.00	2.75	45		45	
SVY	2022	99233	Subsequent hospital inpatient or observation	HIGH	50	0.046	2.40	25th	2.40	2.90	3.24	52		52	
RUC-2021	2021	99349	Home or residence visit for the evaluation and	MOD	40	0.036	2.44	25th	2.44	2.70	3.05	68	12	41	15
RUC-2021	2021	99305	Initial nursing facility care, per day, for the eva	MOD	35	0.045	2.50	25th	2.50	2.75	3.00	55	10	35	10
RUC-2019	2019	99204	Office or other outpatient visit for the evaluatio	MOD	45-59	0.043	2.60	med	2.00	2.60	3.24	60	10	40	10
SVY	2022	99222	Initial hospital inpatient or observation care, p	MOD	55	0.047	2.60	25th	2.60	2.81	3.44	55		55	
SVY	2021	99244	Office or other outpatient consultation for a ne	MOD	40	0.045	2.69	crosswalk	2.60	2.80	3.10	60	10	40	10
SVY	2022	99254	Inpatient or observation consultation for a new	MOD	60	0.050	2.72	25th	2.72	3.00	3.50	60		60	
RUC-2018	2018	99495	Transitional Care Management Services with	MOD		0.051	2.78	med		2.78		54		54	
RUC-2019	2019	99215	Office or other outpatient visit for the evaluatio	HIGH	40-54	0.040	2.80	med	2.15	2.80	3.50	70	10	45	15
RUC-2021	2021	99310	Subsequent nursing facility care, per day, for	HIGH	45	0.040	2.80	25th	2.80	3.00	3.60	70	10	45	15
RUC-2021	2021	99344	Home or residence visit for the evaluation and	MOD	60	0.031	2.87	25th	2.87	3.50	3.79	92	15	60	17
SVY	2022	99235	Hospital inpatient or observation care, for the	MOD	70	0.043	3.24	current	2.88	3.50	3.83	76		68	8
RUC-2019	2019	99205	Office or other outpatient visit for the evaluatio	HIGH	60-74	0.040	3.50	med	2.80	3.50	4.00	88	14	59	15
RUC-2021	2021	99306	Initial nursing facility care, per day, for the eva	HIGH	45	0.044	3.50	25th	3.50	3.75	4.00	80	15	50	15
SVY	2022	99223	Initial hospital inpatient or observation care, p	HIGH	75	0.052	3.50	25th	3.50	4.00	4.25	74		74	
RUC-2021	2021	99350	Home or residence visit for the evaluation and	HIGH	60	0.037	3.60	med	3.10	3.60	4.00	97	17	60	20
SVY	2021	99245	Office or other outpatient consultation for a ne	HIGH	55	0.043	3.75	med	3.50	3.75	4.00	87	15	55	17
RUC2018	2018	99496	Transitional Care Management Services with	HIGH		0.051	3.79	med		3.79		75		75	
SVY	2022	99255	Inpatient or observation consultation for a new	HIGH	80	0.050	3.86	crosswalk	3.55	4.00	4.50	80		80	
RUC-2021	2021	99345	Home or residence visit for the evaluation and	HIGH	75	0.031	3.88	25th	3.88	4.00	4.50	126	25	74	26.5
SVY	2022	99236	Hospital inpatient or observation care, for the	HIGH	85	0.044	4.30	med	3.55	4.30	4.58	97		85	12
RUC-2005	2005	99291	Critical care, evaluation and management of t	HIGH	30-74	0.064	4.50	med		4.50		70	15	40	15
SVY	2022	99238	Hospital inpatient or observation discharge da	NA	<30	0.039	1.50	25th	1.50	1.90	2.50	38		28	10
RUC-2021	2021	99315	Nursing facility discharge day management; 3	NA	<30	0.038	1.50	25th	1.50	2.10	2.78	40	10	25	5
RUC-2021	2021	99316	Nursing facility discharge day management; r	NA	>30	0.040	2.50	25th	2.50	3.01	3.80	63	15	40	8
SVY	2022	99239	Hospital inpatient or observation discharge da	NA	>30	0.034	2.15	25th	2.15	2.90	3.50	64		45	19

FACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 10/2021

CPT Code	Long Descriptor	Global Period
▲99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99238	Hospital inpatient or observation discharge day management; 30 minutes or less	XXX
▲99239	more than 30 minutes	XXX
▲99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX

FACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Vignette(s) (*vignette required even if PE only code(s)***):**

99221	A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services.
99222	A patient with an acute illness with systemic symptoms or acute~~,~~ complicated injury is admitted for either initial inpatient or observation care services.
99223	A patient with a chronic illness with severe exacerbation, or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services.
99231	A patient with an acute illness or injury whose condition is improving or is stable receives subsequent hospital inpatient or observation care.
99232	A patient with an illness or acute injury that is progressing or requires ongoing diagnostic evaluation, medical management or potential surgical treatment receives subsequent hospital inpatient or observation care.
99233	A patient who is unstable or has developed a significant complication or a significant new problem receives subsequent hospital inpatient or observation care encounter.
99238	A patient receives hospital inpatient or observation discharge day management services requiring 30 minutes or less of total time.
99239	A patient receives Hospital inpatient or observation discharge day management services requiring greater than 30 minutes of total time.
99234	A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)
99235	A patient with an acute illness with systemic symptoms or a patient with an acute complicated injury that requires medical management or potential surgical treatment is admitted for either initial inpatient or observation care services. The patient is discharged later that same day.(This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)
99236	A patient with a severe exacerbation of a chronic illness or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The specialty Advisors reviewed the PE input history of the current codes.

In 2001, the RUC agreed that there are clinical staff activities associated with discharge day services. Typically, the office based physician staff will make a call to the patient's family and also one to the pharmacy. The RUC estimated that there are two 3-minute phone calls associated with code 99238 for a total of six minutes, and three 3-minute phone calls for a total of nine minutes total for 99239.

In 2002, the RUC discussed various methodologies for recognizing office based clinical staff time for hospital visits (99231-99233) that is spent in support of patients in the hospital and attempted to better define the activities involved in coordination of care. The activities considered as coordination of care are those phone calls that office based clinical staff have with 1) family

members who have clinical questions regarding care about a hospitalized patient, and 2) hospital clinical staff to exchange clinical data between the office and the hospital. These could be calls initiated by the hospital staff or by the office staff. The RUC reached a consensus that the office based staff do spend time on phone calls with a patient's family and with the hospital staff and these activities are in support of hospitalized patients and are necessary to provide good patient care.

The RUC discussed various ways to capture the time spent by clinical office staff on these activities. One proposal was to assign clinical staff time to the three hospital visit E/M codes (99231, 99232, 99233). Currently there are no direct inputs assigned to these codes. Under this proposal, the time would be assigned directly to the three codes and then applied to each global surgical code according to the number of times these codes appear in the global surgical package.

The RUC did not agree that assigning time to these E/M codes would be appropriate because the RUC was not convinced that such a building block methodology would lead to accurate time allocation. A building block approach worked for assigning time to the post operative office visits since there is typically contact with clinical office staff during these visits. However, the RUC did not feel that a similar methodology was appropriate for the hospital visit codes since it was not convinced that each hospital visit also includes clinical staff coordination of care activities. The RUC concluded that it was not possible to standardize the coordination of care time by allocating the time to the hospital visit codes.

However, the RUC felt it was important to validate the hospital E/M codes as this time while the global surgical codes are being reviewed, rather than at a later date. The RUC agreed that zero time should be assigned to the hospital visit codes due to the inability to develop a methodology to assign time to these codes.

The RUC then discussed an alternative methodology to assign time that would allocate additional time to the discharge day management codes. The rational is that for every code that has a full 99238 or 99239, additional time spent by office based clinical staff was necessary during the associated hospitalization. The RUC felt that developing a single standard of 6 minutes would simplify the refinement process as well as account for a typical time spent on coordination of care activities during the hospitalization. The time would be added to the time of the discharge day management codes (99238, 99239) and would therefore cover the staff activities performed in support of discharge day management and activities during the hospitalization.

The RUC approved the following two recommendations in 2002:

1. The RUC recommends that the hospital E/M codes 99231, 99232, and 99233 need to be validated at this time and the RUC proposes assigning zero direct inputs to these codes. These codes currently have zero inputs. The RUC agreed that assigning coordination of care time to each hospital visit would overstate the amount of time spent of these activities. The RUC could not agree that coordination of care activities occurred with each hospital visit or each day of hospitalization. Additionally, the work of coordination of care is currently included in the physician post-service work for these codes and assigning additional time specifically to these codes would lead to duplicate accounting of work.

2. The RUC recommends assigning an additional six minutes to the current times (from 2001) for

discharge day management codes 99238 and 99329, bringing the total time to 12 and 15 minutes, respectively. The RUC felt that there are coordination of care activities associated with hospitalization and therefore a suitable methodology for capturing this time would be to assign 6 minutes whenever a full discharge day management code is contained in either the RUC or CMS databases. The RUC agreed that the additional 6 minutes sufficiently captured the time of clinical office staff to perform coordination of care activities during a hospitalization.

CMS agreed with these recommendations.

In 2003, the PEAC E/M Workgroup examined each code family separately. For many of the codes the clinical staff times presented were crosswalked to previously approved times for selected E/M codes. For each crosswalk, the workgroup discussed the similarities and differences in clinical staff time between the reference code and the codes under refinement. **For the observation care codes 99234-99236,** the workgroup discussed in detail the appropriateness of cross walking the full 12 or 15 minutes currently assigned to 99238 and 99239. Although the observation care codes include admission and discharge on the same date the workgroup felt that the severity of these cases warrant using the full 12 and 15 minutes.

CMS initially agreed with this recommendation and published 12 minutes for 99234 and 15 minutes for 99235 and 99236 in the CY 2004 final rule PE detail file.

However, in the CY 2005 final rule PE detail file, the time for these three codes was reduced to zero minutes based on further refinement of earlier PEAC recommendations and unrefined codes [CMS–1429–FC, pp 66244]:

Adjustments To Conform With PEAC Standards
We also reviewed those codes that are currently unrefined or that were refined early in the PEAC process to apply some of the major PEAC-agreed standards.

The PEAC recommended that the discharge day management time apply only to 10-day and 90-day global services and we were complying with this recommendation. We also believe that this PEAC recommendation is reasonable; it is hard to imagine what tasks a physician's clinical staff back in the office is performing for a patient during the period that the patient is undergoing a same-day procedure in the hospital outpatient department. We also believe that it was appropriate to apply the PEAC standards to codes that were not refined or that were refined before the standards were developed. The application of these standards is not only fair, but can also help to avoid the possible rank order anomalies cited by the commenter.

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Current codes are used as references.

3. Is this code(s) typically reported with an E/M service?

FACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

no

4. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, 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

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

no

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the 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. 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):

99238 and 99239
When discharge occurs on a date other than the date of admission, six minutes is allocated to 99238 and 99239 as a proxy for office clinical staff to perform coordination of care activities during a hospitalization including phone calls that office based clinical staff have with 1) family members who have clinical questions regarding care about a hospitalized patient, and 2) phone calls with hospital clinical staff to exchange clinical data between the office and the hospital. These could be calls initiated by the hospital staff or by the office staff. These activities are in support of hospitalized patients and are necessary to provide good patient care.

In addition to the six minutes for clinical staff work during a hospitalization, there are clinical staff activities associated with discharge day management services. Typically, there will be discharge management related calls to the patient/family/pharmacy/other providers. This work has not changed since the RUC approved two calls related to 99238 and three calls related to 99239.
In summary, 12 minutes (4 calls @ 3 min) is recommended for 99238 and 15 minutes (5 calls @ 3 min)

FACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

is recommended for 99239.

c. Post-service period:

n/a

9. 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*):

n/a

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

n/a

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

n/a

15. 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

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

n/a

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

n/a

FACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

18. 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

19. 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

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

****** No Nonfacility PE inputs are recommended for these facility-only codes******

Meeting Date: 10/2021

CPT Code	Long Descriptor	Global Period
▲99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99238	Hospital inpatient or observation discharge day management; 30 minutes or less	XXX
▲99239	more than 30 minutes	XXX
▲99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
▲99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Vignette(s) (*vignette required even if PE only code(s)***):**

99221	A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services.
99222	A patient with an acute illness with systemic symptoms or acute~~,~~ complicated injury is admitted for either initial inpatient or observation care services.
99223	A patient with a chronic illness with severe exacerbation, or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services.
99231	A patient with an acute illness or injury whose condition is improving or is stable receives subsequent hospital inpatient or observation care.
99232	A patient with an illness or acute injury that is progressing or requires ongoing diagnostic evaluation, medical management or potential surgical treatment receives subsequent hospital inpatient or observation care.
99233	A patient who is unstable or has developed a significant complication or a significant new problem receives subsequent hospital inpatient or observation care encounter.
99238	A patient receives hospital inpatient or observation discharge day management services requiring 30 minutes or less of total time.
99239	A patient receives Hospital inpatient or observation discharge day management services requiring greater than 30 minutes of total time.
99234	A patient with an acute, uncomplicated illness or injury is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)
99235	A patient with an acute illness with systemic symptoms or a patient with an acute complicated injury that requires medical management or potential surgical treatment is admitted for either initial inpatient or observation care services. The patient is discharged later that same day.(This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)
99236	A patient with a severe exacerbation of a chronic illness or an acute illness/injury that poses a threat to life or bodily function is admitted for either initial inpatient or observation care services. The patient is discharged later that same day. (This service includes two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.)

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:

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 (NOTE: *For services reviewed prior to the implementation of*

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes):

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 the *Billed Together* tab in the RUC Database)

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 the *Billed Together* tab in the RUC Database)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, 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:

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

8. 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:

9. 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

NONFACILITY DIRECT PE INPUTS
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SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
PRESENTER(S): Thad Waites, MD, Edward Tuohy, MD

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:

10. 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):
    c. Post-service period:

11. 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:*

12. 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.

13. 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*):

14. 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.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

18. Are you recommending a PE supply pack for this recommendation? Yes or No.

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

19. 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.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

22. 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)?

23. 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:

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 99221-99223, 99231-99233, 99238-99239, 99234-99236
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

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	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet					03-2003	03-2003	REC	03-2003	03-2003	REC	03-2003	03-2003	REC	03-2003	10-2009	REC	03-2003	10-2009	REC	03-2003	10-2009	REC
2						99221	99218D	99221	99222	99219D	99222	99223	99220D	99223	99231	99224D	99231	99232	99225D	99232	99233	99226D	99233
3	Clinical Activity Code	Meeting Date: 01/22 Tab: 13 Specialty: AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Initial hospital care, per day, for the evaluation and management of a patient, which	Initial observation care, per day, for the evaluation and management of	Initial hospital inpatient or observation care, per day, for the evaluation and	Initial hospital care, per day, for the evaluation and management of a patient, which	Initial observation care, per day, for the evaluation and management of	Initial hospital inpatient or observation care, per day, for the evaluation and	Initial hospital care, per day, for the evaluation and management of a patient, which	Initial observation care, per day, for the evaluation and management of	Initial hospital inpatient or observation care, per day, for the evaluation and	Subsequent hospital care, per day, for the evaluation and management of a patient, which	Subsequent observation care, per day, for the evaluation and management of	Subsequent hospital inpatient or observation care, per day, for the	Subsequent hospital care, per day, for the evaluation and management of a patient, which	Subsequent observation care, per day, for the evaluation and management of	Subsequent hospital inpatient or observation care, per day, for the	Subsequent hospital care, per day, for the evaluation and management of a patient, which	Subsequent observation care, per day, for the evaluation and management of	Subsequent hospital inpatient or observation care, per day, for the
4		LOCATION				FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC
5		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7		TOTAL CLINICAL STAFF TIME	L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12		PRE-SERVICE PERIOD																					
13		Start: Following visit when decision for surgery/procedure made																					
28		End: When patient enters office/facility for surgery/procedure																					
29		SERVICE PERIOD																					
30		Start: When patient enters office/facility for surgery/procedure:																					
31		Pre-Service (of service period)																					
73	CA036		L037D			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
80		End: Patient leaves office/facility																					
81		POST-SERVICE PERIOD																					
82		Start: Patient leaves office/facility																					
98		End: with last office visit before end of global period																					
99	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT																			
100		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
104	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute																		
105		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	RUC Practice Expense Spreadsheet		03-2003	REC	03-2003	REC	03-2003	REC	03-2001	03-2003	REC	03-2001	REC
2			99234	99234	99235	99235	99236	99236	99238	99217D	99238	99239	99239
3	Clinical Activity Code	Meeting Date: 01/22 Tab: 13 Specialty: AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, SHM, STS, SVS	Observation or inpatient hospital care, for the evaluation and management of	Hospital inpatient or observation care, for the evaluation and management of	Observation or inpatient hospital care, for the evaluation and management of	Hospital inpatient or observation care, for the evaluation and management of	Observation or inpatient hospital care, for the evaluation and management of	Hospital inpatient or observation care, for the evaluation and management of	Hospital discharge day management; 30 minutes or less	Observation care discharge day management (This code is to be utilized to	Hospital inpatient or observation discharge day management; 30 minutes or	Hospital discharge day management; more than 30 minutes	Hospital inpatient or observation discharge day management; more than 30
4		LOCATION	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC
5		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	12.0	12.0	12.0	15.0	15.0
8		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	0.0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	12.0	12.0	12.0	15.0	15.0
10		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	0.0
11		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12		PRE-SERVICE PERIOD											
13		Start: Following visit when decision for surgery/procedure made											
28		End: When patient enters office/facility for surgery/procedure											
29		SERVICE PERIOD											
30		Start: When patient enters office/facility for surgery/procedure:											
31		Pre-Service (of service period)											
73	CA036		n/a	n/a	n/a	n/a	n/a	n/a	12	12	12	15	15
80		End: Patient leaves office/facility											
81		POST-SERVICE PERIOD											
82		Start: Patient leaves office/facility											
98		End: with last office visit before end of global period											
99	Supply Code	MEDICAL SUPPLIES											
100		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
104	Equipment Code	EQUIPMENT											
105		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

CPT Code*	Long Descriptor	Global	Total CY2023 Physician Time - before applying post-op visit increase	Total CY2023 Physician Time with RUC Recommended Office Visit, Hospital Visit and Discharge Visit Times	Change in Total Physician Time	Percent Change - Total Time	CY2023 Work RVU before applying post-op visit increase	Surgical Global Work RVU After Incorporating RUC Recommendation for Bundled Office, Hospital and Discharge Visits	Change in Work RVU	Percent Change - Work RVU	Change in Clinical Staff Time	_99204	_99211	_99212	_99213	_99214	_99215	_99231	_99232	_99233	_99238	_99239
10040	Acne surgery (eg, marsupializ	010	34	36	2	6%	0.91	1.13	0.22	24%	0			1								
10060	Incision and drainage of absc	010	57	59	2	4%	1.22	1.44	0.22	18%	0			1								
10061	Incision and drainage of absc	010	83	87	4	5%	2.45	2.89	0.44	18%	0			2								
10080	Incision and drainage of pilon	010	47	49	2	4%	1.22	1.44	0.22	18%	0			1								
10081	Incision and drainage of pilon	010	61	63	2	3%	2.50	2.72	0.22	9%	0			1								
10120	Incision and removal of foreig	010	48	50	2	4%	1.22	1.44	0.22	18%	0			1								
10121	Incision and removal of foreig	010	88	90	2	2%	2.74	2.96	0.22	8%	0			1								
10140	Incision and drainage of hema	010	66	68	2	3%	1.58	1.80	0.22	14%	0			1								
10160	Puncture aspiration of absces	010	61	63	2	3%	1.25	1.47	0.22	18%	0			1								
10180	Incision and drainage, comple	010	52	54	2	4%	2.30	2.52	0.22	10%	0			1								
11004	Debridement of skin, subcuta	000	240	237	-3	-1%	10.80	11.20	0.40	4%	0									1		
11005	Debridement of skin, subcuta	000	265	262	-3	-1%	14.24	14.64	0.40	3%	0									1		
11006	Debridement of skin, subcuta	000	270	267	-3	-1%	13.10	13.50	0.40	3%	0									1		
11200	Removal of skin tags, multiple	010	29	31	2	7%	0.82	1.04	0.22	27%	0			1								
11400	Excision, benign lesion includi	010	36	38	2	6%	0.90	1.12	0.22	24%	0			1								
11401	Excision, benign lesion includi	010	51	53	2	4%	1.28	1.50	0.22	17%	0			1								
11402	Excision, benign lesion includi	010	56	58	2	4%	1.45	1.67	0.22	15%	0			1								
11403	Excision, benign lesion includi	010	76	78	2	3%	1.84	2.06	0.22	12%	0			1								
11404	Excision, benign lesion includi	010	86	88	2	2%	2.11	2.33	0.22	10%	0			1								
11406	Excision, benign lesion includi	010	113	120	7	6%	3.52	3.85	0.33	9%	0				1							
11420	Excision, benign lesion includi	010	36	38	2	6%	1.03	1.25	0.22	21%	0			1								
11421	Excision, benign lesion includi	010	51	53	2	4%	1.47	1.69	0.22	15%	0			1								
11422	Excision, benign lesion includi	010	56	58	2	4%	1.68	1.90	0.22	13%	0			1								
11423	Excision, benign lesion includi	010	76	78	2	3%	2.06	2.28	0.22	11%	0			1								
11424	Excision, benign lesion includi	010	86	88	2	2%	2.48	2.70	0.22	9%	0			1								
11426	Excision, benign lesion includi	010	113	120	7	6%	4.09	4.42	0.33	8%	0				1							
11440	Excision, other benign lesion i	010	36	38	2	6%	1.05	1.27	0.22	21%	0			1								
11441	Excision, other benign lesion i	010	51	53	2	4%	1.53	1.75	0.22	14%	0			1								
11442	Excision, other benign lesion i	010	56	58	2	4%	1.77	1.99	0.22	12%	0			1								
11443	Excision, other benign lesion i	010	76	78	2	3%	2.34	2.56	0.22	9%	0			1								
11444	Excision, other benign lesion i	010	86	88	2	2%	3.19	3.41	0.22	7%	0			1								
11446	Excision, other benign lesion i	010	113	120	7	6%	4.80	5.13	0.33	7%	0				1							
11450	Excision of skin and subcutan	090	93.5	104	10.5	11%	3.22	3.72	0.50	15%	0				1.5							
11451	Excision of skin and subcutan	090	99.5	110	10.5	11%	4.43	4.93	0.50	11%	0				1.5							
11462	Excision of skin and subcutan	090	98.5	109	10.5	11%	3.00	3.50	0.50	17%	0				1.5							
11463	Excision of skin and subcutan	090	109.5	120	10.5	10%	4.43	4.93	0.50	11%	0				1.5							
11470	Excision of skin and subcutan	090	100.5	111	10.5	10%	3.74	4.24	0.50	13%	0				1.5							
11471	Excision of skin and subcutan	090	107.5	118	10.5	10%	4.89	5.39	0.50	10%	0				1.5							
11600	Excision, malignant lesion inc	010	48	55	7	15%	1.63	1.96	0.33	20%	0				1							
11601	Excision, malignant lesion inc	010	63	70	7	11%	2.07	2.40	0.33	16%	0				1							
11602	Excision, malignant lesion inc	010	68	75	7	10%	2.27	2.60	0.33	15%	0				1							
11603	Excision, malignant lesion inc	010	93	100	7	8%	2.82	3.15	0.33	12%	0				1							
11604	Excision, malignant lesion inc	010	103	110	7	7%	3.17	3.50	0.33	10%	0				1							
11606	Excision, malignant lesion inc	010	153	160	7	5%	5.02	5.35	0.33	7%	0				1							
11620	Excision, malignant lesion inc	010	48	55	7	15%	1.64	1.97	0.33	20%	0				1							
11621	Excision, malignant lesion inc	010	63	70	7	11%	2.08	2.41	0.33	16%	0				1							
11622	Excision, malignant lesion inc	010	68	75	7	10%	2.41	2.74	0.33	14%	0				1							
11623	Excision, malignant lesion inc	010	93	100	7	8%	3.11	3.44	0.33	11%	0				1							
11624	Excision, malignant lesion inc	010	103	110	7	7%	3.62	3.95	0.33	9%	0				1							
11626	Excision, malignant lesion inc	010	123	130	7	6%	4.61	4.94	0.33	7%	0				1							
11640	Excision, malignant lesion inc	010	48	55	7	15%	1.67	2.00	0.33	20%	0				1							
11641	Excision, malignant lesion inc	010	63	70	7	11%	2.17	2.50	0.33	15%	0				1							
11642	Excision, malignant lesion inc	010	68	75	7	10%	2.62	2.95	0.33	13%	0				1							
11643	Excision, malignant lesion inc	010	93	100	7	8%	3.42	3.75	0.33	10%	0				1							
11644	Excision, malignant lesion inc	010	108	115	7	6%	4.34	4.67	0.33	8%	0				1							
11646	Excision, malignant lesion inc	010	128	135	7	5%	6.26	6.59	0.33	5%	0				1							
11750	Excision of nail and nail matri	010	63	65	2	3%	1.58	1.80	0.22	14%	0			1								
11760	Repair of nail bed	010	63	65	2	3%	1.63	1.85	0.22	13%	0			1								
11762	Reconstruction of nail bed wi	010	111	113	2	2%	2.94	3.16	0.22	7%	0			1								

11765	Wedge excision of skin of nail	010	59	61	2	3%	1.22	1.44	0.22	18%	0			1								
11770	Excision of pilonidal cyst or si	010	71	73	2	3%	2.66	2.88	0.22	8%	0			1								
11771	Excision of pilonidal cyst or si	090	236	250.5	14.5	6%	6.09	7.44	1.35	22%	0			3.5				1.5			1	
11772	Excision of pilonidal cyst or si	090	269	284.5	15.5	6%	7.35	8.81	1.46	20%	0			4				1.5			1	
11960	Insertion of tissue expander(s	090	357	408	51	14%	11.49	14.13	2.64	23%	0			1	7						0.5	
11970	Replacement of tissue expan	090	216	227	11	5%	7.49	8.37	0.88	12%	0			2	1						0.5	
11971	Removal of tissue expander w	090	215	228	13	6%	7.02	8.12	1.10	16%	0			3	1						0.5	
12020	Treatment of superficial wou	010	64	66	2	3%	2.67	2.89	0.22	8%	0			1								
12021	Treatment of superficial wou	010	51	53	2	4%	1.89	2.11	0.22	12%	0			1								
12031	Repair, intermediate, wounds	010	56	58	2	4%	2.00	2.22	0.22	11%	0			1								
12032	Repair, intermediate, wounds	010	68	70	2	3%	2.52	2.74	0.22	9%	0			1								
12034	Repair, intermediate, wounds	010	85	87	2	2%	2.97	3.19	0.22	7%	0			1								
12035	Repair, intermediate, wounds	010	124	126	2	2%	3.50	3.83	0.33	9%	0			1							0.5	
12036	Repair, intermediate, wounds	010	138	140	2	1%	4.23	4.56	0.33	8%	0			1							0.5	
12037	Repair, intermediate, wounds	010	158	160	2	1%	5.00	5.33	0.33	7%	0			1							0.5	
12041	Repair, intermediate, wounds	010	59	61	2	3%	2.10	2.32	0.22	10%	0			1								
12042	Repair, intermediate, wounds	010	69	71	2	3%	2.79	3.01	0.22	8%	0			1								
12044	Repair, intermediate, wounds	010	85	87	2	2%	3.19	3.41	0.22	7%	0			1								
12045	Repair, intermediate, wounds	010	146	155	9	6%	3.75	4.41	0.66	18%	0			1	1						0.5	
12046	Repair, intermediate, wounds	010	164	173	9	5%	4.30	4.96	0.66	15%	0			1	1						0.5	
12047	Repair, intermediate, wounds	010	185	194	9	5%	4.95	5.61	0.66	13%	0			1	1						0.5	
12051	Repair, intermediate, wounds	010	58	60	2	3%	2.33	2.55	0.22	9%	0			1								
12052	Repair, intermediate, wounds	010	70	72	2	3%	2.87	3.09	0.22	8%	0			1								
12053	Repair, intermediate, wounds	010	80	82	2	2%	3.17	3.39	0.22	7%	0			1								
12054	Repair, intermediate, wounds	010	96	98	2	2%	3.50	3.72	0.22	6%	0			1								
12055	Repair, intermediate, wounds	010	152	161	9	6%	4.50	5.16	0.66	15%	0			1	1						0.5	
12056	Repair, intermediate, wounds	010	162	171	9	6%	5.30	5.96	0.66	12%	0			1	1						0.5	
12057	Repair, intermediate, wounds	010	184	193	9	5%	6.00	6.66	0.66	11%	0			1	1						0.5	
13100	Repair, complex, trunk; 1.1 cr	010	69	71	2	3%	3.00	3.22	0.22	7%	0			1								
13101	Repair, complex, trunk; 2.6 cr	010	82	84	2	2%	3.50	3.72	0.22	6%	0			1								
13120	Repair, complex, scalp, arms,	010	74	76	2	3%	3.23	3.45	0.22	7%	0			1								
13121	Repair, complex, scalp, arms,	010	85	87	2	2%	4.00	4.22	0.22	5%	0			1								
13131	Repair, complex, forehead, ch	010	92	94	2	2%	3.73	3.95	0.22	6%	0			1								
13132	Repair, complex, forehead, ch	010	97	99	2	2%	4.78	5.00	0.22	5%	0			1								
13151	Repair, complex, eyelids, nose	010	95	97	2	2%	4.34	4.56	0.22	5%	0			1								
13152	Repair, complex, eyelids, nose	010	100	102	2	2%	5.34	5.56	0.22	4%	0			1								
13160	Secondary closure of surgical	090	363	403.5	40.5	11%	12.04	14.18	2.14	18%	0				4			2.5			1	
14000	Adjacent tissue transfer or re	090	191.5	216	24.5	13%	6.37	7.53	1.16	18%	0				3.5							
14001	Adjacent tissue transfer or re	090	291	319	28	10%	8.78	10.21	1.43	16%	0				4						0.5	
14020	Adjacent tissue transfer or re	090	223	251	28	13%	7.22	8.54	1.32	18%	0				4							
14021	Adjacent tissue transfer or re	090	288	316	28	10%	9.72	11.04	1.32	14%	0				4							
14040	Adjacent tissue transfer or re	090	223	241	18	8%	8.60	9.70	1.10	13%	0			2	2							
14041	Adjacent tissue transfer or re	090	303	331	28	9%	10.83	12.15	1.32	12%	0				4							
14060	Adjacent tissue transfer or re	090	183	201	18	10%	9.23	10.33	1.10	12%	0			2	2							
14061	Adjacent tissue transfer or re	090	341.5	373	31.5	9%	11.48	12.97	1.49	13%	0				4.5							
14301	Adjacent tissue transfer or re	090	287	310	23	8%	12.65	13.97	1.32	10%	0			1	3						0.5	
14350	Filleted finger or toe flap, incl	090	318.5	350	31.5	10%	11.05	12.65	1.60	14%	0				4.5						0.5	
15050	Pinch graft, single or multiple	090	190	218	28	15%	5.57	6.89	1.32	24%	0				4							
15100	Split-thickness autograft, trur	090	281	304	23	8%	9.90	11.46	1.56	16%	0			2	2			1			1	
15110	Epidermal autograft, trunk, ar	090	306	296	-10	-3%	10.97	12.43	1.46	13%	0			3					4			
15115	Epidermal autograft, face, sca	090	356	346	-10	-3%	11.28	12.96	1.68	15%	0			3					4		1	
15120	Split-thickness autograft, face	090	258	274	16	6%	10.15	11.14	0.99	10%	0			1	2						0.5	
15130	Dermal autograft, trunk, arm	090	215	219	4	2%	7.53	8.83	1.30	17%	0			4					1		1	
15135	Dermal autograft, face, scalp,	090	223	227	4	2%	11.03	12.33	1.30	12%	0			4					1		1	
15150	Tissue cultured skin autograft	090	326	320	-6	-2%	9.39	10.87	1.48	16%	0			3					3		1	
15155	Tissue cultured skin autograft	090	336	330	-6	-2%	10.14	11.62	1.48	15%	0			3					3		1	
15200	Full thickness graft, free, inclu	090	287.5	312	24.5	9%	9.15	10.53	1.38	15%	0				3.5						1	
15220	Full thickness graft, free, inclu	090	250	259	9	4%	8.09	9.19	1.10	14%	0			4.5							0.5	
15240	Full thickness graft, free, inclu	090	288	320	32	11%	10.41	12.28	1.87	18%	0			2	4						0.5	
15260	Full thickness graft, free, inclu	090	273	308	35	13%	11.64	13.29	1.65	14%	0				5							
15570	Formation of direct or tubed	090	363	393	30	8%	10.21	11.97	1.76	17%	-2			1	2	1		1			1	
15572	Formation of direct or tubed	090	297	320	23	8%	10.12	11.44	1.32	13%	0			1	3						0.5	
15574	Formation of direct or tubed	090	314	337	23	7%	10.70	12.02	1.32	12%	0			1	3						0.5	
15576	Formation of direct or tubed	090	271	287	16	6%	9.37	10.36	0.99	11%	0			1	2						0.5	
15600	Delay of flap or sectioning of	090	179	183	4	2%	2.01	2.56	0.55	27%	0			2							0.5	
15610	Delay of flap or sectioning of	090	179	183	4	2%	2.52	3.07	0.55	22%	0			2							0.5	

15620	Delay of flap or sectioning of	090	175.5	193	17.5	10%	3.75	4.58	0.83	22%	0				2.5							
15630	Delay of flap or sectioning of	090	181.5	199	17.5	10%	4.08	4.91	0.83	20%	0				2.5							
15650	Transfer, intermediate, of any	090	221.5	239	17.5	8%	4.77	5.71	0.94	20%	0				2.5						0.5	
15730	Midface flap (ie, zygomaticofa	090	255.5	268.5	13	5%	13.50	14.60	1.10	8%	0			3	1						0.5	
15731	Forehead flap with preservati	090	369	401	32	9%	14.38	16.12	1.74	12%	-2			1	3	1					0.5	
15733	Muscle, myocutaneous, or fas	090	305	323	18	6%	15.68	16.89	1.21	8%	0			2	2						0.5	
15734	Muscle, myocutaneous, or fas	090	596	617	21	4%	23.00	25.78	2.78	12%	-2			2	2	1		1	2	1	1	
15736	Muscle, myocutaneous, or fas	090	396	428	32	8%	17.04	18.78	1.74	10%	-2			1	3	1					0.5	
15738	Muscle, myocutaneous, or fas	090	516	548	32	6%	19.04	21.68	2.64	14%	0			1	4			2	2		1	
15740	Flap; island pedicle requiring	090	365.5	402	36.5	10%	11.80	13.75	1.95	16%	0				4.5			1			1	
15750	Flap; neurovascular pedicle	090	400.5	437	36.5	9%	12.96	14.91	1.95	15%	0				4.5			1			1	
15756	Free muscle or myocutaneous	090	809	869	60	7%	36.94	40.40	3.46	9%	-2		1	3	2			8			1	
15757	Free skin flap with microvascu	090	829	880	51	6%	37.15	40.57	3.42	9%	-2		1	3	2			7	1		1	
15758	Free fascial flap with microva	090	809	855	46	6%	36.90	40.08	3.18	9%	-2		1	3	2			6	1		1	
15760	Graft; composite (eg, full thic	090	278.5	303	24.5	9%	9.86	11.13	1.27	13%	0				3.5						0.5	
15769	Grafting of autologous soft tis	090	191	202	11	6%	6.68	7.67	0.99	15%	0			2	1						1	
15770	Graft; derma-fat-fascia	090	302.5	334	31.5	10%	8.96	10.56	1.60	18%	0				4.5						0.5	
15771	Grafting of autologous fat har	090	181	192	11	6%	6.73	7.50	0.77	11%	0			2	1							
15773	Grafting of autologous fat har	090	180	191	11	6%	6.83	7.60	0.77	11%	0			2	1							
15780	Dermabrasion; total face (eg,	090	244.5	276	31.5	13%	8.73	10.33	1.60	18%	0				4.5						0.5	
15781	Dermabrasion; segmental, fac	090	144	151	7	5%	5.02	5.79	0.77	15%	0			3.5								
15782	Dermabrasion; regional, othe	090	123	128	5	4%	4.44	4.99	0.55	12%	0			2.5								
15783	Dermabrasion; superficial, an	090	117	122	5	4%	4.41	4.96	0.55	12%	0			2.5								
15786	Abrasion; single lesion (eg, ke	010	53	55	2	4%	2.08	2.30	0.22	11%	0			1								
15793	Chemical peel, nonfacial; derr	090	175	184	9	5%	3.96	4.95	0.99	25%	0			4.5								
15819	Cervicoplasty	090	316	344	28	9%	10.65	12.08	1.43	13%	0				4						0.5	
15820	Blepharoplasty, lower eyelid;	090	178.5	203	24.5	14%	6.27	7.43	1.16	18%	0				3.5							
15821	Blepharoplasty, lower eyelid;	090	191.5	216	24.5	13%	6.84	8.00	1.16	17%	0				3.5							
15822	Blepharoplasty, upper eyelid;	090	151	158	7	5%	4.62	5.39	0.77	17%	0			3.5								
15823	Blepharoplasty, upper eyelid;	090	161	174	13	8%	6.81	7.91	1.10	16%	0			3	1						0.5	
15830	Excision, excessive skin and s	090	429	455	26	6%	17.11	19.20	2.09	12%	0			2	3			1	1		1	
15832	Excision, excessive skin and s	090	364	392	28	8%	12.85	14.39	1.54	12%	0				4						1	
15833	Excision, excessive skin and s	090	342	370	28	8%	11.90	13.44	1.54	13%	0				4						1	
15834	Excision, excessive skin and s	090	352	382.5	30.5	9%	12.17	13.83	1.66	14%	0				4			0.5			1	
15835	Excision, excessive skin and s	090	344	374.5	30.5	9%	12.99	14.65	1.66	13%	0				4			0.5			1	
15836	Excision, excessive skin and s	090	302	330	28	9%	10.61	12.04	1.43	13%	0				4						0.5	
15837	Excision, excessive skin and s	090	239.5	264	24.5	10%	9.55	10.71	1.16	12%	0				3.5							
15838	Excision, excessive skin and s	090	205.5	230	24.5	12%	8.25	9.41	1.16	14%	0				3.5							
15839	Excision, excessive skin and s	090	274.5	299	24.5	9%	10.50	11.77	1.27	12%	0				3.5						0.5	
15840	Graft for facial nerve paralysi	090	443.5	487.5	44	10%	14.99	17.30	2.31	15%	0				4.5			2.5			1	
15841	Graft for facial nerve paralysi	090	769	846	77	10%	25.99	29.87	3.88	15%	0				6			7			1	
15842	Graft for facial nerve paralysi	090	963.5	1051.5	88	9%	41.01	45.42	4.41	11%	0				6.5			8.5			1	
15845	Graft for facial nerve paralysi	090	460.5	499	38.5	8%	14.32	16.36	2.04	14%	0				5.5						1	
15920	Excision, coccygeal pressure u	090	294	308	14	5%	8.29	9.74	1.45	17%	0			4.5				1			1	
15922	Excision, coccygeal pressure u	090	354	374	20	6%	10.38	12.18	1.80	17%	0			5				2			1	
15931	Excision, sacral pressure ulcer	090	334	368.5	34.5	10%	10.07	12.38	2.31	23%	0			3.5				5.5			1	
15933	Excision, sacral pressure ulcer	090	403	441.5	38.5	10%	11.77	14.52	2.75	23%	0			5.5				5.5			1	
15934	Excision, sacral pressure ulcer	090	441	482.5	41.5	9%	13.68	16.45	2.77	20%	0			4.5				6.5			1	
15935	Excision, sacral pressure ulcer	090	524	574.5	50.5	10%	15.78	19.23	3.45	22%	0			6.5				7.5			1	
15936	Excision, sacral pressure ulcer	090	399	432	33	8%	13.16	15.46	2.30	17%	0			4				5			1	
15937	Excision, sacral pressure ulcer	090	466	505	39	8%	15.14	17.79	2.65	18%	0			4.5				6			1	
15940	Excision, ischial pressure ulce	090	340	376	36	11%	10.20	12.52	2.32	23%	0			3				6			1	
15941	Excision, ischial pressure ulce	090	418	459	41	10%	12.41	15.28	2.87	23%	0			5.5				6			1	
15944	Excision, ischial pressure ulce	090	441	482	41	9%	12.44	15.31	2.87	23%	0			5.5				6			1	
15945	Excision, ischial pressure ulce	090	473	517.5	44.5	9%	13.75	16.85	3.10	23%	0			6				6.5			1	
15946	Excision, ischial pressure ulce	090	650	723.5	73.5	11%	24.12	27.82	3.70	15%	-8					4		7.5			1	
15950	Excision, trochanteric pressur	090	282	302.5	20.5	7%	8.03	9.73	1.70	21%	0			4				2.5			1	
15951	Excision, trochanteric pressur	090	389	425	36	9%	11.58	14.21	2.63	23%	0			5.5				5			1	
15952	Excision, trochanteric pressur	090	430	468.5	38.5	9%	12.31	15.06	2.75	22%	0			5.5				5.5			1	
15953	Excision, trochanteric pressur	090	454	493.5	39.5	9%	13.57	16.43	2.86	21%	0			6				5.5			1	
15956	Excision, trochanteric pressur	090	568	621	53	9%	16.79	20.36	3.57	21%	0			6.5				8			1	
15958	Excision, trochanteric pressur	090	572	625	53	9%	16.75	20.32	3.57	21%	0			6.5				8			1	
17000	Destruction (eg, laser surgery	010	23	25	2	9%	0.61	0.83	0.22	36%	0			1								
17004	Destruction (eg, laser surgery	010	35	37	2	6%	1.37	1.59	0.22	16%	0			1								
17106	Destruction of cutaneous vas	090	86	95	9	10%	3.69	4.24	0.55	15%	0			1	1							
17107	Destruction of cutaneous vas	090	112	123	11	10%	4.79	5.56	0.77	16%	0			2	1							

17108	Destruction of cutaneous vas	090	148	161	13	9%	7.49	8.48	0.99	13%	0			3	1							
17110	Destruction (eg, laser surgery	010	29	31	2	7%	0.70	0.92	0.22	31%	0			1								
17111	Destruction (eg, laser surgery	010	31	33	2	6%	0.97	1.19	0.22	23%	0			1								
17260	Destruction, malignant lesion	010	46	48	2	4%	0.96	1.18	0.22	23%	0			1								
17261	Destruction, malignant lesion	010	47	49	2	4%	1.22	1.44	0.22	18%	0			1								
17262	Destruction, malignant lesion	010	50	52	2	4%	1.63	1.85	0.22	13%	0			1								
17263	Destruction, malignant lesion	010	56	58	2	4%	1.84	2.06	0.22	12%	0			1								
17264	Destruction, malignant lesion	010	64	66	2	3%	1.99	2.21	0.22	11%	0			1								
17266	Destruction, malignant lesion	010	67	69	2	3%	2.39	2.61	0.22	9%	0			1								
17270	Destruction, malignant lesion	010	45	47	2	4%	1.37	1.59	0.22	16%	0			1								
17271	Destruction, malignant lesion	010	49	51	2	4%	1.54	1.76	0.22	14%	0			1								
17272	Destruction, malignant lesion	010	52	54	2	4%	1.82	2.04	0.22	12%	0			1								
17273	Destruction, malignant lesion	010	56	58	2	4%	2.10	2.32	0.22	10%	0			1								
17274	Destruction, malignant lesion	010	62	64	2	3%	2.64	2.86	0.22	8%	0			1								
17276	Destruction, malignant lesion	010	70	72	2	3%	3.25	3.47	0.22	7%	0			1								
17280	Destruction, malignant lesion	010	45	47	2	4%	1.22	1.44	0.22	18%	0			1								
17281	Destruction, malignant lesion	010	47	49	2	4%	1.77	1.99	0.22	12%	0			1								
17282	Destruction, malignant lesion	010	55	57	2	4%	2.09	2.31	0.22	11%	0			1								
17283	Destruction, malignant lesion	010	60	62	2	3%	2.69	2.91	0.22	8%	0			1								
17284	Destruction, malignant lesion	010	66	68	2	3%	3.20	3.42	0.22	7%	0			1								
17286	Destruction, malignant lesion	010	78	80	2	3%	4.48	4.70	0.22	5%	0			1								
17340	Cryotherapy (CO2 slush, liqui	010	16.5	16.5	0	0%	0.77	0.77	-	0%	-1		0.5									
17360	Chemical exfoliation for acne	010	29	30	1	3%	1.46	1.57	0.11	8%	0			0.5								
19020	Mastotomy with exploration	090	177	183	6	3%	3.83	4.60	0.77	20%	0			3							0.5	
19101	Biopsy of breast; open, incisio	010	116	118	2	2%	3.23	3.45	0.22	7%	0			1								
19110	Nipple exploration, with or w	090	144	150	6	4%	4.44	5.10	0.66	15%	0			3								
19112	Excision of lactiferous duct fis	090	137	143	6	4%	3.81	4.47	0.66	17%	0			3								
19120	Excision of cyst, fibroadenom	090	136	145	9	7%	5.92	6.47	0.55	9%	0			1	1							
19125	Excision of breast lesion ident	090	196	210	14	7%	6.69	7.35	0.66	10%	0				2							
19296	Placement of radiotherapy af	000	119	119	0	0%	3.63	3.74	0.11	3%	0										0.5	
19298	Placement of radiotherapy af	000	164	164	0	0%	5.75	5.86	0.11	2%	0										0.5	
19300	Mastectomy for gynecomasti	090	184	191	7	4%	5.31	6.19	0.88	17%	0			3.5							0.5	
19301	Mastectomy, partial (eg, lum	090	216	232	16	7%	10.13	11.12	0.99	10%	0			1	2						0.5	
19302	Mastectomy, partial (eg, lum	090	276	294	18	7%	13.99	15.07	1.08	8%	-2			1	1	1					0.5	
19303	Mastectomy, simple, complet	090	283	306	23	8%	15.00	16.19	1.19	8%	-2				2	1					0.5	
19305	Mastectomy, radical, includin	090	463.5	517.5	54	12%	17.46	20.25	2.79	16%	0				4.5			4.5			1	
19306	Mastectomy, radical, includin	090	544.5	610.5	66	12%	18.13	21.49	3.36	19%	0				5.5			5.5			1	
19307	Mastectomy, modified radica	090	343	373	30	9%	17.99	19.51	1.52	8%	-2				3	1					0.5	
19316	Mastopexy	090	301	319	18	6%	11.09	12.30	1.21	11%	0			2	2						0.5	
19318	Breast reduction	090	367	385	18	5%	16.03	17.24	1.21	8%	0			2	2						0.5	
19325	Breast augmentation with im	090	225	233	8	4%	8.12	9.11	0.99	12%	0			4							0.5	
19328	Removal of intact breast impl	090	199	210	11	6%	7.44	8.32	0.88	12%	0			2	1						0.5	
19330	Removal of ruptured breast in	090	229	240	11	5%	9.00	9.88	0.88	10%	0			2	1						0.5	
19340	Insertion of breast implant or	090	261	279	18	7%	10.48	11.69	1.21	12%	0			2	2						0.5	
19342	Insertion or replacement of b	090	252	265	13	5%	10.48	11.58	1.10	10%	0			3	1						0.5	
19350	Nipple/areola reconstruction	090	229	237	8	3%	9.11	9.99	0.88	10%	0			4								
19355	Correction of inverted nipples	090	206	227	21	10%	8.52	9.51	0.99	12%	0				3							
19357	Tissue expander placement in	090	344	383	39	11%	14.84	17.04	2.20	15%	0			2	5						0.5	
19361	Breast reconstruction; with la	090	552	578	26	5%	23.36	25.58	2.22	10%	0			3	2			2	1		1	
19364	Breast reconstruction; with fr	090	767	775	8	1%	42.58	44.85	2.27	5%	-2		1	4	1			1	3		1	
19367	Breast reconstruction; with si	090	590	630	40	7%	26.80	29.04	2.24	8%	-2			1	2	1		3			1	
19368	Breast reconstruction; with si	090	770	824	54	7%	33.90	36.80	2.90	9%	-4			1	2	2		4			1	
19369	Breast reconstruction; with b	090	690	739	49	7%	31.31	33.97	2.66	8%	-4			1	2	2		3			1	
19370	Revision of peri-implant capsu	090	255	276	21	8%	9.17	10.27	1.10	12%	0				3						0.5	
19371	Peri-implant capsulectomy, b	090	261	277	16	6%	9.98	10.97	0.99	10%	0			1	2						0.5	
19380	Revision of reconstructed bre	090	307	325	18	6%	11.17	12.38	1.21	11%	0			2	2						0.5	
20100	Exploration of penetrating wo	010	266	283	17	6%	10.38	11.41	1.03	10%	0				1			2			1	
20101	Exploration of penetrating wo	010	97	97	0	0%	3.23	3.23	-	0%	-2		1									
20102	Exploration of penetrating wo	010	106	108	2	2%	3.98	4.20	0.22	6%	0			1								
20103	Exploration of penetrating wo	010	136	138	2	1%	5.34	5.56	0.22	4%	0			1								
20150	Excision of epiphyseal bar, wi	090	337	363	26	8%	14.75	16.20	1.45	10%	0				3			1			1	
20250	Biopsy, vertebral body, open;	010	248	255	7	3%	5.19	5.87	0.68	13%	0			1				1			1	
20251	Biopsy, vertebral body, open;	010	238	245	7	3%	5.72	6.40	0.68	12%	0			1				1			1	
20500	Injection of sinus tract; therap	010	56	58	2	4%	1.28	1.50	0.22	17%	0			1								
20520	Removal of foreign body in m	010	65	67	2	3%	1.90	2.12	0.22	12%	0			1								
20525	Removal of foreign body in m	010	136	138	2	1%	3.54	3.87	0.33	9%	0			1							0.5	

20615	Aspiration and injection for tr	010	88	90	2	2%	2.33	2.55	0.22	9%	0			1								
20650	Insertion of wire or pin with a	010	114	116	2	2%	2.28	2.61	0.33	14%	0			1							0.5	
20661	Application of halo, including	090	266	281.5	15.5	6%	5.26	6.72	1.46	28%	0			4				1.5			1	
20662	Application of halo, including	090	285	298	13	5%	6.38	7.72	1.34	21%	0			4				1			1	
20663	Application of halo, including	090	264	277	13	5%	5.74	7.08	1.34	23%	0			4				1			1	
20664	Application of halo, including	090	405	440	35	9%	10.06	12.48	2.42	24%	0				4			2		1	1	
20665	Removal of tongs or halo app	010	57	59	2	4%	1.36	1.58	0.22	16%	0			1								
20670	Removal of implant; superfici	010	57	59	2	4%	1.79	2.01	0.22	12%	0			1								
20680	Removal of implant; deep (eg	090	181	185	4	2%	5.96	6.51	0.55	9%	0			2							0.5	
20690	Application of a uniplane (pin	090	300	317	17	6%	8.78	10.32	1.54	18%	0			1	2			1	1		1	
20692	Application of a multiplane (p	090	474	518	44	9%	16.27	19.08	2.81	17%	0			4	3			3			1	
20693	Adjustment or revision of ext	090	208	216.5	8.5	4%	6.06	7.06	1.00	17%	0			3				0.5			1	
20694	Removal, under anesthesia, o	090	140	145	5	4%	4.28	4.94	0.66	15%	0			2.5							0.5	
20696	Application of multiplane (pin	090	468	505	37	8%	17.56	19.91	2.35	13%	0			3	3			2			1	
20802	Replantation, arm (includes s	090	1041	1107	66	6%	42.62	46.35	3.73	9%	-2			3	3	1		6			1	
20805	Replantation, forearm (includ	090	1012	1078	66	7%	51.46	55.19	3.73	7%	-2			3	3	1		6			1	
20808	Replantation, hand (includes	090	1112	1173	61	5%	63.09	66.58	3.49	6%	-2			3	3	1		5			1	
20816	Replantation, digit, excluding	090	697	747	50	7%	31.95	34.80	2.85	9%	0			2	3			5			1	
20822	Replantation, digit, excluding	090	590	632	42	7%	26.66	29.25	2.59	10%	0			3	3			3			1	
20824	Replantation, thumb (include	090	690	740	50	7%	31.95	34.80	2.85	9%	0			2	3			5			1	
20827	Replantation, thumb (include	090	625	672	47	8%	27.48	30.31	2.83	10%	0			3	3			4			1	
20838	Replantation, foot, complete	090	986	1062	76	8%	42.88	47.09	4.21	10%	-2			3	3	1		8			1	
20910	Cartilage graft; costochondra	090	227	235	8	4%	5.53	6.52	0.99	18%	0			4							0.5	
20912	Cartilage graft; nasal septum	090	256	264	8	3%	6.54	7.53	0.99	15%	0			4							0.5	
20920	Fascia lata graft; by stripper	090	195	203.5	8.5	4%	5.51	6.51	1.00	18%	0			3				0.5			1	
20922	Fascia lata graft; by incision a	090	224	237.5	13.5	6%	6.93	8.17	1.24	18%	0			3				1.5			1	
20924	Tendon graft, from a distance	090	194	202.5	8.5	4%	6.68	7.68	1.00	15%	0			3				0.5			1	
20955	Bone graft with microvascula	090	957	1014	57	6%	40.26	43.57	3.31	8%	0			3	3			6			1	
20956	Bone graft with microvascula	090	894	963	69	8%	41.18	45.32	4.14	10%	0			5	2			9			1	
20957	Bone graft with microvascula	090	930	1001	71	8%	42.61	46.97	4.36	10%	0			6	2			9			1	
20969	Free osteocutaneous flap wit	090	1048	1124	76	7%	45.43	49.51	4.08	9%	-4			2	2	2		8			1	
20970	Free osteocutaneous flap wit	090	988	1064	76	8%	44.58	48.66	4.08	9%	-4			2	2	2		8			1	
20972	Free osteocutaneous flap wit	090	898	959	61	7%	44.51	47.87	3.36	8%	-4			2	2	2		5			1	
20973	Free osteocutaneous flap wit	090	988	1049	61	6%	47.27	50.63	3.36	7%	-4			2	2	2		5			1	
21010	Arthrotomy, temporomandib	090	337	351	14	4%	11.04	12.69	1.65	15%	0			3	1			1	1		1	
21011	Excision, tumor, soft tissue of	090	107	116	9	8%	2.99	3.54	0.55	18%	0			1	1							
21012	Excision, tumor, soft tissue of	090	148	157	9	6%	4.45	5.11	0.66	15%	0			1	1						0.5	
21013	Excision, tumor, soft tissue of	090	174	183	9	5%	5.42	6.08	0.66	12%	0			1	1						0.5	
21014	Excision, tumor, soft tissue of	090	217	233	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
21015	Radical resection of tumor (e	090	277	300	23	8%	9.89	11.21	1.32	13%	0			1	3						0.5	
21016	Radical resection of tumor (e	090	398	424	26	7%	15.26	17.22	1.96	13%	-2			1	2	1		1	1		1	
21025	Excision of bone (eg, for oste	090	283	301	18	6%	10.03	11.13	1.10	11%	0			2	2							
21026	Excision of bone (eg, for oste	090	261	284	23	9%	5.70	7.26	1.56	27%	0			2	2			1			1	
21029	Removal by contouring of ber	090	196	212	16	8%	8.39	9.38	0.99	12%	0			1	2						0.5	
21030	Excision of benign tumor or c	090	133	144	11	8%	4.91	5.68	0.77	16%	0			2	1							
21031	Excision of torus mandibularis	090	93	95	2	2%	3.30	3.52	0.22	7%	-2		1	1								
21032	Excision of maxillary torus pa	090	125	129	4	3%	3.34	3.78	0.44	13%	0			2								
21034	Excision of malignant tumor c	090	365	395	30	8%	17.38	19.14	1.76	10%	-2			1	2	1		1			1	
21040	Excision of benign tumor or c	090	137	148	11	8%	4.91	5.68	0.77	16%	0			2	1							
21044	Excision of malignant tumor c	090	325	350	25	8%	12.80	14.45	1.65	13%	-2			2	1	1		1			1	
21045	Excision of malignant tumor c	090	599	629	30	5%	18.37	21.19	2.82	15%	-2			2	2	1		2	1	1	1	
21046	Excision of benign tumor or c	090	400	432	32	8%	14.21	16.32	2.11	15%	0			3	3			1			1	
21047	Excision of benign tumor or c	090	565	602	37	7%	20.07	22.42	2.35	12%	0			3	3			2			1	
21048	Excision of benign tumor or c	090	400	432	32	8%	14.71	16.82	2.11	14%	0			3	3			1			1	
21049	Excision of benign tumor or c	090	550	587	37	7%	19.32	21.67	2.35	12%	0			3	3			2			1	
21050	Condylectomy, temporomand	090	377	404	27	7%	11.76	13.63	1.87	16%	-2			3	1	1		1			1	
21060	Meniscectomy, partial or com	090	334	357	23	7%	11.07	12.63	1.56	14%	0			2	2			1			1	
21070	Coronoidectomy (separate pr	090	246	257	11	4%	8.62	9.50	0.88	10%	-2		1	2	1						0.5	
21073	Manipulation of temporoman	090	134	142	8	6%	3.45	4.33	0.88	26%	0			4								
21100	Application of halo type appli	090	232	247	15	6%	4.73	6.05	1.32	28%	0			4	1						0.5	
21110	Application of interdental fixa	090	239	259	20	8%	5.99	7.31	1.32	22%	0			3	2							
21120	Genioplasty; augmentation (a	090	184	191	7	4%	5.10	5.87	0.77	15%	0			3.5								
21121	Genioplasty; sliding osteotom	090	193	200	7	4%	7.81	8.58	0.77	10%	0			3.5								
21122	Genioplasty; sliding osteotom	090	247	255	8	3%	8.71	9.70	0.99	11%	0			4							0.5	
21123	Genioplasty; sliding, augment	090	297	305	8	3%	11.34	12.44	1.10	10%	0			4							1	
21125	Augmentation, mandibular bo	090	297	305	8	3%	10.80	11.90	1.10	10%	0			4							1	

21127	Augmentation, mandibular bo	090	358	388.5	30.5	9%	12.44	14.10	1.66	13%	0				4			0.5			1	
21137	Reduction forehead; contouri	090	310	321	11	4%	10.24	11.23	0.99	10%	-2		1	2	1						1	
21138	Reduction forehead; contouri	090	400	416	16	4%	12.87	13.97	1.10	9%	-2		1	1	2						1	
21139	Reduction forehead; contouri	090	466	482	16	3%	15.02	16.25	1.23	8%	-2		1	2	1			1			1	
21141	Reconstruction midface, LeFo	090	474	515	41	9%	19.57	22.23	2.66	14%	-2			4	2	1		2			1	
21142	Reconstruction midface, LeFo	090	485	526	41	8%	20.28	22.94	2.66	13%	-2			4	2	1		2			1	
21143	Reconstruction midface, LeFo	090	497	538	41	8%	21.05	23.71	2.66	13%	-2			4	2	1		2			1	
21145	Reconstruction midface, LeFo	090	515	564.5	49.5	10%	23.94	26.50	2.56	11%	0				6			1.5			1	
21146	Reconstruction midface, LeFo	090	567.5	623	55.5	10%	24.87	27.72	2.85	11%	0				6.5			2			1	
21147	Reconstruction midface, LeFo	090	707.5	765.5	58	8%	26.47	29.44	2.97	11%	0				6.5			2.5			1	
21150	Reconstruction midface, LeFo	090	623	646	23	4%	25.96	27.52	1.56	6%	-4		2	2	2			1			1	
21151	Reconstruction midface, LeFo	090	686	714	28	4%	29.02	30.82	1.80	6%	-4		2	2	2			2			1	
21154	Reconstruction midface, LeFo	090	853	891.5	38.5	5%	31.29	33.57	2.28	7%	-5		2	2	1		1	2.5			1	
21155	Reconstruction midface, LeFo	090	939	975	36	4%	35.22	37.38	2.16	6%	-5		2	2	1		1	2			1	
21159	Reconstruction midface, LeFo	090	986	1027	41	4%	43.14	45.54	2.40	6%	-5		2	2	1		1	3			1	
21160	Reconstruction midface, LeFo	090	1121	1137	16	1%	47.19	49.37	2.18	5%	-5		2	2	1		1		2.5		1	
21172	Reconstruction superior-later	090	641	646	5	1%	28.20	29.49	1.29	5%	-4		2	2	1				1.5		1	
21175	Reconstruction, bifrontal, sup	090	731	738	7	1%	33.56	34.75	1.19	4%	-4		2	2	1				1		1	
21179	Reconstruction, entire or maj	090	590	601	11	2%	22.65	23.64	0.99	4%	-2		1	2	1						1	
21180	Reconstruction, entire or maj	090	670	681	11	2%	25.58	26.57	0.99	4%	-2		1	2	1						1	
21181	Reconstruction by contouring	090	396	410	14	4%	10.28	11.29	1.01	10%	-4		2	1	1			1			1	
21182	Reconstruction of orbital wall	090	801	808	7	1%	32.58	33.77	1.19	4%	-4		2	2	1				1		1	
21183	Reconstruction of orbital wall	090	891	894	3	0%	35.70	37.09	1.39	4%	-4		2	2	1				2		1	
21184	Reconstruction of orbital wall	090	996	999	3	0%	38.62	40.01	1.39	4%	-4		2	2	1				2		1	
21188	Reconstruction midface, oste	090	572	599	27	5%	23.15	24.63	1.48	6%	-5		2		1		1	1			1	
21193	Reconstruction of mandibular	090	386	428.5	42.5	11%	18.90	21.13	2.23	12%	0				5			1.5			1	
21194	Reconstruction of mandibular	090	482.5	531	48.5	10%	21.82	24.34	2.52	12%	0				5.5			2			1	
21195	Reconstruction of mandibular	090	384.5	430.5	46	12%	19.16	21.56	2.40	13%	0				5.5			1.5			1	
21196	Reconstruction of mandibular	090	411.5	457.5	46	11%	20.83	23.23	2.40	11%	0				5.5			1.5			1	
21198	Osteotomy, mandible, segme	090	359.5	396	36.5	10%	15.71	17.66	1.95	12%	0				4.5			1			1	
21199	Osteotomy, mandible, segme	090	283	290	7	2%	16.73	17.92	1.19	7%	0			2	1				1		1	
21206	Osteotomy, maxilla, segment	090	361.5	395.5	34	9%	15.59	17.42	1.83	12%	0				4.5			0.5			1	
21208	Osteoplasty, facial bones; aug	090	320	349	29	9%	11.42	13.27	1.85	16%	-2			3	2	1					0.5	
21209	Osteoplasty, facial bones; red	090	270	297	27	10%	7.82	9.58	1.76	23%	0			3	3						0.5	
21210	Graft, bone; nasal, maxillary c	090	318	352	34	11%	11.69	13.54	1.85	16%	-2			2	3	1						
21215	Graft, bone; mandible (includ	090	334	368	34	10%	12.23	14.08	1.85	15%	-2			2	3	1						
21230	Graft; rib cartilage, autogenou	090	342	353	11	3%	11.17	12.16	0.99	9%	0			2	1						1	
21235	Graft; ear cartilage, autogenc	090	265	285	20	8%	7.50	8.93	1.43	19%	0			3	2						0.5	
21240	Arthroplasty, temporomandib	090	425	472	47	11%	16.07	18.51	2.44	15%	0				6			1			1	
21242	Arthroplasty, temporomandib	090	402	432	30	7%	14.59	16.99	2.40	16%	-2			3	2	1		1	1		1	
21243	Arthroplasty, temporomandib	090	751	827	76	10%	24.53	28.73	4.20	17%	0				10			2	1		1	
21244	Reconstruction of mandible, e	090	387	422	35	9%	13.62	16.26	2.64	19%	-2			3	2	1		2	1		1	
21245	Reconstruction of mandible o	090	376	408	32	9%	13.12	15.10	1.98	15%	-2			2	2	1		1			1	
21246	Reconstruction of mandible o	090	369	382	13	4%	12.92	14.13	1.21	9%	0			3	1						1	
21247	Reconstruction of mandibular	090	544	590	46	8%	24.37	27.14	2.77	11%	-2			3	3	1		2			1	
21248	Reconstruction of mandible o	090	223	251	28	13%	12.74	14.06	1.32	10%	0				4							
21249	Reconstruction of mandible o	090	295	323	28	9%	18.77	20.09	1.32	7%	0				4							
21255	Reconstruction of zygomatic a	090	457	503	46	10%	18.46	21.23	2.77	15%	-2			3	3	1		2			1	
21256	Reconstruction of orbit with c	090	444	467	23	5%	17.66	19.38	1.72	10%	-2			2	2	1			1			
21260	Periorbital osteotomies for or	090	426	436	10	2%	17.90	19.62	1.72	10%	0			2	2				2		1	
21261	Periorbital osteotomies for or	090	674	697	23	3%	34.07	36.94	2.87	8%	-2			2	3	1			2	1	1	
21263	Periorbital osteotomies for or	090	639	662	23	4%	31.01	33.88	2.87	9%	-2			2	3	1			2	1	1	
21267	Orbital repositioning, periorb	090	476	495	19	4%	20.69	22.83	2.14	10%	-2			2	2	1			2		1	
21268	Orbital repositioning, periorb	090	614	637	23	4%	27.07	29.94	2.87	11%	-2			2	3	1			2	1	1	
21270	Malar augmentation, prosthe	090	362	373	11	3%	10.63	11.40	0.77	7%	0			2	1							
21275	Secondary revision of orbitoc	090	360	376	16	4%	11.76	12.99	1.23	10%	0			2	1			1			1	
21280	Medial canthopexy (separate	090	251	276	25	10%	7.13	8.43	1.30	18%	-2			1	2	1						
21282	Lateral canthopexy	090	209	227	18	9%	4.27	5.24	0.97	23%	-2			1	1	1						
21295	Reduction of masseter muscle	090	101	110	9	9%	1.90	2.45	0.55	29%	0			1	1							
21296	Reduction of masseter muscle	090	219	235	16	7%	4.78	6.01	1.23	26%	0			2	1			1			1	
21325	Open treatment of nasal fract	090	217	228	11	5%	4.18	5.17	0.99	24%	0			2	1						1	
21330	Open treatment of nasal fract	090	251	262	11	4%	5.79	6.78	0.99	17%	0			2	1						1	
21335	Open treatment of nasal fract	090	293	304	11	4%	9.02	10.01	0.99	11%	0			2	1						1	
21336	Open treatment of nasal sept	090	243	268	25	10%	6.77	8.20	1.43	21%	0			2	3							
21337	Closed treatment of nasal sep	090	154	170	16	10%	3.39	4.27	0.88	26%	0			1	2							
21338	Open treatment of nasoethm	090	291	302	11	4%	6.87	7.86	0.99	14%	0			2	1						1	

21339	Open treatment of nasoethm	090	315	326	11	3%	8.50	9.49	0.99	12%	0			2	1						1	
21340	Percutaneous treatment of n	090	347	365	18	5%	11.49	12.81	1.32	11%	0			2	2						1	
21343	Open treatment of depressed	090	389	410	21	5%	14.32	16.17	1.85	13%	0			2	3				1		1	
21344	Open treatment of complicat	090	519	537	18	3%	21.57	23.82	2.25	10%	0			2	3				1	1	1	
21345	Closed treatment of nasomax	090	312	337	25	8%	9.06	10.84	1.78	20%	0			3	2			1			1	
21346	Open treatment of nasomaxil	090	352	375	23	7%	11.45	13.01	1.56	14%	0			2	2			1			1	
21347	Open treatment of nasomaxil	090	393	416	23	6%	13.53	15.09	1.56	12%	0			2	2			1			1	
21348	Open treatment of nasomaxil	090	452	475	23	5%	17.52	19.08	1.56	9%	0			2	2			1			1	
21355	Percutaneous treatment of fr	010	176	192	16	9%	4.45	5.33	0.88	20%	0			1	2							
21356	Open treatment of depressed	010	185	201	16	9%	4.83	5.71	0.88	18%	0			1	2							
21360	Open treatment of depressed	090	273	291	18	7%	7.19	8.29	1.10	15%	0			2	2							
21365	Open treatment of complicat	090	432	477	45	10%	16.77	19.12	2.35	14%	0				5			2			1	
21366	Open treatment of complicat	090	467	490	23	5%	18.60	20.16	1.56	8%	0			2	2			1			1	
21385	Open treatment of orbital flo	090	324	335	11	3%	9.57	10.56	0.99	10%	0			2	1						1	
21386	Open treatment of orbital flo	090	320	331	11	3%	9.57	10.56	0.99	10%	0			2	1						1	
21387	Open treatment of orbital flo	090	335	346	11	3%	10.11	11.10	0.99	10%	0			2	1						1	
21390	Open treatment of orbital flo	090	346	360	14	4%	11.23	12.40	1.17	10%	-2			1	1	1			1			
21395	Open treatment of orbital flo	090	347	357	10	3%	14.70	15.91	1.21	8%	0			1	1			1	1		1	
21400	Closed treatment of fracture	090	102	106	4	4%	1.50	1.94	0.44	29%	0			2								
21401	Closed treatment of fracture	090	204	215	11	5%	3.68	4.67	0.99	27%	0			2	1						1	
21406	Open treatment of fracture o	090	284	295	11	4%	7.42	8.41	0.99	13%	0			2	1						1	
21407	Open treatment of fracture o	090	316	327	11	3%	9.02	10.01	0.99	11%	0			2	1						1	
21408	Open treatment of fracture o	090	385	396	11	3%	12.78	13.77	0.99	8%	0			2	1						1	
21421	Closed treatment of palatal o	090	256	278	22	9%	6.02	7.54	1.52	25%	-2			3	1	1					0.5	
21422	Open treatment of palatal or	090	319	330	11	3%	8.73	9.72	0.99	11%	0			2	1						1	
21423	Open treatment of palatal or	090	359	372	13	4%	10.85	12.06	1.21	11%	0			3	1						1	
21431	Closed treatment of craniofac	090	295	318	23	8%	7.90	9.46	1.56	20%	0			2	2			1			1	
21432	Open treatment of craniofaci	090	330	339	9	3%	8.82	9.72	0.90	10%	0			2				1			1	
21433	Open treatment of craniofaci	090	592	620	28	5%	26.29	28.09	1.80	7%	0			2	2			2			1	
21435	Open treatment of craniofaci	090	1001	1024	23	2%	20.26	23.68	3.42	17%	-2			2	2	1		2	2	2	1	
21436	Open treatment of craniofaci	090	644	671	27	4%	30.30	32.97	2.67	9%	-2			2	3	1			1	1	1	
21440	Closed treatment of mandibu	090	162	180	18	11%	3.44	4.54	1.10	32%	0			2	2							
21445	Open treatment of mandibula	090	252	274	22	9%	6.26	7.78	1.52	24%	-2			3	1	1					0.5	
21450	Closed treatment of mandibu	090	162	180	18	11%	3.71	4.81	1.10	30%	0			2	2							
21451	Closed treatment of mandibu	090	252	272	20	8%	5.65	7.08	1.43	25%	0			3	2						0.5	
21452	Percutaneous treatment of m	090	133	144	11	8%	2.40	3.28	0.88	37%	0			2	1						0.5	
21453	Closed treatment of mandibu	090	261	288	27	10%	6.64	8.40	1.76	27%	0			3	3						0.5	
21454	Open treatment of mandibula	090	288	313	25	9%	7.36	9.14	1.78	24%	0			3	2			1			1	
21461	Open treatment of mandibula	090	318	350	32	10%	9.31	11.42	2.11	23%	0			3	3			1			1	
21462	Open treatment of mandibula	090	342	374	32	9%	11.01	13.12	2.11	19%	0			3	3			1			1	
21465	Open treatment of mandibula	090	373	405	32	9%	13.12	15.23	2.11	16%	0			3	3			1			1	
21470	Open treatment of complicat	090	469	523.5	54.5	12%	17.54	20.34	2.80	16%	0				6			2.5			1	
21485	Closed treatment of temporo	090	203	223	20	10%	4.77	6.09	1.32	28%	0			3	2							
21490	Open treatment of temporon	090	368	395	27	7%	12.95	14.71	1.76	14%	0			3	3						0.5	
21497	Interdental wiring, for conditi	090	239	259	20	8%	4.64	6.07	1.43	31%	0			3	2						0.5	
21501	Incision and drainage, deep a	090	176	183	7	4%	3.98	4.86	0.88	22%	0			3.5							0.5	
21502	Incision and drainage, deep a	090	275	293	18	7%	7.55	9.13	1.58	21%	0			4				2			1	
21510	Incision, deep, with opening c	090	295	314	19	6%	6.20	7.89	1.69	27%	0			4.5				2			1	
21550	Biopsy, soft tissue of neck or	010	89	91	2	2%	2.11	2.33	0.22	10%	0			1								
21552	Excision, tumor, soft tissue of	090	194	203	9	5%	6.49	7.15	0.66	10%	0			1	1						0.5	
21554	Excision, tumor, soft tissue of	090	320	341	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
21555	Excision, tumor, soft tissue of	090	138	147	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
21556	Excision, tumor, soft tissue of	090	234	250	16	7%	7.66	8.65	0.99	13%	0			1	2						0.5	
21557	Radical resection of tumor (e	090	398	422	24	6%	14.75	16.62	1.87	13%	0			1	3			1	1		1	
21558	Radical resection of tumor (e	090	502	524	22	4%	21.58	23.74	2.16	10%	-2			1	2	1		1	2		1	
21600	Excision of rib, partial	090	251	266.5	15.5	6%	7.26	8.72	1.46	20%	0			4				1.5			1	
21601	Excision of chest wall tumor i	090	510.5	565	54.5	11%	17.78	20.60	2.82	16%	0				3.5			6			1	
21602	Excision of chest wall tumor i	090	669.5	745	75.5	11%	22.19	26.00	3.81	17%	0				6.5			6			1	
21603	Excision of chest wall tumor i	090	760	846.5	86.5	11%	25.17	29.50	4.33	17%	0				7			7.5			1	
21610	Costotransversectomy (separ	090	440	476	36	8%	15.91	17.84	1.93	12%	0				3			3			1	
21615	Excision first and/or cervical r	090	334	358	24	7%	10.45	12.38	1.93	18%	0			4.5				3			1	
21616	Excision first and/or cervical r	090	393	420.5	27.5	7%	12.69	14.85	2.16	17%	0			5				3.5			1	
21620	Ostectomy of sternum, partia	090	285	305.5	20.5	7%	7.28	8.98	1.70	23%	0			4				2.5			1	
21627	Sternal debridement	090	264	284.5	20.5	8%	7.30	9.00	1.70	23%	0			4				2.5			1	
21630	Radical resection of sternum;	090	597	640.5	43.5	7%	19.18	22.17	2.99	16%	0			5.5				6.5			1	
21632	Radical resection of sternum;	090	602	645.5	43.5	7%	19.68	22.67	2.99	15%	0			5.5				6.5			1	

21685	Hyoid myotomy and suspensi	090	440	479	39	9%	15.26	17.82	2.56	17%	-6			1	2	3			1		1	
21700	Division of scalenus anticus; v	090	188	193	5	3%	6.31	7.08	0.77	12%	0			2.5							1	
21705	Division of scalenus anticus; v	090	273	286.5	13.5	5%	9.92	11.16	1.24	13%	0			3				1.5			1	
21720	Division of sternocleidomasto	090	157	162	5	3%	5.80	6.46	0.66	11%	0			2.5							0.5	
21725	Division of sternocleidomasto	090	258	266.5	8.5	3%	7.19	8.19	1.00	14%	0			3				0.5			1	
21740	Reconstructive repair of pect	090	391	406	15	4%	17.57	18.89	1.32	8%	0				2			1	1		1	
21750	Closure of median sternotom	090	306	309	3	1%	11.40	12.15	0.75	7%	0				1				1		1	
21820	Closed treatment of sternum	090	59	62	3	5%	1.36	1.69	0.33	24%	0			1.5								
21825	Open treatment of sternum f	090	253	267.5	14.5	6%	7.76	9.11	1.35	17%	0			3.5				1.5			1	
21920	Biopsy, soft tissue of back or	010	69	71	2	3%	2.11	2.33	0.22	10%	0			1								
21925	Biopsy, soft tissue of back or	090	145	151	6	4%	4.63	5.40	0.77	17%	0			3							0.5	
21930	Excision, tumor, soft tissue of	090	165	174	9	5%	4.94	5.60	0.66	13%	0			1	1						0.5	
21931	Excision, tumor, soft tissue of	090	206	215	9	4%	6.88	7.54	0.66	10%	0			1	1						0.5	
21932	Excision, tumor, soft tissue of	090	276	292	16	6%	9.82	11.05	1.23	13%	0			2	1			1			1	
21933	Excision, tumor, soft tissue of	090	315	336	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
21935	Radical resection of tumor (e	090	408	432	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
21936	Radical resection of tumor (e	090	510	532	22	4%	22.55	24.71	2.16	10%	-2			1	2	1		1	2		1	
22010	Incision and drainage, open, d	090	378	412	34	9%	12.75	15.10	2.35	18%	0			1	3			3	1		1	
22015	Incision and drainage, open, d	090	373	407	34	9%	12.64	14.99	2.35	19%	0			1	3			3	1		1	
22100	Partial excision of posterior v	090	372	410	38	10%	11.00	13.02	2.02	18%	0				4			2			1	
22101	Partial excision of posterior v	090	387	430	43	11%	11.08	13.34	2.26	20%	0				4			3			1	
22102	Partial excision of posterior v	090	387	430	43	11%	11.08	13.34	2.26	20%	0				4			3			1	
22110	Partial excision of vertebral b	090	479	537	58	12%	14.00	16.98	2.98	21%	0				4			6			1	
22112	Partial excision of vertebral b	090	530	590.5	60.5	11%	14.07	17.17	3.10	22%	0				4			6.5			1	
22114	Partial excision of vertebral b	090	530	590.5	60.5	11%	14.07	17.17	3.10	22%	0				4			6.5			1	
22206	Osteotomy of spine, posterio	090	758	779	21	3%	37.18	39.69	2.51	7%	0			1	3			2	3		1	
22207	Osteotomy of spine, posterio	090	758	779	21	3%	36.68	39.19	2.51	7%	0			1	3			2	3		1	
22210	Osteotomy of spine, posterio	090	609	679	70	11%	25.38	28.93	3.55	14%	0				5			7			1	
22212	Osteotomy of spine, posterio	090	640	710	70	11%	20.99	24.54	3.55	17%	0				5			7			1	
22214	Osteotomy of spine, posterio	090	624	694	70	11%	21.02	24.57	3.55	17%	0				5			7			1	
22220	Osteotomy of spine, including	090	585	652.5	67.5	12%	22.94	26.37	3.43	15%	0				5			6.5			1	
22222	Osteotomy of spine, including	090	651	723.5	72.5	11%	23.09	26.76	3.67	16%	0				5			7.5			1	
22224	Osteotomy of spine, including	090	666	738.5	72.5	11%	23.09	26.76	3.67	16%	0				5			7.5			1	
22310	Closed treatment of vertebra	090	131	137	6	5%	3.45	4.22	0.77	22%	0			3							0.5	
22315	Closed treatment of vertebra	090	252	285	33	13%	10.11	11.89	1.78	18%	0				4			1			1	
22318	Open treatment and/or reduc	090	451	484	33	7%	22.72	24.63	1.91	8%	0			1	3			2			1	
22319	Open treatment and/or reduc	090	483	521	38	8%	25.33	27.48	2.15	8%	0			1	3			3			1	
22325	Open treatment and/or reduc	090	528	590.5	62.5	12%	19.87	23.06	3.19	16%	0				5			5.5			1	
22326	Open treatment and/or reduc	090	480	535.5	55.5	12%	20.84	23.70	2.86	14%	0				4			5.5			1	
22327	Open treatment and/or reduc	090	604	684	80	13%	20.77	24.80	4.03	19%	0				5			9			1	
22510	Percutaneous vertebroplasty	010	150	157	7	5%	7.90	8.34	0.44	6%	0				1						0.5	
22511	Percutaneous vertebroplasty	010	150	157	7	5%	7.33	7.77	0.44	6%	0				1						0.5	
22513	Percutaneous vertebral augm	010	155	162	7	5%	8.65	9.09	0.44	5%	0				1						0.5	
22514	Percutaneous vertebral augm	010	150	157	7	5%	7.99	8.43	0.44	6%	0				1						0.5	
22526	Percutaneous intradiscal elec	010	145	147	2	1%	5.85	6.18	0.33	6%	0			1							0.5	
22532	Arthrodesis, lateral extracavit	090	583	613	30	5%	25.99	28.54	2.55	10%	0			1	3			3	2		1	
22533	Arthrodesis, lateral extracavit	090	549	583	34	6%	24.79	27.14	2.35	9%	0			1	3			3	1		1	
22548	Arthrodesis, anterior transora	090	673	741	68	10%	27.06	30.52	3.46	13%	0				4			8			1	
22551	Arthrodesis, anterior interbo	090	395	412	17	4%	25.00	26.41	1.41	6%	0				3				1		1	
22554	Arthrodesis, anterior interbo	090	362	379	17	5%	17.69	19.10	1.41	8%	0				3				1		1	
22556	Arthrodesis, anterior interbo	090	557	600	43	8%	24.70	26.96	2.26	9%	0				4			3			1	
22558	Arthrodesis, anterior interbo	090	525	563	38	7%	23.53	25.55	2.02	9%	0				4			2			1	
22586	Arthrodesis, pre-sacral interb	090	500	534	34	7%	28.12	30.34	2.22	8%	0				4			2	1		1	
22590	Arthrodesis, posterior techni	090	501	544	43	9%	21.76	24.02	2.26	10%	0				4			3			1	
22595	Arthrodesis, posterior techni	090	521	579	58	11%	20.64	23.62	2.98	14%	0				4			6			1	
22600	Arthrodesis, posterior or post	090	490	548	58	12%	17.40	20.38	2.98	17%	0				4			6			1	
22610	Arthrodesis, posterior or post	090	549	614.5	65.5	12%	17.28	20.62	3.34	19%	0				4			7.5			1	
22612	Arthrodesis, posterior or post	090	482	500	18	4%	23.53	25.38	1.85	8%	0				3			1	2		1	
22630	Arthrodesis, posterior interbo	090	479	499	20	4%	22.09	24.03	1.94	9%	-2				2	1		1	2		1	
22633	Arthrodesis, combined poster	090	509	529	20	4%	26.80	28.74	1.94	7%	-2				2	1		1	2		1	
22800	Arthrodesis, posterior, for spi	090	571	634	63	11%	19.50	22.72	3.22	17%	0				4			7			1	
22802	Arthrodesis, posterior, for spi	090	538	586	48	9%	32.11	34.61	2.50	8%	0				4			4			1	
22804	Arthrodesis, posterior, for spi	090	595	648	53	9%	37.50	40.24	2.74	7%	0				4			5			1	
22808	Arthrodesis, anterior, for spin	090	530	583	53	10%	27.51	30.25	2.74	10%	0				4			5			1	
22810	Arthrodesis, anterior, for spin	090	595	648	53	9%	31.50	34.24	2.74	9%	0				4			5			1	
22812	Arthrodesis, anterior, for spin	090	700	772.5	72.5	10%	34.25	37.92	3.67	11%	0				5			7.5			1	

22818	Kyphectomy, circumferential	090	747	781	34	5%	34.33	37.34	3.01	9%	0				3			5	3		1	
22819	Kyphectomy, circumferential	090	795	841	46	6%	39.38	42.96	3.58	9%	0				4			6	3		1	
22830	Exploration of spinal fusion	090	301	317	16	5%	11.22	12.58	1.36	12%	0			3				2			1	
22849	Reinsertion of spinal fixation	090	397	425.5	28.5	7%	19.17	21.13	1.96	10%	0			3				4.5			1	
22850	Removal of posterior nonsegi	090	243	255.5	12.5	5%	9.82	10.95	1.13	12%	0			2.5				1.5			1	
22852	Removal of posterior segmen	090	266	281	15	6%	9.37	10.62	1.25	13%	0			2.5				2			1	
22855	Removal of anterior instrume	090	418	449	31	7%	15.86	17.94	2.08	13%	0			3				5			1	
22856	Total disc arthroplasty (artific	090	367	393	26	7%	24.05	25.50	1.45	6%	0				3			1			1	
22857	Total disc arthroplasty (artific	090	550	575	25	5%	27.13	29.31	2.18	8%	0				4			1	2		1	
22861	Revision including replaceme	090	477	490	13	3%	33.36	34.97	1.61	5%	0				3				2		1	
22862	Revision including replaceme	090	620	645	25	4%	32.63	34.81	2.18	7%	0				4			1	2		1	
22864	Removal of total disc arthrop	090	457	470	13	3%	29.40	31.01	1.61	5%	0				3				2		1	
22865	Removal of total disc arthrop	090	600	630	30	5%	31.75	34.17	2.42	8%	0				4			2	2		1	
22867	Insertion of interlaminar/inte	090	271	292	21	8%	15.00	16.10	1.10	7%	0				3						0.5	
22869	Insertion of interlaminar/inte	090	175	184	9	5%	7.03	7.69	0.66	9%	0			1	1						0.5	
22900	Excision, tumor, soft tissue of	090	244	260	16	7%	8.32	9.55	1.23	15%	0			2	1			1			1	
22901	Excision, tumor, soft tissue of	090	284	300	16	6%	10.11	11.34	1.23	12%	0			2	1			1			1	
22902	Excision, tumor, soft tissue of	090	148	157	9	6%	4.42	5.08	0.66	15%	0			1	1						0.5	
22903	Excision, tumor, soft tissue of	090	179	188	9	5%	6.39	7.05	0.66	10%	0			1	1						0.5	
22904	Radical resection of tumor (e	090	396	420	24	6%	16.69	18.56	1.87	11%	0			1	3			1	1		1	
22905	Radical resection of tumor (e	090	463	494	31	7%	21.58	23.78	2.20	10%	-2			1	2	1		2	1		1	
23000	Removal of subdeltoid calcare	090	153	158	5	3%	4.48	5.14	0.66	15%	0			2.5							0.5	
23020	Capsular contracture release	090	292	310	18	6%	9.36	10.94	1.58	17%	0			4				2			1	
23030	Incision and drainage, should	010	152	154	2	1%	3.47	3.91	0.44	13%	0			1							1	
23031	Incision and drainage, should	010	94	96	2	2%	2.79	3.01	0.22	8%	0			1								
23035	Incision, bone cortex (eg, oste	090	300	323	23	8%	9.16	10.98	1.82	20%	0			4				3			1	
23040	Arthrotomy, glenohumeral jo	090	305	328	23	8%	9.75	11.57	1.82	19%	0			4				3			1	
23044	Arthrotomy, acromioclavicula	090	253	272.5	19.5	8%	7.59	9.18	1.59	21%	0			3.5				2.5			1	
23065	Biopsy, soft tissue of shoulde	010	64	65	1	2%	2.30	2.41	0.11	5%	0			0.5								
23066	Biopsy, soft tissue of shoulde	090	133	139	6	5%	4.30	4.96	0.66	15%	0			3								
23071	Excision, tumor, soft tissue of	090	191	200	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
23073	Excision, tumor, soft tissue of	090	285	306	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1	
23075	Excision, tumor, soft tissue of	090	142	151	9	6%	4.21	4.87	0.66	16%	0			1	1						0.5	
23076	Excision, tumor, soft tissue of	090	221	237	16	7%	7.41	8.40	0.99	13%	0			1	2						0.5	
23077	Radical resection of tumor (e	090	433	457	24	6%	17.66	19.53	1.87	11%	0			1	3			1	1		1	
23078	Radical resection of tumor (e	090	490	516	26	5%	22.55	24.51	1.96	9%	-2			1	2	1		1	1		1	
23100	Arthrotomy, glenohumeral jo	090	216	223	7	3%	6.20	7.19	0.99	16%	0			3.5							1	
23101	Arthrotomy, acromioclavicula	090	195	201	6	3%	5.72	6.60	0.88	15%	0			3							1	
23105	Arthrotomy; glenohumeral jo	090	276	286.5	10.5	4%	8.48	9.70	1.22	14%	0			4				0.5			1	
23106	Arthrotomy; sternoclavicular	090	214	221	7	3%	6.13	7.12	0.99	16%	0			3.5							1	
23107	Arthrotomy, glenohumeral jo	090	260	270.5	10.5	4%	8.87	10.09	1.22	14%	0			4				0.5			1	
23120	Claviculectomy; partial	090	227	245	18	8%	7.39	8.60	1.21	16%	0			2	2						0.5	
23125	Claviculectomy; total	090	279	289.5	10.5	4%	9.64	10.86	1.22	13%	0			4				0.5			1	
23130	Acromioplasty or acromionec	090	231	240	9	4%	7.77	8.87	1.10	14%	0			4.5							0.5	
23140	Excision or curettage of bone	090	242	251.5	9.5	4%	7.12	8.23	1.11	16%	0			3.5				0.5			1	
23145	Excision or curettage of bone	090	307	320	13	4%	9.40	10.74	1.34	14%	0			4				1			1	
23146	Excision or curettage of bone	090	269	279.5	10.5	4%	8.08	9.30	1.22	15%	0			4				0.5			1	
23150	Excision or curettage of bone	090	296	314	18	6%	8.91	10.49	1.58	18%	0			4				2			1	
23155	Excision or curettage of bone	090	355	376.5	21.5	6%	10.86	12.67	1.81	17%	0			4.5				2.5			1	
23156	Excision or curettage of bone	090	310	328	18	6%	9.11	10.69	1.58	17%	0			4				2			1	
23170	Sequestrectomy (eg, for oste	090	247	261.5	14.5	6%	7.21	8.56	1.35	19%	0			3.5				1.5			1	
23172	Sequestrectomy (eg, for oste	090	277	294	17	6%	7.31	8.78	1.47	20%	0			3.5				2			1	
23174	Sequestrectomy (eg, for oste	090	352	374.5	22.5	6%	10.05	11.97	1.92	19%	0			5				2.5			1	
23180	Partial excision (craterization,	090	299	318	19	6%	8.99	10.68	1.69	19%	0			4.5				2			1	
23182	Partial excision (craterization,	090	314	333	19	6%	8.61	10.30	1.69	20%	0			4.5				2			1	
23184	Partial excision (craterization,	090	339	360.5	21.5	6%	9.90	11.71	1.81	18%	0			4.5				2.5			1	
23190	Ostectomy of scapula, partial	090	249	258.5	9.5	4%	7.47	8.58	1.11	15%	0			3.5				0.5			1	
23195	Resection, humeral head	090	322	345	23	7%	10.36	12.18	1.82	18%	0			4				3			1	
23200	Radical resection of tumor; cl	090	497	519	22	4%	22.71	24.87	2.16	10%	-2			1	2	1		1	2		1	
23210	Radical resection of tumor; sc	090	560	582	22	4%	27.21	29.37	2.16	8%	-2			1	2	1		1	2		1	
23220	Radical resection of tumor, pr	090	602	629	27	4%	30.21	32.61	2.40	8%	-2			1	2	1		2	2		1	
23330	Removal of foreign body, sho	010	70	72	2	3%	1.90	2.12	0.22	12%	0			1								
23333	Removal of foreign body, sho	090	178	187	9	5%	6.00	6.66	0.66	11%	0			1	1						0.5	
23334	Removal of prosthesis, includ	090	418	433	15	4%	15.50	17.33	1.83	12%	0			1	3				2		1	
23335	Removal of prosthesis, includ	090	448	463	15	3%	19.00	20.83	1.83	10%	0			1	3				2		1	
23395	Muscle transfer, any type, sh	090	423	463	40	9%	18.54	20.65	2.11	11%	0				5			1			1	

23397	Muscle transfer, any type, sh	090	399	425.5	26.5	7%	16.76	18.81	2.05	12%	0			4.5				3.5			1	
23400	Scapulopexy (eg, Sprengels d	090	315	329	14	4%	13.87	15.32	1.45	10%	0			4.5				1			1	
23405	Tenotomy, shoulder area; sin	090	192	199	7	4%	8.54	9.42	0.88	10%	0			3.5							0.5	
23406	Tenotomy, shoulder area; mu	090	239	248.5	9.5	4%	11.01	12.12	1.11	10%	0			3.5				0.5			1	
23410	Repair of ruptured musculote	090	277	295	18	6%	11.39	12.60	1.21	11%	0			2	2						0.5	
23412	Repair of ruptured musculote	090	287	305	18	6%	11.93	13.14	1.21	10%	0			2	2						0.5	
23415	Coracoacromial ligament rele	090	247	265	18	7%	9.23	10.44	1.21	13%	0			2	2						0.5	
23420	Reconstruction of complete s	090	328	348	20	6%	13.54	14.97	1.43	11%	0			3	2						0.5	
23430	Tenodesis of long tendon of b	090	237	255	18	8%	10.17	11.38	1.21	12%	0			2	2						0.5	
23440	Resection or transplantation	090	208	215	7	3%	10.64	11.52	0.88	8%	0			3.5							0.5	
23450	Capsulorrhaphy, anterior; Put	090	287	300	13	5%	13.70	15.04	1.34	10%	0			4				1			1	
23455	Capsulorrhaphy, anterior; wit	090	307	320	13	4%	14.67	16.01	1.34	9%	0			4				1			1	
23460	Capsulorrhaphy, anterior, any	090	344	363	19	6%	15.82	17.51	1.69	11%	0			4.5				2			1	
23462	Capsulorrhaphy, anterior, any	090	327	345	18	6%	15.72	17.30	1.58	10%	0			4				2			1	
23465	Capsulorrhaphy, glenohumer	090	356	375	19	5%	16.30	17.99	1.69	10%	0			4.5				2			1	
23466	Capsulorrhaphy, glenohumer	090	348	383	35	10%	15.80	17.67	1.87	12%	0				5						1	
23470	Arthroplasty, glenohumeral jo	090	390	421.5	31.5	8%	17.89	20.18	2.29	13%	0			4.5				4.5			1	
23472	Arthroplasty, glenohumeral jo	090	448	477	29	6%	22.13	24.24	2.11	10%	0			1	3			2	1		1	
23473	Revision of total shoulder art	090	488	517	29	6%	25.00	27.11	2.11	8%	0			1	3			2	1		1	
23474	Revision of total shoulder art	090	513	542	29	6%	27.21	29.32	2.11	8%	0			1	3			2	1		1	
23480	Osteotomy, clavicle, with or v	090	275	290.5	15.5	6%	11.54	13.00	1.46	13%	0			4				1.5			1	
23485	Osteotomy, clavicle, with or v	090	331	351.5	20.5	6%	13.91	15.61	1.70	12%	0			4				2.5			1	
23490	Prophylactic treatment (nailin	090	291	304	13	4%	12.16	13.50	1.34	11%	0			4				1			1	
23491	Prophylactic treatment (nailin	090	315	329	14	4%	14.54	15.99	1.45	10%	0			4.5				1			1	
23500	Closed treatment of clavicula	090	79	84	5	6%	2.21	2.76	0.55	25%	0			2.5								
23505	Closed treatment of clavicula	090	121	127	6	5%	3.83	4.49	0.66	17%	0			3								
23515	Open treatment of clavicular	090	287	305	18	6%	9.69	10.90	1.21	12%	0			2	2						0.5	
23520	Closed treatment of sternocla	090	82	87	5	6%	2.29	2.84	0.55	24%	0			2.5								
23525	Closed treatment of sternocla	090	130	138	8	6%	3.79	4.67	0.88	23%	0			4								
23530	Open treatment of sternoclav	090	210	217	7	3%	7.48	8.36	0.88	12%	0			3.5							0.5	
23532	Open treatment of sternoclav	090	280	288	8	3%	8.20	9.30	1.10	13%	0			4							1	
23540	Closed treatment of acromioc	090	82	87	5	6%	2.36	2.91	0.55	23%	0			2.5								
23545	Closed treatment of acromioc	090	115	122	7	6%	3.43	4.20	0.77	22%	0			3.5								
23550	Open treatment of acromiocl	090	267	281.5	14.5	5%	7.59	8.94	1.35	18%	0			3.5				1.5			1	
23552	Open treatment of acromiocl	090	299	314.5	15.5	5%	8.82	10.28	1.46	17%	0			4				1.5			1	
23570	Closed treatment of scapular	090	82	87	5	6%	2.36	2.91	0.55	23%	0			2.5								
23575	Closed treatment of scapular	090	138	145	7	5%	4.23	5.00	0.77	18%	0			3.5								
23585	Open treatment of scapular fr	090	407	435	28	7%	14.23	16.03	1.80	13%	0			2	2			2			1	
23600	Closed treatment of proximal	090	100	113	13	13%	3.00	3.99	0.99	33%	0			3	1							
23605	Closed treatment of proximal	090	172	180	8	5%	5.06	6.05	0.99	20%	0			4							0.5	
23615	Open treatment of proximal h	090	338	366	28	8%	12.30	13.97	1.67	14%	0			1	3			1			1	
23616	Open treatment of proximal h	090	413	437	24	6%	18.37	20.24	1.87	10%	0			1	3			1	1		1	
23620	Closed treatment of greater h	090	92	98	6	7%	2.55	3.21	0.66	26%	0			3								
23625	Closed treatment of greater h	090	151	158	7	5%	4.10	4.98	0.88	21%	0			3.5							0.5	
23630	Open treatment of greater hu	090	306	334	28	9%	10.57	12.24	1.67	16%	0			1	3			1			1	
23650	Closed treatment of shoulder	090	133	139	6	5%	3.53	4.19	0.66	19%	0			3								
23655	Closed treatment of shoulder	090	165	173	8	5%	4.76	5.75	0.99	21%	0			4							0.5	
23660	Open treatment of acute sho	090	245	252	7	3%	7.66	8.65	0.99	13%	0			3.5							1	
23665	Closed treatment of shoulder	090	165	173	8	5%	4.66	5.65	0.99	21%	0			4							0.5	
23670	Open treatment of shoulder d	090	326	349	23	7%	12.28	13.84	1.56	13%	0			2	2			1			1	
23675	Closed treatment of shoulder	090	222	231	9	4%	6.27	7.48	1.21	19%	0			4.5							1	
23680	Open treatment of shoulder d	090	361	384	23	6%	13.15	14.71	1.56	12%	0			2	2			1			1	
23700	Manipulation under anesthes	010	65	67	2	3%	2.57	2.79	0.22	9%	0			1								
23800	Arthrodesis, glenohumeral jo	090	378	402	24	6%	14.73	16.66	1.93	13%	0			4.5				3			1	
23802	Arthrodesis, glenohumeral jo	090	448	493	45	10%	18.42	20.77	2.35	13%	0				5			2			1	
23900	Interthoracoscapular amputa	090	537	579.5	42.5	8%	20.72	23.60	2.88	14%	0			5				6.5			1	
23920	Disarticulation of shoulder;	090	475	518	43	9%	16.23	18.49	2.26	14%	0				4			3			1	
23921	Disarticulation of shoulder; se	090	241	250.5	9.5	4%	5.72	6.83	1.11	19%	0			3.5				0.5			1	
23930	Incision and drainage, upper a	010	92	94	2	2%	2.99	3.32	0.33	11%	0			1							0.5	
23931	Incision and drainage, upper a	010	75	77	2	3%	1.84	2.17	0.33	18%	0			1							0.5	
23935	Incision, deep, with opening d	090	233	245	12	5%	6.38	7.61	1.23	19%	0			3.5				1			1	
24000	Arthrotomy, elbow, including	090	217	228	11	5%	6.08	7.20	1.12	18%	0			3				1			1	
24006	Arthrotomy of the elbow, wit	090	282	300	18	6%	9.74	11.32	1.58	16%	0			4				2			1	
24065	Biopsy, soft tissue of upper ar	010	80	82	2	2%	2.13	2.35	0.22	10%	0			1								
24066	Biopsy, soft tissue of upper ar	090	172	178	6	3%	5.35	6.12	0.77	14%	0			3							0.5	
24071	Excision, tumor, soft tissue of	090	183	192	9	5%	5.70	6.36	0.66	12%	0			1	1						0.5	

24073	Excision, tumor, soft tissue of	090	283	304	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1	
24075	Excision, tumor, soft tissue of	090	142	151	9	6%	4.24	4.90	0.66	16%	0			1	1						0.5	
24076	Excision, tumor, soft tissue of	090	229	245	16	7%	7.41	8.40	0.99	13%	0			1	2						0.5	
24077	Radical resection of tumor (e	090	405	429	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
24079	Radical resection of tumor (e	090	472	503	31	7%	20.61	22.81	2.20	11%	-2			1	2	1		2	1		1	
24100	Arthrotomy, elbow; with syn	090	157	163	6	4%	5.07	5.84	0.77	15%	0			3							0.5	
24101	Arthrotomy, elbow; with joint	090	189	196	7	4%	6.30	7.18	0.88	14%	0			3.5							0.5	
24102	Arthrotomy, elbow; with syn	090	251	260.5	9.5	4%	8.26	9.37	1.11	13%	0			3.5				0.5			1	
24105	Excision, olecranon bursa	090	143	150	7	5%	3.78	4.55	0.77	20%	0			3.5								
24110	Excision or curettage of bone	090	224	232	8	4%	7.58	8.57	0.99	13%	0			4							0.5	
24115	Excision or curettage of bone	090	339	359.5	20.5	6%	10.12	11.82	1.70	17%	0			4				2.5			1	
24116	Excision or curettage of bone	090	326	344	18	6%	12.23	13.81	1.58	13%	0			4				2			1	
24120	Excision or curettage of bone	090	195	202	7	4%	6.82	7.70	0.88	13%	0			3.5							0.5	
24125	Excision or curettage of bone	090	278	288.5	10.5	4%	8.14	9.36	1.22	15%	0			4				0.5			1	
24126	Excision or curettage of bone	090	272	285	13	5%	8.62	9.96	1.34	16%	0			4				1			1	
24130	Excision, radial head	090	192	199	7	4%	6.42	7.30	0.88	14%	0			3.5							0.5	
24134	Sequestrectomy (eg, for oste	090	303	323.5	20.5	7%	10.22	11.92	1.70	17%	0			4				2.5			1	
24136	Sequestrectomy (eg, for oste	090	263	280	17	6%	8.40	9.87	1.47	18%	0			3.5				2			1	
24138	Sequestrectomy (eg, for oste	090	277	295.5	18.5	7%	8.50	10.29	1.79	21%	0			5.5				1.5			1	
24140	Partial excision (craterization,	090	284	299.5	15.5	5%	9.55	11.01	1.46	15%	0			4				1.5			1	
24145	Partial excision (craterization,	090	240	249.5	9.5	4%	7.81	8.92	1.11	14%	0			3.5				0.5			1	
24147	Partial excision (craterization,	090	252	264.5	12.5	5%	7.84	9.28	1.44	18%	0			5				0.5			1	
24149	Radical resection of capsule, s	090	456	503	47	10%	16.22	18.66	2.44	15%	0				6			1			1	
24150	Radical resection of tumor, sh	090	502	533	31	6%	23.46	25.66	2.20	9%	-2			1	2	1		2	1		1	
24152	Radical resection of tumor, ra	090	440	466	26	6%	19.99	21.95	1.96	10%	-2			1	2	1		1	1		1	
24155	Resection of elbow joint (arth	090	322	337.5	15.5	5%	12.09	13.55	1.46	12%	0			4				1.5			1	
24160	Removal of prosthesis, includ	090	405	429	24	6%	18.63	20.50	1.87	10%	0			1	3			1	1		1	
24164	Removal of prosthesis, includ	090	228	249	21	9%	10.00	11.10	1.10	11%	0				3						0.5	
24200	Removal of foreign body, upp	010	68	70	2	3%	1.81	2.03	0.22	12%	0			1								
24201	Removal of foreign body, upp	090	164	170	6	4%	4.70	5.47	0.77	16%	0			3							0.5	
24300	Manipulation, elbow, under a	090	205	217	12	6%	4.04	5.47	1.43	35%	0			6							0.5	
24301	Muscle or tendon transfer, ar	090	266	274	8	3%	10.38	11.48	1.10	11%	0			4							1	
24305	Tendon lengthening, upper ar	090	209	216	7	3%	7.62	8.50	0.88	12%	0			3.5							0.5	
24310	Tenotomy, open, elbow to sh	090	171	177	6	4%	6.12	6.89	0.77	13%	0			3							0.5	
24320	Tenoplasty, with muscle trans	090	304	317	13	4%	10.86	12.20	1.34	12%	0			4				1			1	
24330	Flexor-plasty, elbow (eg, Stei	090	263	271	8	3%	9.79	10.89	1.10	11%	0			4							1	
24331	Flexor-plasty, elbow (eg, Stei	090	303	316	13	4%	10.95	12.29	1.34	12%	0			4				1			1	
24332	Tenolysis, triceps	090	230	243	13	6%	7.91	9.01	1.10	14%	0			3	1						0.5	
24340	Tenodesis of biceps tendon at	090	225	233	8	4%	8.08	9.07	0.99	12%	0			4							0.5	
24341	Repair, tendon or muscle, up	090	318	353	35	11%	9.49	11.36	1.87	20%	0				5						1	
24342	Reinsertion of ruptured bicep	090	290	300.5	10.5	4%	10.86	12.08	1.22	11%	0			4				0.5			1	
24343	Repair lateral collateral ligam	090	281	296	15	5%	9.16	10.48	1.32	14%	0			4	1						0.5	
24344	Reconstruction lateral collate	090	385	417	32	8%	15.21	17.32	2.11	14%	0			3	3			1			1	
24345	Repair medial collateral ligam	090	284	299	15	5%	9.16	10.48	1.32	14%	0			4	1						0.5	
24346	Reconstruction medial collate	090	385	417	32	8%	15.21	17.32	2.11	14%	0			3	3			1			1	
24357	Tenotomy, elbow, lateral or m	090	168	176	8	5%	5.44	6.43	0.99	18%	0			4							0.5	
24358	Tenotomy, elbow, lateral or m	090	193	201	8	4%	6.66	7.65	0.99	15%	0			4							0.5	
24359	Tenotomy, elbow, lateral or m	090	213	221	8	4%	8.98	9.97	0.99	11%	0			4							0.5	
24360	Arthroplasty, elbow; with me	090	320	334	14	4%	12.67	14.12	1.45	11%	0			4.5				1			1	
24361	Arthroplasty, elbow; with dist	090	322	336	14	4%	14.41	15.86	1.45	10%	0			4.5				1			1	
24362	Arthroplasty, elbow; with imp	090	350	364	14	4%	15.32	16.77	1.45	9%	0			4.5				1			1	
24363	Arthroplasty, elbow; with dist	090	435	464	29	7%	22.00	24.11	2.11	10%	0			1	3			2	1		1	
24365	Arthroplasty, radial head;	090	229	238.5	9.5	4%	8.62	9.73	1.11	13%	0			3.5				0.5			1	
24366	Arthroplasty, radial head; wit	090	243	252.5	9.5	4%	9.36	10.47	1.11	12%	0			3.5				0.5			1	
24370	Revision of total elbow arthro	090	470	499	29	6%	23.55	25.66	2.11	9%	0			1	3			2	1		1	
24371	Revision of total elbow arthro	090	505	534	29	6%	27.50	29.61	2.11	8%	0			1	3			2	1		1	
24400	Osteotomy, humerus, with or	090	288	299.5	11.5	4%	11.33	12.66	1.33	12%	0			4.5				0.5			1	
24410	Multiple osteotomies with re	090	344	356.5	12.5	4%	15.11	16.55	1.44	10%	0			5				0.5			1	
24420	Osteoplasty, humerus (eg, sh	090	329	341.5	12.5	4%	13.73	15.17	1.44	10%	0			5				0.5			1	
24430	Repair of nonunion or maluni	090	343	376	33	10%	15.25	17.16	1.91	13%	0			1	3			2			1	
24435	Repair of nonunion or maluni	090	433	478	45	10%	14.99	17.34	2.35	16%	0				5			2			1	
24470	Hemiepiphyseal arrest (eg, cu	090	236	244	8	3%	8.93	10.03	1.10	12%	0			4							1	
24495	Decompression fasciotomy, fo	090	255	267	12	5%	8.41	9.64	1.23	15%	0			3.5				1			1	
24498	Prophylactic treatment (nailin	090	308	323.5	15.5	5%	12.28	13.74	1.46	12%	0			4				1.5			1	
24500	Closed treatment of humeral	090	121	129	8	7%	3.41	4.29	0.88	26%	0			4								
24505	Closed treatment of humeral	090	188	197	9	5%	5.39	6.49	1.10	20%	0			4.5							0.5	

24515	Open treatment of humeral s	090	340	360	20	6%	12.12	13.92	1.80	15%	0			5				2			1	
24516	Treatment of humeral shaft f	090	352	375	23	7%	12.19	14.01	1.82	15%	0			4				3			1	
24530	Closed treatment of supracor	090	136	144	8	6%	3.69	4.57	0.88	24%	0			4								
24535	Closed treatment of supracor	090	206	216	10	5%	7.11	8.32	1.21	17%	0			5							0.5	
24538	Percutaneous skeletal fixatio	090	284	298	14	5%	9.77	11.22	1.45	15%	0			4.5				1			1	
24545	Open treatment of humeral s	090	361	384	23	6%	13.15	14.71	1.56	12%	0			2	2			1			1	
24546	Open treatment of humeral s	090	448	472	24	5%	14.91	16.78	1.87	13%	0			1	3			1	1		1	
24560	Closed treatment of humeral	090	118	125	7	6%	2.98	3.75	0.77	26%	0			3.5								
24565	Closed treatment of humeral	090	190	199	9	5%	5.78	6.88	1.10	19%	0			4.5							0.5	
24566	Percutaneous skeletal fixatio	090	257	285	28	11%	9.06	10.38	1.32	15%	0				4							
24575	Open treatment of humeral e	090	308	336	28	9%	9.71	11.38	1.67	17%	0			1	3			1			1	
24576	Closed treatment of humeral	090	129	137	8	6%	3.06	3.94	0.88	29%	0			4								
24577	Closed treatment of humeral	090	192	201	9	5%	6.01	7.11	1.10	18%	0			4.5							0.5	
24579	Open treatment of humeral c	090	338	366	28	8%	11.44	13.11	1.67	15%	0			1	3			1			1	
24582	Percutaneous skeletal fixatio	090	295	330	35	12%	10.14	11.79	1.65	16%	0				5							
24586	Open treatment of periarticul	090	375	399	24	6%	15.78	17.71	1.93	12%	0			4.5				3			1	
24587	Open treatment of periarticul	090	415	441.5	26.5	6%	15.79	17.84	2.05	13%	0			4.5				3.5			1	
24600	Treatment of closed elbow di	090	121	127	6	5%	4.37	5.03	0.66	15%	0			3								
24605	Treatment of closed elbow di	090	179	188	9	5%	5.64	6.74	1.10	20%	0			4.5							0.5	
24615	Open treatment of acute or c	090	277	294	17	6%	9.83	11.30	1.47	15%	0			3.5				2			1	
24620	Closed treatment of Montegg	090	211	221	10	5%	7.22	8.43	1.21	17%	0			5							0.5	
24635	Open treatment of Monteggia	090	291	314	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
24640	Closed treatment of radial he	010	39	41	2	5%	1.25	1.47	0.22	18%	0			1								
24650	Closed treatment of radial he	090	87	93	6	7%	2.31	2.97	0.66	29%	0			3								
24655	Closed treatment of radial he	090	142	151	9	6%	4.62	5.61	0.99	21%	0			4.5								
24665	Open treatment of radial hea	090	256	265	9	4%	8.36	9.57	1.21	14%	0			4.5							1	
24666	Open treatment of radial hea	090	286	301.5	15.5	5%	9.86	11.32	1.46	15%	0			4				1.5			1	
24670	Closed treatment of ulnar fra	090	102	108	6	6%	2.69	3.35	0.66	25%	0			3								
24675	Closed treatment of ulnar fra	090	153	161	8	5%	4.91	5.79	0.88	18%	0			4								
24685	Open treatment of ulnar fract	090	252	270	18	7%	8.37	9.58	1.21	14%	0			2	2						0.5	
24800	Arthrodesis, elbow joint; loca	090	290	299	9	3%	11.41	12.62	1.21	11%	0			4.5							1	
24802	Arthrodesis, elbow joint; with	090	399	425.5	26.5	7%	14.32	16.37	2.05	14%	0			4.5				3.5			1	
24900	Amputation, arm through hur	090	312	336	24	8%	10.18	12.11	1.93	19%	0			4.5				3			1	
24920	Amputation, arm through hur	090	282	306.5	24.5	9%	10.13	11.96	1.83	18%	0			3.5				3.5			1	
24925	Amputation, arm through hur	090	221	230.5	9.5	4%	7.30	8.41	1.11	15%	0			3.5				0.5			1	
24930	Amputation, arm through hur	090	294	318.5	24.5	8%	10.83	12.66	1.83	17%	0			3.5				3.5			1	
24931	Amputation, arm through hur	090	358	388.5	30.5	9%	13.44	15.62	2.18	16%	0			4				4.5			1	
24935	Stump elongation, upper extr	090	458	495.5	37.5	8%	16.45	19.09	2.64	16%	0			5				5.5			1	
25000	Incision, extensor tendon she	090	135	142	7	5%	3.55	4.32	0.77	22%	0			3.5								
25001	Incision, flexor tendon sheath	090	154	165	11	7%	3.79	4.67	0.88	23%	0			2	1						0.5	
25020	Decompression fasciotomy, fo	090	204	210	6	3%	6.06	6.94	0.88	15%	0			3							1	
25023	Decompression fasciotomy, fo	090	400	436.5	36.5	9%	13.83	16.36	2.53	18%	0			4.5				5.5			1	
25024	Decompression fasciotomy, fo	090	385	397	12	3%	10.79	12.86	2.07	19%	0			4	1			1	2		1	
25025	Decompression fasciotomy, fo	090	460	477	17	4%	17.94	20.25	2.31	13%	0			4	1			2	2		1	
25028	Incision and drainage, forearr	090	181	187	6	3%	5.39	6.27	0.88	16%	0			3							1	
25031	Incision and drainage, forearr	090	141	146	5	4%	4.26	4.92	0.66	15%	0			2.5							0.5	
25035	Incision, deep, bone cortex, fo	090	241	253	12	5%	7.65	8.88	1.23	16%	0			3.5				1			1	
25040	Arthrotomy, radiocarpal or m	090	227	240.5	13.5	6%	7.50	8.74	1.24	17%	0			3				1.5			1	
25065	Biopsy, soft tissue of forearm	010	64	66	2	3%	2.04	2.26	0.22	11%	0			1								
25066	Biopsy, soft tissue of forearm	090	156	162	6	4%	4.27	5.04	0.77	18%	0			3							0.5	
25071	Excision, tumor, soft tissue of	090	178	187	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
25073	Excision, tumor, soft tissue of	090	221	237	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
25075	Excision, tumor, soft tissue of	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
25076	Excision, tumor, soft tissue of	090	206	222	16	8%	6.74	7.73	0.99	15%	0			1	2						0.5	
25077	Radical resection of tumor (e	090	345	373	28	8%	12.93	14.60	1.67	13%	0			1	3			1			1	
25078	Radical resection of tumor (e	090	422	448	26	6%	17.69	19.65	1.96	11%	-2			1	2	1		1	1		1	
25085	Capsulotomy, wrist (eg, contr	090	197	203	6	3%	5.64	6.52	0.88	16%	0			3							1	
25100	Arthrotomy, wrist joint; with	090	142	147	5	4%	4.02	4.68	0.66	16%	0			2.5							0.5	
25101	Arthrotomy, wrist joint; with	090	163	169	6	4%	4.83	5.60	0.77	16%	0			3							0.5	
25105	Arthrotomy, wrist joint; with	090	201	208	7	3%	6.02	6.90	0.88	15%	0			3.5							0.5	
25107	Arthrotomy, distal radioulnar	090	257	285	28	11%	7.70	9.02	1.32	17%	0				4							
25109	Excision of tendon, forearm a	090	191	207	16	8%	6.94	7.93	0.99	14%	0			1	2						0.5	
25110	Excision, lesion of tendon she	090	132	137	5	4%	4.04	4.59	0.55	14%	0			2.5								
25111	Excision of ganglion, wrist (de	090	140	146	6	4%	3.53	4.19	0.66	19%	0			3								
25112	Excision of ganglion, wrist (de	090	148	154	6	4%	4.67	5.33	0.66	14%	0			3								
25115	Radical excision of bursa, syn	090	257	285	28	11%	10.09	11.41	1.32	13%	0				4							

25116	Radical excision of bursa, syn	090	249	272	23	9%	7.56	8.88	1.32	17%	0			1	3						0.5	
25118	Synovectomy, extensor tendo	090	158	164	6	4%	4.51	5.28	0.77	17%	0			3							0.5	
25119	Synovectomy, extensor tendo	090	214	221	7	3%	6.21	7.20	0.99	16%	0			3.5							1	
25120	Excision or curettage of bone	090	217	224	7	3%	6.27	7.26	0.99	16%	0			3.5							1	
25125	Excision or curettage of bone	090	270	278	8	3%	7.67	8.77	1.10	14%	0			4							1	
25126	Excision or curettage of bone	090	260	268	8	3%	7.74	8.84	1.10	14%	0			4							1	
25130	Excision or curettage of bone	090	167	174	7	4%	5.43	6.20	0.77	14%	0			3.5								
25135	Excision or curettage of bone	090	234	242	8	3%	7.08	8.07	0.99	14%	0			4							0.5	
25136	Excision or curettage of bone	090	204	211	7	3%	6.14	7.02	0.88	14%	0			3.5							0.5	
25145	Sequestrectomy (eg, for oste	090	225	232	7	3%	6.54	7.53	0.99	15%	0			3.5							1	
25150	Partial excision (craterization,	090	257	269	12	5%	7.38	8.61	1.23	17%	0			3.5				1			1	
25151	Partial excision (craterization,	090	266	278	12	5%	7.68	8.91	1.23	16%	0			3.5				1			1	
25170	Radical resection of tumor, ra	090	470	496	26	6%	22.21	24.17	1.96	9%	-2			1	2	1		1	1		1	
25210	Carpectomy; 1 bone	090	194	201	7	4%	6.12	7.00	0.88	14%	0			3.5							0.5	
25215	Carpectomy; all bones of pro	090	269	279.5	10.5	4%	8.14	9.36	1.22	15%	0			4				0.5			1	
25230	Radial styloidectomy (separat	090	190	196	6	3%	5.37	6.25	0.88	16%	0			3							1	
25240	Excision distal ulna partial or	090	176	182	6	3%	5.31	6.08	0.77	15%	0			3							0.5	
25248	Exploration with removal of d	090	163	170	7	4%	5.31	6.08	0.77	15%	0			3.5								
25250	Removal of wrist prosthesis; (	090	205	212	7	3%	6.77	7.65	0.88	13%	0			3.5							0.5	
25251	Removal of wrist prosthesis; c	090	300	310.5	10.5	3%	9.82	11.04	1.22	12%	0			4				0.5			1	
25259	Manipulation, wrist, under an	090	201	213	12	6%	4.04	5.47	1.43	35%	0			6							0.5	
25260	Repair, tendon or muscle, fle	090	215	225	10	5%	8.04	9.25	1.21	15%	0			5							0.5	
25263	Repair, tendon or muscle, fle	090	229	238	9	4%	8.04	9.25	1.21	15%	0			4.5							1	
25265	Repair, tendon or muscle, fle	090	259	268	9	3%	10.10	11.20	1.10	11%	0			4.5							0.5	
25270	Repair, tendon or muscle, ext	090	176	183	7	4%	6.17	7.05	0.88	14%	0			3.5							0.5	
25272	Repair, tendon or muscle, ext	090	189	196	7	4%	7.21	8.09	0.88	12%	0			3.5							0.5	
25274	Repair, tendon or muscle, ext	090	242	250	8	3%	8.94	9.93	0.99	11%	0			4							0.5	
25275	Repair, tendon sheath, exten	090	223	236	13	6%	8.96	10.06	1.10	12%	0			3	1						0.5	
25280	Lengthening or shortening of	090	195	202	7	4%	7.39	8.27	0.88	12%	0			3.5							0.5	
25290	Tenotomy, open, flexor or ext	090	164	170	6	4%	5.43	6.20	0.77	14%	0			3							0.5	
25295	Tenolysis, flexor or extensor t	090	191	198	7	4%	6.72	7.60	0.88	13%	0			3.5							0.5	
25300	Tenodesis at wrist; flexors of	090	247	256	9	4%	9.02	10.12	1.10	12%	0			4.5							0.5	
25301	Tenodesis at wrist; extensors	090	235	243	8	3%	8.59	9.58	0.99	12%	0			4							0.5	
25310	Tendon transplantation or tra	090	235	248	13	6%	8.08	9.18	1.10	14%	0			3	1						0.5	
25312	Tendon transplantation or tra	090	284	294.5	10.5	4%	9.82	11.04	1.22	12%	0			4				0.5			1	
25315	Flexor origin slide (eg, for cer	090	300	320.5	20.5	7%	10.68	12.38	1.70	16%	0			4				2.5			1	
25316	Flexor origin slide (eg, for cer	090	356	380	24	7%	12.90	14.83	1.93	15%	0			4.5				3			1	
25320	Capsulorrhaphy or reconstruc	090	452	495	43	10%	12.75	14.76	2.01	16%	-8				1	4						
25332	Arthroplasty, wrist, with or w	090	314	328	14	4%	11.74	13.19	1.45	12%	0			4.5				1			1	
25335	Centralization of wrist on ulna	090	370	391.5	21.5	6%	13.39	15.20	1.81	14%	0			4.5				2.5			1	
25337	Reconstruction for stabilizatio	090	353	387	34	10%	11.73	13.32	1.59	14%	-6				1	3						
25350	Osteotomy, radius; distal thir	090	266	279	13	5%	9.09	10.43	1.34	15%	0			4				1			1	
25355	Osteotomy, radius; middle or	090	289	304.5	15.5	5%	10.53	11.99	1.46	14%	0			4				1.5			1	
25360	Osteotomy; ulna	090	259	272	13	5%	8.74	10.08	1.34	15%	0			4				1			1	
25365	Osteotomy; radius AND ulna	090	354	375.5	21.5	6%	12.91	14.72	1.81	14%	0			4.5				2.5			1	
25370	Multiple osteotomies, with re	090	424	455	31	7%	14.10	16.49	2.39	17%	0			5.5				4			1	
25375	Multiple osteotomies, with re	090	382	403.5	21.5	6%	13.55	15.36	1.81	13%	0			4.5				2.5			1	
25390	Osteoplasty, radius OR ulna; s	090	295	308	13	4%	10.70	12.04	1.34	13%	0			4				1			1	
25391	Osteoplasty, radius OR ulna; l	090	383	409.5	26.5	7%	14.28	16.33	2.05	14%	0			4.5				3.5			1	
25392	Osteoplasty, radius AND ulna	090	390	416.5	26.5	7%	14.58	16.63	2.05	14%	0			4.5				3.5			1	
25393	Osteoplasty, radius AND ulna	090	432	461	29	7%	16.56	18.73	2.17	13%	0			4.5				4			1	
25394	Osteoplasty, carpal bone, sho	090	250	263	13	5%	10.85	11.95	1.10	10%	0			3	1						0.5	
25400	Repair of nonunion or maluni	090	308	323.5	15.5	5%	11.28	12.74	1.46	13%	0			4				1.5			1	
25405	Repair of nonunion or maluni	090	387	413.5	26.5	7%	15.01	17.06	2.05	14%	0			4.5				3.5			1	
25415	Repair of nonunion or maluni	090	367	386	19	5%	13.80	15.49	1.69	12%	0			4.5				2			1	
25420	Repair of nonunion or maluni	090	444	474	30	7%	17.04	19.32	2.28	13%	0			5				4			1	
25425	Repair of defect with autogra	090	343	364.5	21.5	6%	13.72	15.53	1.81	13%	0			4.5				2.5			1	
25426	Repair of defect with autogra	090	411	437.5	26.5	6%	16.45	18.50	2.05	12%	0			4.5				3.5			1	
25430	Insertion of vascular pedicle i	090	270	283	13	5%	9.71	10.81	1.10	11%	0			3	1						0.5	
25431	Repair of nonunion of carpal	090	278	291	13	5%	10.89	11.99	1.10	10%	0			3	1						0.5	
25440	Repair of nonunion, scaphoid	090	278	288.5	10.5	4%	10.68	11.90	1.22	11%	0			4				0.5			1	
25441	Arthroplasty with prosthetic r	090	358	374.5	16.5	5%	13.29	14.86	1.57	12%	0			4.5				1.5			1	
25442	Arthroplasty with prosthetic r	090	331	342.5	11.5	3%	11.12	12.45	1.33	12%	0			4.5				0.5			1	
25443	Arthroplasty with prosthetic r	090	307	318.5	11.5	4%	10.66	11.99	1.33	12%	0			4.5				0.5			1	
25444	Arthroplasty with prosthetic r	090	304	315.5	11.5	4%	11.42	12.75	1.33	12%	0			4.5				0.5			1	
25445	Arthroplasty with prosthetic r	090	283	291	8	3%	9.88	10.98	1.10	11%	0			4							1	

25446	Arthroplasty with prosthetic r	090	425	456.5	31.5	7%	17.30	19.59	2.29	13%	0			4.5				4.5			1	
25447	Arthroplasty, interposition, in	090	278	298	20	7%	11.14	12.57	1.43	13%	0			3	2						0.5	
25449	Revision of arthroplasty, inclu	090	369	388	19	5%	14.94	16.63	1.69	11%	0			4.5				2			1	
25450	Epiphyseal arrest by epiphysi	090	203	211	8	4%	8.06	8.94	0.88	11%	0			4								
25455	Epiphyseal arrest by epiphysi	090	260	269	9	3%	9.71	10.81	1.10	11%	0			4.5							0.5	
25490	Prophylactic treatment (nailin	090	280	288	8	3%	9.73	10.83	1.10	11%	0			4							1	
25491	Prophylactic treatment (nailin	090	271	279	8	3%	10.15	11.25	1.10	11%	0			4							1	
25492	Prophylactic treatment (nailin	090	343	357	14	4%	12.66	14.11	1.45	11%	0			4.5				1			1	
25500	Closed treatment of radial sh	090	84	90	6	7%	2.60	3.26	0.66	25%	0			3								
25505	Closed treatment of radial sh	090	171	181	10	6%	5.45	6.55	1.10	20%	0			5								
25515	Open treatment of radial shaf	090	247	265	18	7%	8.80	10.01	1.21	14%	0			2	2						0.5	
25520	Closed treatment of radial sh	090	219	229	10	5%	6.50	7.71	1.21	19%	0			5							0.5	
25525	Open treatment of radial shaf	090	303	331	28	9%	10.55	12.22	1.67	16%	0			1	3			1			1	
25526	Open treatment of radial shaf	090	367	392	25	7%	13.15	14.93	1.78	14%	0			3	2			1			1	
25530	Closed treatment of ulnar sha	090	88	94	6	7%	2.24	2.90	0.66	29%	0			3								
25535	Closed treatment of ulnar sha	090	163	172	9	6%	5.36	6.35	0.99	18%	0			4.5								
25545	Open treatment of ulnar shaf	090	286	309	23	8%	7.94	9.50	1.56	20%	0			2	2			1			1	
25560	Closed treatment of radial an	090	101	107	6	6%	2.59	3.25	0.66	25%	0			3								
25565	Closed treatment of radial an	090	182	191	9	5%	5.85	6.95	1.10	19%	0			4.5							0.5	
25574	Open treatment of radial AN	090	296	319	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
25575	Open treatment of radial AN	090	342	367	25	7%	12.29	14.07	1.78	14%	0			3	2			1			1	
25600	Closed treatment of distal rad	090	108	118	10	9%	2.78	3.88	1.10	40%	0			5								
25605	Closed treatment of distal rad	090	169	184	15	9%	6.25	7.57	1.32	21%	0			4	1						0.5	
25606	Percutaneous skeletal fixation	090	260	285	25	10%	8.31	9.85	1.54	19%	0			2	3						0.5	
25607	Open treatment of distal radi	090	275	300	25	9%	9.56	11.10	1.54	16%	0			2	3						0.5	
25608	Open treatment of distal radi	090	305	330	25	8%	11.07	12.61	1.54	14%	0			2	3						0.5	
25609	Open treatment of distal radi	090	358	390	32	9%	14.38	16.25	1.87	13%	0			2	4						0.5	
25622	Closed treatment of carpal sc	090	101	108	7	7%	2.79	3.56	0.77	28%	0			3.5								
25624	Closed treatment of carpal sc	090	155	165	10	6%	4.77	5.87	1.10	23%	0			5								
25628	Open treatment of carpal sca	090	277	295	18	6%	9.67	10.88	1.21	13%	0			2	2						0.5	
25630	Closed treatment of carpal bo	090	91	97	6	7%	3.03	3.69	0.66	22%	0			3								
25635	Closed treatment of carpal bo	090	143	152	9	6%	4.61	5.60	0.99	21%	0			4.5								
25645	Open treatment of carpal bon	090	222	229	7	3%	7.42	8.41	0.99	13%	0			3.5							1	
25650	Closed treatment of ulnar sty	090	111	118	7	6%	3.23	4.00	0.77	24%	0			3.5								
25651	Percutaneous skeletal fixation	090	190	203	13	7%	5.82	6.92	1.10	19%	0			3	1						0.5	
25652	Open treatment of ulnar styl	090	225	238	13	6%	8.06	9.16	1.10	14%	0			3	1						0.5	
25660	Closed treatment of radiocarp	090	145	154	9	6%	4.98	5.97	0.99	20%	0			4.5								
25670	Open treatment of radiocarpa	090	224	231	7	3%	8.09	9.08	0.99	12%	0			3.5							1	
25671	Percutaneous skeletal fixation	090	210	223	13	6%	6.46	7.56	1.10	17%	0			3	1						0.5	
25675	Closed treatment of distal rad	090	152	161	9	6%	4.89	5.88	0.99	20%	0			4.5								
25676	Open treatment of distal radi	090	242	252.5	10.5	4%	8.29	9.51	1.22	15%	0			4				0.5			1	
25680	Closed treatment of trans-sca	090	203	213	10	5%	6.23	7.44	1.21	19%	0			5							0.5	
25685	Open treatment of trans-scap	090	279	292	13	5%	10.09	11.43	1.34	13%	0			4				1			1	
25690	Closed treatment of lunate di	090	187	196	9	5%	5.72	6.82	1.10	19%	0			4.5							0.5	
25695	Open treatment of lunate dis	090	244	251	7	3%	8.51	9.50	0.99	12%	0			3.5							1	
25800	Arthrodesis, wrist; complete,	090	298	311	13	4%	10.07	11.41	1.34	13%	0			4				1			1	
25805	Arthrodesis, wrist; with slidin	090	351	370	19	5%	11.73	13.42	1.69	14%	0			4.5				2			1	
25810	Arthrodesis, wrist; with iliac c	090	370	403	33	9%	11.95	13.73	1.78	15%	0				4			1			1	
25820	Arthrodesis, wrist; limited, wi	090	222	230	8	4%	7.64	8.63	0.99	13%	0			4							0.5	
25825	Arthrodesis, wrist; with autog	090	321	338.5	17.5	5%	9.69	11.37	1.68	17%	0			5				1.5			1	
25830	Arthrodesis, distal radioulnar	090	310	330	20	6%	10.88	12.07	1.19	11%	-2			2	1	1						
25900	Amputation, forearm, throug	090	345	370	25	7%	9.61	11.65	2.04	21%	0			5				3			1	
25905	Amputation, forearm, throug	090	264	283.5	19.5	7%	9.59	11.18	1.59	17%	0			3.5				2.5			1	
25907	Amputation, forearm, throug	090	235	247	12	5%	8.09	9.32	1.23	15%	0			3.5				1			1	
25909	Amputation, forearm, throug	090	257	271.5	14.5	6%	9.31	10.66	1.35	15%	0			3.5				1.5			1	
25915	Krukenberg procedure	090	431	444	13	3%	17.52	18.51	0.99	6%	0			3	1							
25920	Disarticulation through wrist;	090	249	263.5	14.5	6%	9.03	10.38	1.35	15%	0			3.5				1.5			1	
25922	Disarticulation through wrist;	090	224	233.5	9.5	4%	7.65	8.76	1.11	15%	0			3.5				0.5			1	
25924	Disarticulation through wrist;	090	242	256.5	14.5	6%	8.81	10.16	1.35	15%	0			3.5				1.5			1	
25927	Transmetacarpal amputation;	090	242	254	12	5%	9.09	10.32	1.23	14%	0			3.5				1			1	
25929	Transmetacarpal amputation;	090	226	235.5	9.5	4%	7.82	8.93	1.11	14%	0			3.5				0.5			1	
25931	Transmetacarpal amputation;	090	233	242.5	9.5	4%	8.04	9.15	1.11	14%	0			3.5				0.5			1	
26010	Drainage of finger abscess; si	010	51	53	2	4%	1.59	1.81	0.22	14%	0			1								
26011	Drainage of finger abscess; cc	010	69	71	2	3%	2.24	2.46	0.22	10%	0			1								
26020	Drainage of tendon sheath, d	090	262	285	23	9%	6.84	8.53	1.69	25%	0			3	1			2			1	
26025	Drainage of palmar bursa; sin	090	200	211	11	5%	5.08	6.20	1.12	22%	0			3				1			1	

26030	Drainage of palmar bursa; mu	090	226	239.5	13.5	6%	6.25	7.49	1.24	20%	0			3				1.5			1	
26034	Incision, bone cortex, hand or	090	250	266.5	16.5	7%	6.63	8.20	1.57	24%	0			4.5				1.5			1	
26035	Decompression fingers and/o	090	351.5	400.5	49	14%	11.37	13.92	2.55	22%	0				4.5			3.5			1	
26037	Decompressive fasciotomy, h	090	228	241.5	13.5	6%	7.57	8.81	1.24	16%	0			3				1.5			1	
26040	Fasciotomy, palmar (eg, Dupu	090	135	140	5	4%	3.46	4.12	0.66	19%	0			2.5							0.5	
26045	Fasciotomy, palmar (eg, Dupu	090	207	214	7	3%	5.73	6.61	0.88	15%	0			3.5							0.5	
26055	Tendon sheath incision (eg, fo	090	119	128	9	8%	3.11	3.77	0.66	21%	0			1	1						0.5	
26060	Tenotomy, percutaneous, sin	090	91	95	4	4%	2.91	3.35	0.44	15%	0			2								
26070	Arthrotomy, with exploration	090	168	173	5	3%	3.81	4.58	0.77	20%	0			2.5							1	
26075	Arthrotomy, with exploration	090	164	169	5	3%	3.91	4.68	0.77	20%	0			2.5							1	
26080	Arthrotomy, with exploration	090	157	164	7	4%	4.47	5.35	0.88	20%	0			3.5							0.5	
26100	Arthrotomy with biopsy; carp	090	119	124	5	4%	3.79	4.34	0.55	15%	0			2.5								
26105	Arthrotomy with biopsy; met	090	119	124	5	4%	3.83	4.38	0.55	14%	0			2.5								
26110	Arthrotomy with biopsy; inter	090	114	119	5	4%	3.65	4.20	0.55	15%	0			2.5								
26111	Excision, tumor or vascular m	090	173	182	9	5%	5.42	6.08	0.66	12%	0			1	1						0.5	
26113	Excision, tumor, soft tissue, o	090	214	230	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
26115	Excision, tumor or vascular m	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
26116	Excision, tumor, soft tissue, o	090	201	217	16	8%	6.74	7.73	0.99	15%	0			1	2						0.5	
26117	Radical resection of tumor (e	090	271	294	23	8%	10.13	11.45	1.32	13%	0			1	3						0.5	
26118	Radical resection of tumor (e	090	368	400	32	9%	14.81	16.79	1.98	13%	-2			2	2	1		1			1	
26121	Fasciectomy, palm only, with	090	200	208	8	4%	7.73	8.61	0.88	11%	0			4								
26123	Fasciectomy, partial palmar w	090	308	343	35	11%	10.88	12.53	1.65	15%	0				5							
26130	Synovectomy, carpometacarp	090	180	187	7	4%	5.59	6.47	0.88	16%	0			3.5							0.5	
26135	Synovectomy, metacarpopha	090	181	188	7	4%	7.13	8.01	0.88	12%	0			3.5							0.5	
26140	Synovectomy, proximal interp	090	174	181	7	4%	6.34	7.22	0.88	14%	0			3.5							0.5	
26145	Synovectomy, tendon sheath	090	178	185	7	4%	6.49	7.37	0.88	14%	0			3.5							0.5	
26160	Excision of lesion of tendon s	090	121	130	9	7%	3.57	4.23	0.66	18%	0			1	1						0.5	
26170	Excision of tendon, palm, flex	090	135	141	6	4%	4.91	5.57	0.66	13%	0			3								
26180	Excision of tendon, finger, fle	090	153	160	7	5%	5.35	6.12	0.77	14%	0			3.5								
26185	Sesamoidectomy, thumb or fi	090	202	230	28	14%	6.52	7.84	1.32	20%	0				4							
26200	Excision or curettage of bone	090	164	170	6	4%	5.65	6.42	0.77	14%	0			3							0.5	
26205	Excision or curettage of bone	090	229	238.5	9.5	4%	7.93	9.04	1.11	14%	0			3.5				0.5			1	
26210	Excision or curettage of bone	090	155	162	7	5%	5.32	6.09	0.77	14%	0			3.5								
26215	Excision or curettage of bone	090	199	206	7	4%	7.27	8.15	0.88	12%	0			3.5							0.5	
26230	Partial excision (craterization,	090	186	192	6	3%	6.47	7.35	0.88	14%	0			3							1	
26235	Partial excision (craterization,	090	185	191	6	3%	6.33	7.21	0.88	14%	0			3							1	
26236	Partial excision (craterization,	090	171	177	6	4%	5.46	6.34	0.88	16%	0			3							1	
26250	Radical resection of tumor, m	090	353	383	30	8%	15.21	16.97	1.76	12%	-2			1	2	1		1			1	
26260	Radical resection of tumor, pr	090	256	274	18	7%	11.16	12.24	1.08	10%	-2			1	1	1					0.5	
26262	Radical resection of tumor, di	090	212	230	18	8%	8.29	9.37	1.08	13%	-2			1	1	1					0.5	
26320	Removal of implant from fing	090	150	155	5	3%	4.10	4.76	0.66	16%	0			2.5							0.5	
26340	Manipulation, finger joint, un	090	170	182	12	7%	2.80	4.23	1.43	51%	0			6							0.5	
26341	Manipulation, palmar fascial c	010	52	54	2	4%	0.91	1.13	0.22	24%	0			1								
26350	Repair or advancement, flexo	090	180	189	9	5%	6.21	7.20	0.99	16%	0			4.5								
26352	Repair or advancement, flexo	090	258	266	8	3%	7.87	8.97	1.10	14%	0			4							1	
26356	Repair or advancement, flexo	090	277	299	22	8%	9.56	11.21	1.65	17%	0			4	2						0.5	
26357	Repair or advancement, flexo	090	302	324	22	7%	11.00	12.65	1.65	15%	0			4	2						0.5	
26358	Repair or advancement, flexo	090	327	349	22	7%	12.60	14.25	1.65	13%	0			4	2						0.5	
26370	Repair or advancement of pro	090	221	228	7	3%	7.28	8.27	0.99	14%	0			3.5							1	
26372	Repair or advancement of pro	090	278	288.5	10.5	4%	9.01	10.23	1.22	14%	0			4				0.5			1	
26373	Repair or advancement of pro	090	258	268.5	10.5	4%	8.41	9.63	1.22	15%	0			4				0.5			1	
26390	Excision flexor tendon, with in	090	220	228	8	4%	9.43	10.53	1.10	12%	0			4							1	
26392	Removal of synthetic rod and	090	254	264.5	10.5	4%	10.50	11.72	1.22	12%	0			4				0.5			1	
26410	Repair, extensor tendon, han	090	162	168	6	4%	4.77	5.54	0.77	16%	0			3							0.5	
26412	Repair, extensor tendon, han	090	215	222	7	3%	6.48	7.47	0.99	15%	0			3.5							1	
26415	Excision of extensor tendon, v	090	191	198	7	4%	8.51	9.39	0.88	10%	0			3.5							0.5	
26416	Removal of synthetic rod and	090	216	224	8	4%	9.56	10.55	0.99	10%	0			4							0.5	
26418	Repair, extensor tendon, fing	090	153	162	9	6%	4.47	5.46	0.99	22%	0			4.5								
26420	Repair, extensor tendon, fing	090	224	231	7	3%	6.94	7.93	0.99	14%	0			3.5							1	
26426	Repair of extensor tendon, ce	090	190	197	7	4%	6.32	7.20	0.88	14%	0			3.5							0.5	
26428	Repair of extensor tendon, ce	090	218	226	8	4%	7.40	8.39	0.99	13%	0			4							0.5	
26432	Closed treatment of distal ext	090	134	140	6	4%	4.16	4.82	0.66	16%	0			3								
26433	Repair of extensor tendon, di	090	148	154	6	4%	4.70	5.36	0.66	14%	0			3								
26434	Repair of extensor tendon, di	090	190	197	7	4%	6.26	7.14	0.88	14%	0			3.5							0.5	
26437	Realignment of extensor tend	090	183	190	7	4%	5.99	6.87	0.88	15%	0			3.5							0.5	
26440	Tenolysis, flexor tendon; palm	090	162	168	6	4%	5.16	5.93	0.77	15%	0			3							0.5	

26442	Tenolysis, flexor tendon; paln	090	280	315	35	13%	9.75	11.40	1.65	17%	0				5							
26445	Tenolysis, extensor tendon, h	090	137	143	6	4%	4.45	5.11	0.66	15%	0			3								
26449	Tenolysis, complex, extensor	090	275	310	35	13%	8.59	10.24	1.65	19%	0				5							
26450	Tenotomy, flexor, palm, open	090	111	116	5	5%	3.79	4.34	0.55	15%	0			2.5								
26455	Tenotomy, flexor, finger, ope	090	113	118	5	4%	3.76	4.31	0.55	15%	0			2.5								
26460	Tenotomy, extensor, hand or	090	107	112	5	5%	3.58	4.13	0.55	15%	0			2.5								
26471	Tenodesis; of proximal interp	090	171	178	7	4%	5.90	6.67	0.77	13%	0			3.5								
26474	Tenodesis; of distal joint, eac	090	162	169	7	4%	5.49	6.26	0.77	14%	0			3.5								
26476	Lengthening of tendon, exten	090	153	160	7	5%	5.35	6.12	0.77	14%	0			3.5								
26477	Shortening of tendon, extens	090	153	160	7	5%	5.32	6.09	0.77	14%	0			3.5								
26478	Lengthening of tendon, flexor	090	163	170	7	4%	5.97	6.74	0.77	13%	0			3.5								
26479	Shortening of tendon, flexor,	090	159	166	7	4%	5.91	6.68	0.77	13%	0			3.5								
26480	Transfer or transplant of tend	090	222	235	13	6%	6.90	8.00	1.10	16%	0			3	1						0.5	
26483	Transfer or transplant of tend	090	242	250	8	3%	8.48	9.58	1.10	13%	0			4							1	
26485	Transfer or transplant of tend	090	233	241	8	3%	7.89	8.99	1.10	14%	0			4							1	
26489	Transfer or transplant of tend	090	282	295	13	5%	9.86	11.20	1.34	14%	0			4				1			1	
26490	Opponensplasty; superficialis	090	241	249	8	3%	8.60	9.70	1.10	13%	0			4							1	
26492	Opponensplasty; tendon tran	090	273	282	9	3%	9.84	11.05	1.21	12%	0			4.5							1	
26494	Opponensplasty; hypothenar	090	243	251	8	3%	8.66	9.76	1.10	13%	0			4							1	
26496	Opponensplasty; other metho	090	253	261	8	3%	9.78	10.88	1.10	11%	0			4							1	
26497	Transfer of tendon to restore	090	249	257	8	3%	9.76	10.86	1.10	11%	0			4							1	
26498	Transfer of tendon to restore	090	294	303	9	3%	14.21	15.42	1.21	9%	0			4.5							1	
26499	Correction claw finger, other	090	272	280	8	3%	9.17	10.27	1.10	12%	0			4							1	
26500	Reconstruction of tendon pul	090	179	186	7	4%	6.13	7.01	0.88	14%	0			3.5							0.5	
26502	Reconstruction of tendon pul	090	223	230	7	3%	7.31	8.30	0.99	14%	0			3.5							1	
26508	Release of thenar muscle(s) (	090	206	213	7	3%	6.18	7.17	0.99	16%	0			3.5							1	
26510	Cross intrinsic transfer, each	090	254	261	7	3%	5.60	6.59	0.99	18%	0			3.5							1	
26516	Capsulodesis, metacarpophal	090	217	224	7	3%	7.32	8.31	0.99	14%	0			3.5							1	
26517	Capsulodesis, metacarpophal	090	260	270.5	10.5	4%	9.08	10.30	1.22	13%	0			4				0.5			1	
26518	Capsulodesis, metacarpophal	090	283	293.5	10.5	4%	9.27	10.49	1.22	13%	0			4				0.5			1	
26520	Capsulectomy or capsulotom	090	176	183	7	4%	5.47	6.35	0.88	16%	0			3.5							0.5	
26525	Capsulectomy or capsulotom	090	175	182	7	4%	5.50	6.38	0.88	16%	0			3.5							0.5	
26530	Arthroplasty, metacarpophala	090	205	213	8	4%	6.88	7.87	0.99	14%	0			4							0.5	
26531	Arthroplasty, metacarpophala	090	215	224	9	4%	8.13	9.23	1.10	14%	0			4.5							0.5	
26535	Arthroplasty, interphalangeal	090	196	203	7	4%	5.41	6.29	0.88	16%	0			3.5							0.5	
26536	Arthroplasty, interphalangeal	090	211	219	8	4%	6.56	7.55	0.99	15%	0			4							0.5	
26540	Repair of collateral ligament,	090	204	211	7	3%	6.60	7.59	0.99	15%	0			3.5							1	
26541	Reconstruction, collateral liga	090	245	253	8	3%	8.81	9.91	1.10	12%	0			4							1	
26542	Reconstruction, collateral liga	090	220	227	7	3%	6.95	7.94	0.99	14%	0			3.5							1	
26545	Reconstruction, collateral liga	090	227	235	8	4%	7.11	8.21	1.10	15%	0			4							1	
26546	Repair non-union, metacarpa	090	341	383	42	12%	10.83	13.03	2.20	20%	0				6						1	
26548	Repair and reconstruction, fin	090	226	234	8	4%	8.22	9.32	1.10	13%	0			4							1	
26550	Pollicization of a digit	090	491	504	13	3%	21.68	22.67	0.99	5%	0			3	1							
26551	Transfer, toe-to-hand with mi	090	1004	1073	69	7%	48.48	52.62	4.14	9%	0			5	2			9			1	
26553	Transfer, toe-to-hand with mi	090	989	1058	69	7%	48.17	52.31	4.14	9%	0			5	2			9			1	
26554	Transfer, toe-to-hand with mi	090	1155	1231	76	7%	57.01	61.61	4.60	8%	0			6	2			10			1	
26555	Transfer, finger to another po	090	401	414	13	3%	17.08	18.07	0.99	6%	0			3	1							
26556	Transfer, free toe joint, with r	090	1004	1085	81	8%	49.75	54.33	4.58	9%	0			4	4			9			1	
26560	Repair of syndactyly (web fing	090	183	189	6	3%	5.52	6.18	0.66	12%	0			3								
26561	Repair of syndactyly (web fing	090	258	266	8	3%	11.10	12.20	1.10	10%	0			4							1	
26562	Repair of syndactyly (web fing	090	425	462	37	9%	16.68	18.64	1.96	12%	-2				4	1					1	
26565	Osteotomy; metacarpal, each	090	194	201	7	4%	6.91	7.79	0.88	13%	0			3.5							0.5	
26567	Osteotomy; phalanx of finger	090	195	202	7	4%	6.99	7.87	0.88	13%	0			3.5							0.5	
26568	Osteoplasty, lengthening, me	090	239	247	8	3%	9.27	10.37	1.10	12%	0			4							1	
26580	Repair cleft hand	090	425	460	35	8%	19.75	21.40	1.65	8%	0				5							
26587	Reconstruction of polydactyl	090	401	414	13	3%	14.50	15.49	0.99	7%	0			3	1							
26590	Repair macrodactylia, each di	090	408	426	18	4%	18.67	19.77	1.10	6%	0			2	2							
26591	Repair, intrinsic muscles of ha	090	222	227	5	2%	3.38	4.15	0.77	23%	0			2.5							1	
26593	Release, intrinsic muscles of h	090	233	241	8	3%	5.50	6.60	1.10	20%	0			4							1	
26596	Excision of constricting ring o	090	210	218	8	4%	9.14	10.13	0.99	11%	0			4							0.5	
26600	Closed treatment of metacarp	090	93	101	8	9%	2.60	3.48	0.88	34%	0			4								
26605	Closed treatment of metacarp	090	107	114	7	7%	3.03	3.80	0.77	25%	0			3.5								
26607	Closed treatment of metacarp	090	149	154	5	3%	5.48	6.14	0.66	12%	0			2.5							0.5	
26608	Percutaneous skeletal fixation	090	191	199	8	4%	5.55	6.54	0.99	18%	0			4							0.5	
26615	Open treatment of metacarpa	090	217	235	18	8%	7.07	8.28	1.21	17%	0			2	2						0.5	
26641	Closed treatment of carpome	090	138	146	8	6%	4.13	5.01	0.88	21%	0			4								

26645	Closed treatment of carpome	090	131	138	7	5%	4.58	5.35	0.77	17%	0			3.5								
26650	Percutaneous skeletal fixatior	090	197	215	18	9%	5.35	6.56	1.21	23%	0			2	2						0.5	
26665	Open treatment of carpometa	090	237	255	18	8%	7.94	9.15	1.21	15%	0			2	2						0.5	
26670	Closed treatment of carpome	090	101	107	6	6%	3.83	4.49	0.66	17%	0			3								
26675	Closed treatment of carpome	090	129	137	8	6%	4.83	5.71	0.88	18%	0			4								
26676	Percutaneous skeletal fixatior	090	171	180	9	5%	5.74	6.73	0.99	17%	0			4.5								
26685	Open treatment of carpometa	090	227	245	18	8%	7.07	8.28	1.21	17%	0			2	2						0.5	
26686	Open treatment of carpometa	090	231	240.5	9.5	4%	8.17	9.28	1.11	14%	0			3.5				0.5			1	
26700	Closed treatment of metacarp	090	110	116	6	5%	3.83	4.49	0.66	17%	0			3								
26705	Closed treatment of metacarp	090	142	150	8	6%	4.38	5.26	0.88	20%	0			4								
26706	Percutaneous skeletal fixatior	090	155	163	8	5%	5.31	6.19	0.88	17%	0			4								
26715	Open treatment of metacarpa	090	220	238	18	8%	7.03	8.24	1.21	17%	0			2	2						0.5	
26720	Closed treatment of phalange	090	63	67	4	6%	1.76	2.20	0.44	25%	0			2								
26725	Closed treatment of phalange	090	104	110	6	6%	3.48	4.14	0.66	19%	0			3								
26727	Percutaneous skeletal fixatior	090	174	182	8	5%	5.42	6.41	0.99	18%	0			4							0.5	
26735	Open treatment of phalangea	090	237	255	18	8%	7.42	8.63	1.21	16%	0			2	2						0.5	
26740	Closed treatment of articular	090	78	83	5	6%	2.07	2.62	0.55	27%	0			2.5								
26742	Closed treatment of articular	090	104	110	6	6%	3.99	4.65	0.66	17%	0			3								
26746	Open treatment of articular fi	090	303	328	25	8%	9.80	11.34	1.54	16%	0			2	3						0.5	
26750	Closed treatment of distal ph	090	65	69	4	6%	1.80	2.24	0.44	24%	0			2								
26755	Closed treatment of distal ph	090	85	90	5	6%	3.23	3.78	0.55	17%	0			2.5								
26756	Percutaneous skeletal fixatior	090	146	154	8	5%	4.58	5.46	0.88	19%	0			4								
26765	Open treatment of distal pha	090	217	235	18	8%	5.86	7.07	1.21	21%	0			2	2						0.5	
26770	Closed treatment of interpha	090	86	91	5	6%	3.15	3.70	0.55	17%	0			2.5								
26775	Closed treatment of interpha	090	142	150	8	6%	3.90	4.78	0.88	23%	0			4								
26776	Percutaneous skeletal fixatior	090	152	160	8	5%	4.99	5.87	0.88	18%	0			4								
26785	Open treatment of interphala	090	227	245	18	8%	6.60	7.81	1.21	18%	0			2	2						0.5	
26820	Fusion in opposition, thumb,	090	254	262	8	3%	8.45	9.55	1.10	13%	0			4							1	
26841	Arthrodesis, carpometacarpa	090	222	231	9	4%	7.35	8.45	1.10	15%	0			4.5							0.5	
26842	Arthrodesis, carpometacarpa	090	258	268.5	10.5	4%	8.49	9.71	1.22	14%	0			4				0.5			1	
26843	Arthrodesis, carpometacarpa	090	232	239	7	3%	7.78	8.77	0.99	13%	0			3.5							1	
26844	Arthrodesis, carpometacarpa	090	275	285.5	10.5	4%	8.98	10.20	1.22	14%	0			4				0.5			1	
26850	Arthrodesis, metacarpophala	090	237	244	7	3%	7.14	8.13	0.99	14%	0			3.5							1	
26852	Arthrodesis, metacarpophala	090	272	282.5	10.5	4%	8.71	9.93	1.22	14%	0			4				0.5			1	
26860	Arthrodesis, interphalangeal	090	163	171	8	5%	4.88	5.76	0.88	18%	0			4								
26862	Arthrodesis, interphalangeal	090	227	235	8	4%	7.56	8.55	0.99	13%	0			4							0.5	
26910	Amputation, metacarpal, with	090	251	259	8	3%	7.79	8.89	1.10	14%	0			4							1	
26951	Amputation, finger or thumb,	090	203	223	20	10%	6.04	7.47	1.43	24%	0			3	2						0.5	
26952	Amputation, finger or thumb,	090	173	180	7	4%	6.48	7.36	0.88	14%	0			3.5							0.5	
26990	Incision and drainage, pelvis c	090	265	284.5	19.5	7%	7.95	9.54	1.59	20%	0			3.5				2.5			1	
26991	Incision and drainage, pelvis c	090	229	245	16	7%	7.06	8.42	1.36	19%	0			3				2			1	
26992	Incision, bone cortex, pelvis a	090	291	310.5	19.5	7%	13.48	15.07	1.59	12%	0			3.5				2.5			1	
27000	Tenotomy, adductor of hip, p	090	147	152	5	3%	5.74	6.51	0.77	13%	0			2.5							1	
27001	Tenotomy, adductor of hip, o	090	189	197.5	8.5	4%	7.14	8.14	1.00	14%	0			3				0.5			1	
27003	Tenotomy, adductor, subcuta	090	267	286.5	19.5	7%	7.81	9.40	1.59	20%	0			3.5				2.5			1	
27005	Tenotomy, hip flexor(s), open	090	248	265	17	7%	10.07	11.54	1.47	15%	0			3.5				2			1	
27006	Tenotomy, abductors and/or	090	254	272	18	7%	10.11	11.69	1.58	16%	0			4				2			1	
27025	Fasciotomy, hip or thigh, any	090	392.5	436.5	44	11%	12.89	15.20	2.31	18%	0				4.5			2.5			1	
27027	Decompression fasciotomy(ie	090	359	383	24	7%	13.04	15.17	2.13	16%	0			3	1			3	1		1	
27030	Arthrotomy, hip, with drainag	090	302	329	27	9%	13.65	15.60	1.95	14%	0			3.5				4			1	
27033	Arthrotomy, hip, including ex	090	342	372.5	30.5	9%	14.11	16.29	2.18	15%	0			4				4.5			1	
27035	Denervation, hip joint, intrap	090	369	398	29	8%	17.37	19.54	2.17	12%	0			4.5				4			1	
27036	Capsulectomy or capsulotom	090	380	418	38	10%	14.38	16.40	2.02	14%	0				4			2			1	
27040	Biopsy, soft tissue of pelvis ar	010	106	108	2	2%	2.92	3.25	0.33	11%	0			1							0.5	
27041	Biopsy, soft tissue of pelvis ar	090	250	262	12	5%	10.18	11.41	1.23	12%	0			3.5				1			1	
27043	Excision, tumor, soft tissue of	090	206	215	9	4%	6.88	7.54	0.66	10%	0			1	1						0.5	
27045	Excision, tumor, soft tissue of	090	320	341	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
27047	Excision, tumor, soft tissue of	090	160	169	9	6%	4.94	5.60	0.66	13%	0			1	1						0.5	
27048	Excision, tumor, soft tissue of	090	288	304	16	6%	8.85	10.08	1.23	14%	0			2	1			1			1	
27049	Radical resection of tumor (e	090	496	516	20	4%	21.55	23.62	2.07	10%	0			1	3			1	2		1	
27050	Arthrotomy, with biopsy; sacr	090	260	276	16	6%	4.74	6.10	1.36	29%	0			3				2			1	
27052	Arthrotomy, with biopsy; hip	090	327	358	31	9%	7.42	9.11	1.69	23%	0				3			2			1	
27054	Arthrotomy with synovectom	090	358	386	28	8%	9.21	11.27	2.06	22%	0			4				4			1	
27057	Decompression fasciotomy(ie	090	389	413	24	6%	14.91	17.04	2.13	14%	0			3	1			3	1		1	
27059	Radical resection of tumor (e	090	608	640	32	5%	29.35	31.99	2.64	9%	-2			1	2	1		3	2		1	
27060	Excision; ischial bursa	090	254	272.5	18.5	7%	5.87	7.35	1.48	25%	0			3				2.5			1	

27062	Excision; trochanteric bursa o	090	185	191	6	3%	5.75	6.52	0.77	13%	0			3							0.5	
27065	Excision of bone cyst or benig	090	329	356	27	8%	6.55	8.50	1.95	30%	0			3.5				4			1	
27066	Excision of bone cyst or benig	090	406	442.5	36.5	9%	11.20	13.73	2.53	23%	0			4.5				5.5			1	
27067	Excision of bone cyst or benig	090	443	480.5	37.5	8%	14.72	17.36	2.64	18%	0			5				5.5			1	
27070	Partial excision, wing of ilium	090	363	398.5	35.5	10%	11.56	13.98	2.42	21%	0			4				5.5			1	
27071	Partial excision, wing of ilium	090	409	448	39	10%	12.39	15.04	2.65	21%	0			4.5				6			1	
27075	Radical resection of tumor; w	090	633	656	23	4%	32.71	35.31	2.60	8%	-2			1	2	1		2	3		1	
27076	Radical resection of tumor; ili	090	840	864	24	3%	40.21	43.25	3.04	8%	-2			1	2	1		3	4		1	
27077	Radical resection of tumor; in	090	905	934	29	3%	45.21	48.49	3.28	7%	-2			1	2	1		4	4		1	
27078	Radical resection of tumor; is	090	665	688	23	3%	32.21	34.81	2.60	8%	-2			1	2	1		2	3		1	
27080	Coccygectomy, primary	090	274	295	21	8%	6.89	8.49	1.60	23%	0			3				3			1	
27086	Removal of foreign body, pelv	010	82	84	2	2%	1.92	2.14	0.22	11%	0			1								
27087	Removal of foreign body, pelv	090	249	261	12	5%	8.83	10.06	1.23	14%	0			3.5				1			1	
27090	Removal of hip prosthesis; (se	090	317	340	23	7%	11.69	13.51	1.82	16%	0			4				3			1	
27091	Removal of hip prosthesis; co	090	577	645	68	12%	24.35	27.81	3.46	14%	0				4			8			1	
27097	Release or recession, hamstri	090	271	290.5	19.5	7%	9.27	10.86	1.59	17%	0			3.5				2.5			1	
27098	Transfer, adductor to ischium	090	303	323.5	20.5	7%	9.32	11.02	1.70	18%	0			4				2.5			1	
27100	Transfer external oblique mus	090	311	322.5	11.5	4%	11.35	12.68	1.33	12%	0			4.5				0.5			1	
27105	Transfer paraspinal muscle to	090	332	343.5	11.5	3%	12.04	13.37	1.33	11%	0			4.5				0.5			1	
27110	Transfer iliopsoas; to greater	090	365	386.5	21.5	6%	13.77	15.58	1.81	13%	0			4.5				2.5			1	
27111	Transfer iliopsoas; to femoral	090	339	358	19	6%	12.60	14.29	1.69	13%	0			4.5				2			1	
27120	Acetabuloplasty; (eg, Whitma	090	515	567.5	52.5	10%	19.25	22.61	3.36	17%	0			5				8.5			1	
27122	Acetabuloplasty; resection, fe	090	436	482.5	46.5	11%	16.09	19.10	3.01	19%	0			4.5				7.5			1	
27125	Hemiarthroplasty, hip, partial	090	430.5	490	59.5	14%	16.64	19.70	3.06	18%	0				3.5			7			1	
27130	Arthroplasty, acetabular and	090	377	390	13	3%	19.60	21.21	1.61	8%	0				3				2		1	
27132	Conversion of previous hip su	090	611	686.5	75.5	12%	25.69	29.51	3.82	15%	0				4			9.5			1	
27134	Revision of total hip arthropla	090	617	673	56	9%	30.28	33.17	2.89	10%	0				3			7			1	
27137	Revision of total hip arthropla	090	492	538	46	9%	22.70	25.11	2.41	11%	0				3			5			1	
27138	Revision of total hip arthropla	090	492	538	46	9%	23.70	26.11	2.41	10%	0				3			5			1	
27140	Osteotomy and transfer of gr	090	335	358	23	7%	12.78	14.60	1.82	14%	0			4				3			1	
27146	Osteotomy, iliac, acetabular c	090	443	481	38	9%	18.92	20.94	2.02	11%	0				4			2			1	
27147	Osteotomy, iliac, acetabular c	090	473	511	38	8%	22.07	24.09	2.02	9%	0				4			2			1	
27151	Osteotomy, iliac, acetabular c	090	523	566	43	8%	24.12	26.38	2.26	9%	0				4			3			1	
27156	Osteotomy, iliac, acetabular c	090	538	581	43	8%	26.23	28.49	2.26	9%	0				4			3			1	
27158	Osteotomy, pelvis, bilateral (e	090	562	617	55	10%	21.04	24.52	3.48	17%	0			5				9			1	
27161	Osteotomy, femoral neck (se	090	489	539	50	10%	17.89	21.13	3.24	18%	0			5				8			1	
27165	Osteotomy, intertrochanteric	090	531.5	603	71.5	13%	20.29	23.92	3.63	18%	0				4.5			8			1	
27170	Bone graft, femoral head, ne	090	444	490	46	10%	17.61	20.02	2.41	14%	0				3			5			1	
27175	Treatment of slipped femoral	090	308	346.5	38.5	13%	9.38	11.82	2.44	26%	0			3				6.5			1	
27176	Treatment of slipped femoral	090	385	421.5	36.5	9%	12.92	15.45	2.53	20%	0			4.5				5.5			1	
27177	Open treatment of slipped fe	090	477	519.5	42.5	9%	16.09	18.97	2.88	18%	0			5				6.5			1	
27178	Open treatment of slipped fe	090	408	447	39	10%	12.92	15.57	2.65	21%	0			4.5				6			1	
27179	Open treatment of slipped fe	090	442	483.5	41.5	9%	13.97	16.74	2.77	20%	0			4.5				6.5			1	
27181	Open treatment of slipped fe	090	445	483	38	9%	16.18	18.20	2.02	12%	0				4			2			1	
27185	Epiphyseal arrest by epiphysi	090	320	345.5	25.5	8%	9.79	11.73	1.94	20%	0			4				3.5			1	
27187	Prophylactic treatment (nailin	090	396	425	29	7%	14.23	16.40	2.17	15%	0			4.5				4			1	
27200	Closed treatment of coccygea	090	63	66	3	5%	1.92	2.25	0.33	17%	0			1.5								
27202	Open treatment of coccygeal	090	216	227.5	11.5	5%	7.31	8.33	1.02	14%	0			2				1.5			1	
27215	Open treatment of iliac spine	090	388	405	17	4%	10.45	12.12	1.67	16%	0			2	1			2	1		1	
27216	Percutaneous skeletal fixation	090	393	427	34	9%	15.73	18.08	2.35	15%	0			1	3			3	1		1	
27217	Open treatment of anterior p	090	443	477	34	8%	14.65	17.00	2.35	16%	0			1	3			3	1		1	
27218	Open treatment of posterior	090	543	587	44	8%	20.93	23.76	2.83	14%	0			1	3			5	1		1	
27220	Closed treatment of acetabul	090	184	191	7	4%	5.50	6.82	1.32	24%	0			3				1	1		1	
27222	Closed treatment of acetabul	090	472	531	59	13%	14.11	17.72	3.61	26%	0			4.5				10			1	
27226	Open treatment of posterior	090	412	440	28	7%	15.57	17.63	2.06	13%	0			4				4			1	
27227	Open treatment of acetabula	090	550	608	58	11%	25.41	28.39	2.98	12%	0				4			6			1	
27228	Open treatment of acetabula	090	680	729	49	7%	29.33	32.27	2.94	10%	0				4			5	1		1	
27230	Closed treatment of femoral	090	205	218	13	6%	5.81	7.15	1.34	23%	0			4				1			1	
27232	Closed treatment of femoral	090	353	397	44	12%	11.72	14.30	2.58	22%	0			2				8			1	
27235	Percutaneous skeletal fixation	090	360	395.5	35.5	10%	13.00	15.42	2.42	19%	0			4				5.5			1	
27236	Open treatment of femoral fr	090	418	438	20	5%	17.61	19.68	2.07	12%	0			1	3			1	2		1	
27238	Closed treatment of intertroc	090	207	216.5	9.5	5%	5.75	6.86	1.11	19%	0			3.5				0.5			1	
27240	Closed treatment of intertroc	090	454	509	55	12%	13.81	17.29	3.48	25%	0			5				9			1	
27244	Treatment of intertrochanter	090	438	463	25	6%	18.18	20.49	2.31	13%	0			1	3			2	2		1	
27245	Treatment of intertrochanter	090	443	468	25	6%	18.18	20.49	2.31	13%	0			1	3			2	2		1	
27246	Closed treatment of greater t	090	141	146	5	4%	4.83	5.60	0.77	16%	0			2.5							1	

27248	Open treatment of greater tr	090	384	394	10	3%	10.78	12.63	1.85	17%	0			3	1			1	2		1	
27252	Closed treatment of hip dislo	090	284	311	27	10%	11.03	12.98	1.95	18%	0			3.5				4			1	
27253	Open treatment of hip disloca	090	344	372	28	8%	13.58	15.64	2.06	15%	0			4				4			1	
27254	Open treatment of hip disloca	090	413	442	29	7%	18.94	21.11	2.17	11%	0			4.5				4			1	
27256	Treatment of spontaneous hi	010	154	161	7	5%	4.28	4.96	0.68	16%	0			1				1			1	
27257	Treatment of spontaneous hi	010	173	180	7	4%	5.38	6.06	0.68	13%	0			1				1			1	
27258	Open treatment of spontaned	090	395	426.5	31.5	8%	16.18	18.47	2.29	14%	0			4.5				4.5			1	
27259	Open treatment of spontaned	090	537	582	45	8%	23.26	25.61	2.35	10%	-2				3	1		3			1	
27265	Closed treatment of post hip	090	150	158	8	5%	5.24	6.23	0.99	19%	0			4							0.5	
27266	Closed treatment of post hip	090	202	214	12	6%	7.78	9.01	1.23	16%	0			3.5				1			1	
27267	Closed treatment of femoral f	090	171	189	18	11%	5.50	7.08	1.58	29%	0			4				2			1	
27268	Closed treatment of femoral f	090	196	214	18	9%	7.12	8.70	1.58	22%	0			4				2			1	
27269	Open treatment of femoral fr	090	404	423	19	5%	18.89	20.78	1.89	10%	0			3	1			2	1		1	
27275	Manipulation, hip joint, requi	010	110	112	2	2%	2.32	2.76	0.44	19%	0			1							1	
27279	Arthrodesis, sacroiliac joint, p	090	241	257	16	7%	12.13	13.12	0.99	8%	0			1	2						0.5	
27280	Arthrodesis, open, sacroiliac j	090	383	400	17	4%	20.00	21.54	1.54	8%	0			1	2			1	1		1	
27282	Arthrodesis, symphysis pubis	090	342	363.5	21.5	6%	11.85	13.66	1.81	15%	0			4.5				2.5			1	
27284	Arthrodesis, hip joint (includi	090	497	529	32	6%	25.06	27.19	2.13	8%	0				3			3	1		1	
27286	Arthrodesis, hip joint (includi	090	540	588	48	9%	25.17	27.67	2.50	10%	0				4			4			1	
27290	Interpelviabdominal amputat	090	615	668.5	53.5	9%	24.55	28.02	3.47	14%	0			5.5				8.5			1	
27295	Disarticulation of hip	090	499	542	43	9%	19.66	22.44	2.78	14%	0			4				7			1	
27301	Incision and drainage, deep a	090	220	232	12	5%	6.78	8.01	1.23	18%	0			3.5				1			1	
27303	Incision, deep, with opening c	090	249	263.5	14.5	6%	8.63	9.98	1.35	16%	0			3.5				1.5			1	
27305	Fasciotomy, iliotibial (tenotor	090	207	218	11	5%	6.18	7.30	1.12	18%	0			3				1			1	
27306	Tenotomy, percutaneous, adc	090	162	167	5	3%	4.74	5.51	0.77	16%	0			2.5							1	
27307	Tenotomy, percutaneous, adc	090	206	217	11	5%	6.06	7.18	1.12	18%	0			3				1			1	
27310	Arthrotomy, knee, with explo	090	311	341.5	30.5	10%	10.00	12.18	2.18	22%	0			4				4.5			1	
27323	Biopsy, soft tissue of thigh or	010	74	76	2	3%	2.33	2.55	0.22	9%	0			1								
27324	Biopsy, soft tissue of thigh or	090	168	174	6	4%	5.04	5.81	0.77	15%	0			3							0.5	
27325	Neurectomy, hamstring musc	090	229	238.5	9.5	4%	7.20	8.31	1.11	15%	0			3.5				0.5			1	
27326	Neurectomy, popliteal (gastro	090	215	222	7	3%	6.47	7.46	0.99	15%	0			3.5							1	
27327	Excision, tumor, soft tissue of	090	140	149	9	6%	3.96	4.62	0.66	17%	0			1	1						0.5	
27328	Excision, tumor, soft tissue of	090	261	277	16	6%	8.85	10.08	1.23	14%	0			2	1			1			1	
27329	Radical resection of tumor (e	090	413	437	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
27330	Arthrotomy, knee; with synov	090	165	171	6	4%	5.11	5.88	0.77	15%	0			3							0.5	
27331	Arthrotomy, knee; including j	090	200	206	6	3%	6.02	6.90	0.88	15%	0			3							1	
27332	Arthrotomy, with excision of s	090	235	243	8	3%	8.46	9.56	1.10	13%	0			4							1	
27333	Arthrotomy, with excision of s	090	263	273.5	10.5	4%	7.55	8.77	1.22	16%	0			4				0.5			1	
27334	Arthrotomy, with synovectom	090	294	314.5	20.5	7%	9.19	10.89	1.70	18%	0			4				2.5			1	
27335	Arthrotomy, with synovectom	090	329	352	23	7%	10.55	12.37	1.82	17%	0			4				3			1	
27337	Excision, tumor, soft tissue of	090	181	190	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
27339	Excision, tumor, soft tissue of	090	310	331	21	7%	11.13	12.47	1.34	12%	0			1	2			1			1	
27340	Excision, prepatellar bursa	090	155	161	6	4%	4.32	5.09	0.77	18%	0			3							0.5	
27345	Excision of synovial cyst of po	090	204	211	7	3%	6.09	6.97	0.88	14%	0			3.5							0.5	
27347	Excision of lesion of meniscus	090	214	235	21	10%	6.73	7.72	0.99	15%	0				3							
27350	Patellectomy or hemipatellec	090	289	309.5	20.5	7%	8.66	10.36	1.70	20%	0			4				2.5			1	
27355	Excision or curettage of bone	090	258	272.5	14.5	6%	8.00	9.35	1.35	17%	0			3.5				1.5			1	
27356	Excision or curettage of bone	090	331	356.5	25.5	8%	10.09	12.03	1.94	19%	0			4				3.5			1	
27357	Excision or curettage of bone	090	361	387.5	26.5	7%	11.16	13.21	2.05	18%	0			4.5				3.5			1	
27360	Partial excision (craterization,	090	386	426.5	40.5	10%	11.46	14.12	2.66	23%	0			4				6.5			1	
27364	Radical resection of tumor (e	090	550	577	27	5%	24.49	26.89	2.40	10%	-2			1	2	1		2	2		1	
27365	Radical resection of tumor, fe	090	633	656	23	4%	32.21	34.81	2.60	8%	-2			1	2	1		2	3		1	
27372	Removal of foreign body, dee	090	168	174	6	4%	5.21	5.98	0.77	15%	0			3							0.5	
27380	Suture of infrapatellar tendor	090	235	247	12	5%	7.45	8.68	1.23	17%	0			3.5				1			1	
27381	Suture of infrapatellar tendor	090	320	338	18	6%	10.76	12.34	1.58	15%	0			4				2			1	
27385	Suture of quadriceps or hams	090	237	250	13	5%	6.93	8.03	1.10	16%	0			3	1						0.5	
27386	Suture of quadriceps or hams	090	350	374	24	7%	11.13	13.06	1.93	17%	0			4.5				3			1	
27390	Tenotomy, open, hamstring, l	090	184	192.5	8.5	5%	5.53	6.53	1.00	18%	0			3				0.5			1	
27391	Tenotomy, open, hamstring, l	090	233	245	12	5%	7.49	8.72	1.23	16%	0			3.5				1			1	
27392	Tenotomy, open, hamstring, l	090	292	310	18	6%	9.63	11.21	1.58	16%	0			4				2			1	
27393	Lengthening of hamstring ten	090	197	205.5	8.5	4%	6.59	7.59	1.00	15%	0			3				0.5			1	
27394	Lengthening of hamstring ten	090	248	260	12	5%	8.79	10.02	1.23	14%	0			3.5				1			1	
27395	Lengthening of hamstring ten	090	348	369.5	21.5	6%	12.24	14.05	1.81	15%	0			4.5				2.5			1	
27396	Transplant or transfer (with n	090	254	266	12	5%	8.15	9.38	1.23	15%	0			3.5				1			1	
27397	Transplant or transfer (with n	090	360	393	33	9%	12.66	14.44	1.78	14%	0				4			1			1	
27400	Transfer, tendon or muscle, h	090	274	287	13	5%	9.33	10.67	1.34	14%	0			4				1			1	

27403	Arthrotomy with meniscus re	090	257	269	12	5%	8.62	9.85	1.23	14%	0			3.5				1			1	
27405	Repair, primary, torn ligamen	090	282	300	18	6%	9.08	10.66	1.58	17%	0			4				2			1	
27407	Repair, primary, torn ligamen	090	349	373	24	7%	10.85	12.78	1.93	18%	0			4.5				3			1	
27409	Repair, primary, torn ligamen	090	410	444	34	8%	13.71	16.12	2.41	18%	0			4.5				5			1	
27412	Autologous chondrocyte impl	090	484	510	26	5%	24.74	26.83	2.09	8%	0			2	3			1	1		1	
27415	Osteochondral allograft, knee	090	424	450	26	6%	20.00	22.09	2.09	10%	0			2	3			1	1		1	
27416	Osteochondral autograft(s), k	090	287	305	18	6%	14.16	15.37	1.21	9%	0			2	2						0.5	
27418	Anterior tibial tubercleplasty	090	358	389.5	31.5	9%	11.60	13.89	2.29	20%	0			4.5				4.5			1	
27420	Reconstruction of dislocating	090	295	313	18	6%	10.26	11.84	1.58	15%	0			4				2			1	
27422	Reconstruction of dislocating	090	297	315	18	6%	10.21	11.79	1.58	15%	0			4				2			1	
27424	Reconstruction of dislocating	090	298	316	18	6%	10.24	11.82	1.58	15%	0			4				2			1	
27425	Lateral retinacular release, op	090	159	166	7	4%	5.39	6.16	0.77	14%	0			3.5								
27427	Ligamentous reconstruction (	090	302	320	18	6%	9.79	11.37	1.58	16%	0			4				2			1	
27428	Ligamentous reconstruction (	090	363	398	35	10%	15.58	17.45	1.87	12%	0				5						1	
27429	Ligamentous reconstruction (	090	466	513	47	10%	17.54	19.98	2.44	14%	0				6			1			1	
27430	Quadricepsplasty (eg, Bennet	090	303	323.5	20.5	7%	10.16	11.86	1.70	17%	0			4				2.5			1	
27435	Capsulotomy, posterior capsu	090	340	373	33	10%	10.88	12.66	1.78	16%	0				4			1			1	
27437	Arthroplasty, patella; without	090	273	292.5	19.5	7%	8.93	10.52	1.59	18%	0			3.5				2.5			1	
27438	Arthroplasty, patella; with pr	090	332	360	28	8%	11.89	13.95	2.06	17%	0			4				4			1	
27440	Arthroplasty, knee, tibial plat	090	334	362	28	8%	11.09	13.15	2.06	19%	0			4				4			1	
27441	Arthroplasty, knee, tibial plat	090	360	390.5	30.5	8%	11.54	13.72	2.18	19%	0			4				4.5			1	
27442	Arthroplasty, femoral condyle	090	307	327.5	20.5	7%	12.37	14.07	1.70	14%	0			4				2.5			1	
27443	Arthroplasty, femoral condyle	090	323	343.5	20.5	6%	11.41	13.11	1.70	15%	0			4				2.5			1	
27445	Arthroplasty, knee, hinge pro	090	447	488.5	41.5	9%	18.66	21.43	2.77	15%	0			4.5				6.5			1	
27446	Arthroplasty, knee, condyle a	090	310	333	23	7%	17.13	18.32	1.19	7%	-2				2	1					0.5	
27447	Arthroplasty, knee, condyle a	090	374	387	13	3%	19.60	21.21	1.61	8%	0				3				2		1	
27448	Osteotomy, femur, shaft or su	090	324	347	23	7%	11.60	13.42	1.82	16%	0			4				3			1	
27450	Osteotomy, femur, shaft or su	090	392	418.5	26.5	7%	14.61	16.66	2.05	14%	0			4.5				3.5			1	
27454	Osteotomy, multiple, with rea	090	430	473	43	10%	19.17	21.43	2.26	12%	0				4			3			1	
27455	Osteotomy, proximal tibia, in	090	344	367	23	7%	13.36	15.18	1.82	14%	0			4				3			1	
27457	Osteotomy, proximal tibia, in	090	370	394.5	24.5	7%	14.03	15.86	1.83	13%	0			3.5				3.5			1	
27465	Osteoplasty, femur; shortenir	090	383.5	416.5	33	9%	18.60	20.64	2.04	11%	0			2	2			3			1	
27466	Osteoplasty, femur; lengthen	090	467	507	40	9%	17.28	20.04	2.76	16%	0			5				6			1	
27468	Osteoplasty, femur; combine	090	515	557.5	42.5	8%	19.97	22.85	2.88	14%	0			5				6.5			1	
27470	Repair, nonunion or malunion	090	400	421	21	5%	17.14	19.25	2.11	12%	0			4	1			2	1		1	
27472	Repair, nonunion or malunion	090	502	544.5	42.5	8%	18.72	21.60	2.88	15%	0			5				6.5			1	
27475	Arrest, epiphyseal, any metho	090	252	264	12	5%	8.93	10.16	1.23	14%	0			3.5				1			1	
27477	Arrest, epiphyseal, any metho	090	262	274	12	5%	10.14	11.37	1.23	12%	0			3.5				1			1	
27479	Arrest, epiphyseal, any metho	090	326	341.5	15.5	5%	13.16	14.62	1.46	11%	0			4				1.5			1	
27485	Arrest, hemiepiphyseal, dista	090	241	253	12	5%	9.13	10.36	1.23	13%	0			3.5				1			1	
27486	Revision of total knee arthrop	090	470	523	53	11%	21.12	23.86	2.74	13%	0				4			5			1	
27487	Revision of total knee arthrop	090	520	573	53	10%	27.11	29.85	2.74	10%	0				4			5			1	
27488	Removal of prosthesis, includ	090	470	523	53	11%	17.60	20.34	2.74	16%	0				4			5			1	
27495	Prophylactic treatment (nailin	090	452	493.5	41.5	9%	16.54	19.31	2.77	17%	0			4.5				6.5			1	
27496	Decompression fasciotomy, t	090	287	315	28	10%	6.78	8.84	2.06	30%	0			4				4			1	
27497	Decompression fasciotomy, t	090	301	327	26	9%	7.79	9.63	1.84	24%	0			3				4			1	
27498	Decompression fasciotomy, t	090	327	355	28	9%	8.66	10.72	2.06	24%	0			4				4			1	
27499	Decompression fasciotomy, t	090	332	350	18	5%	9.43	11.01	1.58	17%	0			4				2			1	
27500	Closed treatment of femoral s	090	216	232	16	7%	6.30	7.66	1.36	22%	0			3				2			1	
27501	Closed treatment of supracon	090	169	185	16	9%	6.45	7.68	1.23	19%	0			2	1			1			1	
27502	Closed treatment of femoral s	090	328	361	33	10%	11.36	13.66	2.30	20%	0			4				5			1	
27503	Closed treatment of supracon	090	249	272	23	9%	11.27	12.96	1.69	15%	0			3	1			2			1	
27506	Open treatment of femoral sh	090	501.5	565.5	64	13%	19.65	22.92	3.27	17%	0				4.5			6.5			1	
27507	Open treatment of femoral sh	090	376	397	21	6%	14.48	16.08	1.60	11%	0			3				3			1	
27508	Closed treatment of femoral f	090	221	236.5	15.5	7%	6.20	7.66	1.46	24%	0			4				1.5			1	
27509	Percutaneous skeletal fixation	090	297	315	18	6%	8.14	9.72	1.58	19%	0			4				2			1	
27510	Closed treatment of femoral f	090	298	326	28	9%	9.80	11.86	2.06	21%	0			4				4			1	
27511	Open treatment of femoral su	090	439	449	10	2%	15.11	16.96	1.85	12%	0			3	1			1	2		1	
27513	Open treatment of femoral su	090	464	474	10	2%	19.25	21.10	1.85	10%	0			3	1			1	2		1	
27514	Open treatment of femoral fr	090	409	419	10	2%	14.60	16.45	1.85	13%	0			3	1			1	2		1	
27516	Closed treatment of distal fer	090	215	224	9	4%	5.59	6.80	1.21	22%	0			4.5							1	
27517	Closed treatment of distal fer	090	249	263	14	6%	9.12	10.57	1.45	16%	0			4.5				1			1	
27519	Open treatment of distal fem	090	359	373	14	4%	13.25	14.90	1.65	12%	0			3	1			1	1		1	
27520	Closed treatment of patellar f	090	124	131	7	6%	3.04	3.81	0.77	25%	0			3.5								
27524	Open treatment of patellar fr	090	274	289.5	15.5	6%	10.37	11.83	1.46	14%	0			4				1.5			1	
27530	Closed treatment of tibial fra	090	91	99	8	9%	2.65	3.53	0.88	33%	0			4								

27532	Closed treatment of tibial fra	090	218	228.5	10.5	5%	7.55	8.77	1.22	16%	0			4				0.5			1	
27535	Open treatment of tibial fract	090	389	394	5	1%	13.41	15.02	1.61	12%	0			3	1				2		1	
27536	Open treatment of tibial fract	090	475	523	48	10%	17.39	19.89	2.50	14%	0				4			4			1	
27538	Closed treatment of intercon	090	140	149	9	6%	5.09	6.08	0.99	19%	0			4.5								
27540	Open treatment of intercond	090	334	343	9	3%	11.30	12.71	1.41	12%	0			3	1				1		1	
27550	Closed treatment of knee disl	090	143	152	9	6%	5.98	6.97	0.99	17%	0			4.5								
27552	Closed treatment of knee disl	090	228	239.5	11.5	5%	8.18	9.51	1.33	16%	0			4.5				0.5			1	
27556	Open treatment of knee dislo	090	369	383	14	4%	13.00	14.65	1.65	13%	0			3	1			1	1		1	
27557	Open treatment of knee dislo	090	399	413	14	4%	15.90	17.55	1.65	10%	0			3	1			1	1		1	
27558	Open treatment of knee dislo	090	429	443	14	3%	18.39	20.04	1.65	9%	0			3	1			1	1		1	
27560	Closed treatment of patellar d	090	105	112	7	7%	3.99	4.76	0.77	19%	0			3.5								
27562	Closed treatment of patellar d	090	168	176	8	5%	5.98	6.97	0.99	17%	0			4							0.5	
27566	Open treatment of patellar di	090	303	323.5	20.5	7%	12.71	14.41	1.70	13%	0			4				2.5			1	
27570	Manipulation of knee joint un	010	71	73	2	3%	1.79	2.01	0.22	12%	0			1								
27580	Arthrodesis, knee, any techni	090	450	498	48	11%	21.10	23.60	2.50	12%	0				4			4			1	
27590	Amputation, thigh, through fe	090	449	509.5	60.5	13%	13.47	17.09	3.62	27%	0			4				10.5			1	
27591	Amputation, thigh, through fe	090	462	515	53	11%	13.94	17.20	3.26	23%	0			4				9			1	
27592	Amputation, thigh, through fe	090	358	398.5	40.5	11%	10.98	13.64	2.66	24%	0			4				6.5			1	
27594	Amputation, thigh, through fe	090	268	283.5	15.5	6%	7.29	8.75	1.46	20%	0			4				1.5			1	
27596	Amputation, thigh, through fe	090	345	374	29	8%	11.29	13.46	2.17	19%	0			4.5				4			1	
27598	Disarticulation at knee	090	340	369	29	9%	11.22	13.39	2.17	19%	0			4.5				4			1	
27600	Decompression fasciotomy, le	090	211	227	16	8%	6.03	7.39	1.36	23%	0			3				2			1	
27601	Decompression fasciotomy, le	090	220	237	17	8%	6.05	7.52	1.47	24%	0			3.5				2			1	
27602	Decompression fasciotomy, le	090	253	272.5	19.5	8%	7.82	9.41	1.59	20%	0			3.5				2.5			1	
27603	Incision and drainage, leg or a	090	199	211	12	6%	5.23	6.46	1.23	24%	0			3.5				1			1	
27604	Incision and drainage, leg or a	090	130	135	5	4%	4.59	5.25	0.66	14%	0			2.5							0.5	
27605	Tenotomy, percutaneous, Ach	010	88	90	2	2%	2.92	3.14	0.22	8%	0			1								
27606	Tenotomy, percutaneous, Ach	010	131	133	2	2%	4.18	4.62	0.44	11%	0			1							1	
27607	Incision (eg, osteomyelitis or	090	281	308	27	10%	8.62	10.57	1.95	23%	0			3.5				4			1	
27610	Arthrotomy, ankle, including	090	311	344	33	11%	9.13	11.43	2.30	25%	0			4				5			1	
27612	Arthrotomy, posterior capsula	090	353	387	34	10%	8.15	10.56	2.41	30%	0			4.5				5			1	
27613	Biopsy, soft tissue of leg or ar	010	77	79	2	3%	2.22	2.44	0.22	10%	0			1								
27614	Biopsy, soft tissue of leg or ar	090	192	198	6	3%	5.80	6.68	0.88	15%	0			3							1	
27615	Radical resection of tumor (eg	090	416	440	24	6%	15.72	17.59	1.87	12%	0			1	3			1	1		1	
27616	Radical resection of tumor (eg	090	463	489	26	6%	19.63	21.59	1.96	10%	-2			1	2	1		1	1		1	
27618	Excision, tumor, soft tissue of	090	137	146	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
27619	Excision, tumor, soft tissue of	090	225	236	11	5%	6.91	7.79	0.88	13%	0			2	1						0.5	
27620	Arthrotomy, ankle, with joint	090	180	187	7	4%	6.15	7.03	0.88	14%	0			3.5							0.5	
27625	Arthrotomy, with synovectom	090	249	257	8	3%	8.49	9.59	1.10	13%	0			4							1	
27626	Arthrotomy, with synovectom	090	268	276	8	3%	9.10	10.20	1.10	12%	0			4							1	
27630	Excision of lesion of tendon s	090	146	152	6	4%	4.94	5.60	0.66	13%	0			3								
27632	Excision, tumor, soft tissue of	090	183	192	9	5%	5.91	6.57	0.66	11%	0			1	1						0.5	
27634	Excision, tumor, soft tissue of	090	281	302	21	7%	10.13	11.47	1.34	13%	0			1	2			1			1	
27635	Excision or curettage of bone	090	267	277.5	10.5	4%	8.03	9.25	1.22	15%	0			4				0.5			1	
27637	Excision or curettage of bone	090	336	355	19	6%	10.31	12.00	1.69	16%	0			4.5				2			1	
27638	Excision or curettage of bone	090	315	333	18	6%	10.99	12.57	1.58	14%	0			4				2			1	
27640	Partial excision (craterization,	090	382	418.5	36.5	10%	12.24	14.77	2.53	21%	0			4.5				5.5			1	
27641	Partial excision (craterization,	090	319	344.5	25.5	8%	9.84	11.78	1.94	20%	0			4				3.5			1	
27645	Radical resection of tumor; tib	090	553	580	27	5%	27.21	29.61	2.40	9%	-2			1	2	1		2	2		1	
27646	Radical resection of tumor; fib	090	540	562	22	4%	23.21	25.37	2.16	9%	-2			1	2	1		1	2		1	
27647	Radical resection of tumor; ta	090	469	484	15	3%	20.26	22.09	1.83	9%	-2			1	1	1		1	2		1	
27650	Repair, primary, open or perc	090	239	264	25	10%	9.21	10.75	1.54	17%	0			2	3						0.5	
27652	Repair, primary, open or perc	090	312	331	19	6%	10.78	12.47	1.69	16%	0			4.5				2			1	
27654	Repair, secondary, Achilles te	090	283	308	25	9%	10.53	12.07	1.54	15%	0			2	3						0.5	
27656	Repair, fascial defect of leg	090	171	177	6	4%	4.71	5.48	0.77	16%	0			3							0.5	
27658	Repair, flexor tendon, leg; pri	090	196	202	6	3%	5.12	6.00	0.88	17%	0			3							1	
27659	Repair, flexor tendon, leg; sec	090	246	258	12	5%	7.10	8.33	1.23	17%	0			3.5				1			1	
27664	Repair, extensor tendon, leg;	090	173	179	6	3%	4.73	5.50	0.77	16%	0			3							0.5	
27665	Repair, extensor tendon, leg;	090	201	208	7	3%	5.57	6.45	0.88	16%	0			3.5							0.5	
27675	Repair, dislocating peroneal t	090	228	235	7	3%	7.35	8.34	0.99	13%	0			3.5							1	
27676	Repair, dislocating peroneal t	090	274	287	13	5%	8.73	10.07	1.34	15%	0			4				1			1	
27680	Tenolysis, flexor or extensor t	090	197	203	6	3%	5.88	6.76	0.88	15%	0			3							1	
27681	Tenolysis, flexor or extensor t	090	232	241.5	9.5	4%	7.05	8.16	1.11	16%	0			3.5				0.5			1	
27685	Lengthening or shortening of	090	200	208	8	4%	6.69	7.68	0.99	15%	0			4							0.5	
27686	Lengthening or shortening of	090	252	264	12	5%	7.75	8.98	1.23	16%	0			3.5				1			1	
27687	Gastrocnemius recession (eg,	090	199	206	7	4%	6.41	7.29	0.88	14%	0			3.5							0.5	

27690	Transfer or transplant of sing	090	258	283	25	10%	9.17	10.71	1.54	17%	0			2	3						0.5	
27691	Transfer or transplant of sing	090	292	317	25	9%	10.49	12.14	1.65	16%	0			2	3						1	
27695	Repair, primary, disrupted lig	090	225	233	8	4%	6.70	7.80	1.10	16%	0			4							1	
27696	Repair, primary, disrupted lig	090	280	293	13	5%	8.58	9.92	1.34	16%	0			4				1			1	
27698	Repair, secondary, disrupted	090	275	285.5	10.5	4%	9.61	10.83	1.22	13%	0			4				0.5			1	
27700	Arthroplasty, ankle;	090	310	325.5	15.5	5%	9.66	11.12	1.46	15%	0			4				1.5			1	
27702	Arthroplasty, ankle; with impl	090	416	447.5	31.5	8%	14.42	16.71	2.29	16%	0			4.5				4.5			1	
27703	Arthroplasty, ankle; revision,	090	488	533	45	9%	16.94	19.94	3.00	18%	0			5				7			1	
27704	Removal of ankle implant	090	251	259	8	3%	7.81	8.91	1.10	14%	0			4							1	
27705	Osteotomy; tibia	090	303	323.5	20.5	7%	10.86	12.56	1.70	16%	0			4				2.5			1	
27707	Osteotomy; fibula	090	243	260	17	7%	4.78	6.25	1.47	31%	0			3.5				2			1	
27709	Osteotomy; tibia and fibula	090	346	374	28	8%	17.48	19.28	1.80	10%	0			2	2			2			1	
27712	Osteotomy; multiple, with rea	090	400	443	43	11%	15.87	18.13	2.26	14%	0				4			3			1	
27715	Osteoplasty, tibia and fibula,	090	457	503.5	46.5	10%	15.50	18.51	3.01	19%	0			4.5				7.5			1	
27720	Repair of nonunion or maluni	090	356	380	24	7%	12.36	14.29	1.93	16%	0			4.5				3			1	
27722	Repair of nonunion or maluni	090	389	415.5	26.5	7%	12.45	14.50	2.05	16%	0			4.5				3.5			1	
27724	Repair of nonunion or maluni	090	460	477	17	4%	19.31	20.85	1.54	8%	0			1	2			1	1		1	
27725	Repair of nonunion or maluni	090	464	511	47	10%	17.41	19.85	2.44	14%	-4				2	2		3			1	
27726	Repair of fibula nonunion and	090	319	337	18	6%	14.34	15.79	1.45	10%	0			3	1			1			1	
27727	Repair of congenital pseudart	090	445	480	35	8%	14.84	17.36	2.52	17%	0			5				5			1	
27730	Arrest, epiphyseal (epiphysio	090	241	253	12	5%	7.70	8.93	1.23	16%	0			3.5				1			1	
27732	Arrest, epiphyseal (epiphysio	090	183	189	6	3%	5.46	6.23	0.77	14%	0			3							0.5	
27734	Arrest, epiphyseal (epiphysio	090	273	287.5	14.5	5%	8.83	10.18	1.35	15%	0			3.5				1.5			1	
27740	Arrest, epiphyseal (epiphysio	090	315	328	13	4%	9.61	10.95	1.34	14%	0			4				1			1	
27742	Arrest, epiphyseal (epiphysio	090	340	354	14	4%	10.63	12.08	1.45	14%	0			4.5				1			1	
27745	Prophylactic treatment (nailin	090	312	330	18	6%	10.49	12.07	1.58	15%	0			4				2			1	
27750	Closed treatment of tibial sha	090	143	150	7	5%	3.37	4.25	0.88	26%	0			3.5							0.5	
27752	Closed treatment of tibial sha	090	250	268	18	7%	6.27	7.85	1.58	25%	0			4				2			1	
27756	Percutaneous skeletal fixation	090	344	372	28	8%	7.45	9.51	2.06	28%	0			4				4			1	
27758	Open treatment of tibial shaf	090	435	471.5	36.5	8%	12.54	15.07	2.53	20%	0			4.5				5.5			1	
27759	Treatment of tibial shaft fract	090	324	347	23	7%	14.45	16.14	1.69	12%	0			3	1			2			1	
27760	Closed treatment of medial m	090	124	132	8	6%	3.21	4.09	0.88	27%	0			4								
27762	Closed treatment of medial m	090	212	221	9	4%	5.47	6.68	1.21	22%	0			4.5							1	
27766	Open treatment of medial ma	090	266	289	23	9%	7.89	9.45	1.56	20%	0			2	2			1			1	
27767	Closed treatment of posterior	090	96	109	13	14%	2.64	3.63	0.99	38%	0			3	1							
27768	Closed treatment of posterior	090	170	183	13	8%	5.14	6.24	1.10	21%	0			3	1						0.5	
27769	Open treatment of posterior	090	279	297	18	6%	10.14	11.59	1.45	14%	0			3	1			1			1	
27780	Closed treatment of proximal	090	110	117	7	6%	2.83	3.60	0.77	27%	0			3.5								
27781	Closed treatment of proximal	090	146	154	8	5%	4.59	5.47	0.88	19%	0			4								
27784	Open treatment of proximal f	090	281	304	23	8%	9.67	11.23	1.56	16%	0			2	2			1			1	
27786	Closed treatment of distal fib	090	114	121	7	6%	3.02	3.79	0.77	25%	0			3.5								
27788	Closed treatment of distal fib	090	148	156	8	5%	4.64	5.52	0.88	19%	0			4								
27792	Open treatment of distal fibu	090	245	263	18	7%	8.75	9.96	1.21	14%	0			2	2						0.5	
27808	Closed treatment of bimalleo	090	127	135	8	6%	3.03	3.91	0.88	29%	0			4								
27810	Closed treatment of bimalleo	090	180	188	8	4%	5.32	6.31	0.99	19%	0			4							0.5	
27814	Open treatment of bimalleola	090	346	360	14	4%	10.62	12.14	1.52	14%	0			2	2				1		1	
27816	Closed treatment of trimalleo	090	119	126	7	6%	3.07	3.84	0.77	25%	0			3.5								
27818	Closed treatment of trimalleo	090	193	201	8	4%	5.69	6.68	0.99	17%	0			4							0.5	
27822	Open treatment of trimalleola	090	353	372	19	5%	11.21	12.84	1.63	15%	0			1	3				1		1	
27823	Open treatment of trimalleola	090	366	385	19	5%	13.16	14.79	1.63	12%	0			1	3				1		1	
27824	Closed treatment of fracture	090	137	148	11	8%	3.31	4.08	0.77	23%	0			2	1							
27825	Closed treatment of fracture	090	345	366	21	6%	6.69	8.29	1.60	24%	0			3				3			1	
27826	Open treatment of fracture o	090	328	347	19	6%	11.10	12.73	1.63	15%	0			1	3				1		1	
27827	Open treatment of fracture o	090	441	472	31	7%	14.79	16.99	2.20	15%	0			1	4			1	1		1	
27828	Open treatment of fracture o	090	471	502	31	7%	18.43	20.63	2.20	12%	0			1	4			1	1		1	
27829	Open treatment of distal tibia	090	271	294	23	8%	8.80	10.36	1.56	18%	0			2	2			1			1	
27830	Closed treatment of proximal	090	152	159	7	5%	3.96	4.84	0.88	22%	0			3.5							0.5	
27831	Closed treatment of proximal	090	166	173	7	4%	4.73	5.61	0.88	19%	0			3.5							0.5	
27832	Open treatment of proximal t	090	301	324	23	8%	10.17	11.73	1.56	15%	0			2	2			1			1	
27840	Closed treatment of ankle dis	090	160	168	8	5%	4.77	5.76	0.99	21%	0			4							0.5	
27842	Closed treatment of ankle dis	090	225	235.5	10.5	5%	6.46	7.68	1.22	19%	0			4				0.5			1	
27846	Open treatment of ankle dislo	090	312	332.5	20.5	7%	10.28	11.98	1.70	17%	0			4				2.5			1	
27848	Open treatment of ankle dislo	090	334	354.5	20.5	6%	11.68	13.38	1.70	15%	0			4				2.5			1	
27860	Manipulation of ankle under a	010	105	107	2	2%	2.39	2.61	0.22	9%	0			1								
27870	Arthrodesis, ankle, open	090	400	438	38	10%	15.41	17.43	2.02	13%	0				4			2			1	
27871	Arthrodesis, tibiofibular joint,	090	301	316.5	15.5	5%	9.54	11.00	1.46	15%	0			4				1.5			1	

27880	Amputation, leg, through tibi	090	400	437	37	9%	15.37	17.87	2.50	16%	0			1	2			5	1		1	
27881	Amputation, leg, through tibi	090	468	515.5	47.5	10%	13.47	16.59	3.12	23%	0			5				7.5			1	
27882	Amputation, leg, through tibi	090	331	366.5	35.5	11%	9.79	12.21	2.42	25%	0			4				5.5			1	
27884	Amputation, leg, through tibi	090	292	315	23	8%	8.76	10.58	1.82	21%	0			4				3			1	
27886	Amputation, leg, through tibi	090	340	369	29	9%	10.02	12.19	2.17	22%	0			4.5				4			1	
27888	Amputation, ankle, through n	090	335	364	29	9%	10.37	12.54	2.17	21%	0			4.5				4			1	
27889	Ankle disarticulation	090	361	397.5	36.5	10%	10.86	13.39	2.53	23%	0			4.5				5.5			1	
27892	Decompression fasciotomy, le	090	307	330	23	7%	7.94	9.76	1.82	23%	0			4				3			1	
27893	Decompression fasciotomy, le	090	307	330	23	7%	7.90	9.72	1.82	23%	0			4				3			1	
27894	Decompression fasciotomy, le	090	433	493	60	14%	12.67	15.74	3.07	24%	0				5			5			1	
28005	Incision, bone cortex (eg, oste	090	320	351.5	31.5	10%	9.44	11.73	2.29	24%	0			4.5				4.5			1	
28008	Fasciotomy, foot and/or toe	090	159	165	6	4%	4.59	5.36	0.77	17%	0			3							0.5	
28010	Tenotomy, percutaneous, toe	090	90	95	5	6%	2.97	3.52	0.55	19%	0			2.5								
28011	Tenotomy, percutaneous, toe	090	123	129	6	5%	4.28	4.94	0.66	15%	0			3								
28020	Arthrotomy, including explora	090	161	167	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28022	Arthrotomy, including explora	090	157	163	6	4%	4.81	5.58	0.77	16%	0			3							0.5	
28024	Arthrotomy, including explora	090	151	157	6	4%	4.52	5.29	0.77	17%	0			3							0.5	
28035	Release, tarsal tunnel (poster	090	169	175	6	4%	5.23	6.00	0.77	15%	0			3							0.5	
28039	Excision, tumor, soft tissue of	090	153	162	9	6%	5.42	6.08	0.66	12%	0			1	1						0.5	
28041	Excision, tumor, soft tissue of	090	217	233	16	7%	7.13	8.12	0.99	14%	0			1	2						0.5	
28043	Excision, tumor, soft tissue of	090	138	147	9	7%	3.96	4.62	0.66	17%	0			1	1						0.5	
28045	Excision, tumor, soft tissue of	090	169	180	11	7%	5.45	6.33	0.88	16%	0			2	1						0.5	
28046	Radical resection of tumor (e	090	334	367	33	10%	12.38	14.29	1.91	15%	0			1	3			2			1	
28047	Radical resection of tumor (e	090	413	439	26	6%	17.45	19.41	1.96	11%	-2			1	2	1		1	1		1	
28050	Arthrotomy with biopsy; inter	090	163	169	6	4%	4.39	5.16	0.77	18%	0			3							0.5	
28052	Arthrotomy with biopsy; met	090	149	154	5	3%	4.06	4.72	0.66	16%	0			2.5							0.5	
28054	Arthrotomy with biopsy; inter	090	133	138	5	4%	3.57	4.23	0.66	18%	0			2.5							0.5	
28055	Neurectomy, intrinsic muscul	090	197	203	6	3%	6.29	7.17	0.88	14%	0			3							1	
28060	Fasciectomy, plantar fascia; p	090	156	163	7	4%	5.40	6.17	0.77	14%	0			3.5								
28062	Fasciectomy, plantar fascia; r	090	221	228	7	3%	6.69	7.57	0.88	13%	0			3.5							0.5	
28070	Synovectomy; intertarsal or t	090	190	196	6	3%	5.24	6.12	0.88	17%	0			3							1	
28072	Synovectomy; metatarsophal	090	166	172	6	4%	4.72	5.49	0.77	16%	0			3							0.5	
28080	Excision, interdigital (Morton	090	169	197	28	17%	4.86	6.18	1.32	27%	-2		1		4							
28086	Synovectomy, tendon sheath,	090	172	178	6	3%	4.92	5.69	0.77	16%	0			3							0.5	
28088	Synovectomy, tendon sheath,	090	142	147	5	4%	3.98	4.64	0.66	17%	0			2.5							0.5	
28090	Excision of lesion, tendon, ter	090	130	136	6	5%	4.55	5.21	0.66	15%	0			3								
28092	Excision of lesion, tendon, ter	090	115	121	6	5%	3.78	4.44	0.66	17%	0			3								
28100	Excision or curettage of bone	090	195	202	7	4%	5.83	6.71	0.88	15%	0			3.5							0.5	
28102	Excision or curettage of bone	090	273	281	8	3%	7.92	9.02	1.10	14%	0			4							1	
28103	Excision or curettage of bone	090	233	240	7	3%	6.67	7.66	0.99	15%	0			3.5							1	
28104	Excision or curettage of bone	090	173	179	6	3%	5.26	6.03	0.77	15%	0			3							0.5	
28106	Excision or curettage of bone	090	243	251	8	3%	7.35	8.45	1.10	15%	0			4							1	
28107	Excision or curettage of bone	090	232	239	7	3%	5.73	6.72	0.99	17%	0			3.5							1	
28108	Excision or curettage of bone	090	134	140	6	4%	4.30	4.96	0.66	15%	0			3								
28110	Ostectomy, partial excision, fi	090	151	157	6	4%	4.22	4.99	0.77	18%	0			3							0.5	
28111	Ostectomy, complete excision	090	171	177	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28112	Ostectomy, complete excision	090	163	169	6	4%	4.63	5.40	0.77	17%	0			3							0.5	
28113	Ostectomy, complete excision	090	178	208	30	17%	6.11	7.65	1.54	25%	0			1	4							
28114	Ostectomy, complete excision	090	339	387	48	14%	12.00	14.25	2.25	19%	-6				3	3						
28116	Ostectomy, excision of tarsal	090	320	353	33	10%	9.14	10.92	1.78	19%	0				4			1			1	
28118	Ostectomy, calcaneus;	090	196	203	7	4%	6.13	7.01	0.88	14%	0			3.5							0.5	
28119	Ostectomy, calcaneus; for spu	090	183	190	7	4%	5.56	6.44	0.88	16%	0			3.5							0.5	
28120	Partial excision (craterization,	090	251	271	20	8%	7.31	8.74	1.43	20%	0			3	2						0.5	
28122	Partial excision (craterization,	090	230	248	18	8%	6.76	7.97	1.21	18%	0			2	2						0.5	
28124	Partial excision (craterization,	090	151	159	8	5%	5.00	5.88	0.88	18%	0			4								
28126	Resection, partial or complete	090	116	121	5	4%	3.64	4.19	0.55	15%	0			2.5								
28130	Talectomy (astragalectomy)	090	330	363	33	10%	9.50	11.28	1.78	19%	0				4			1			1	
28140	Metatarsectomy	090	228	237.5	9.5	4%	7.14	8.25	1.11	16%	0			3.5				0.5			1	
28150	Phalangectomy, toe, each toe	090	151	157	6	4%	4.23	5.00	0.77	18%	0			3							0.5	
28153	Resection, condyle(s), distal e	090	142	148	6	4%	3.80	4.57	0.77	20%	0			3							0.5	
28160	Hemiphalangectomy or interp	090	129	135	6	5%	3.88	4.54	0.66	17%	0			3								
28171	Radical resection of tumor; ta	090	365	388	23	6%	16.41	17.84	1.43	9%	-2			1	1	1		1			1	
28173	Radical resection of tumor; m	090	304	327	23	8%	14.16	15.59	1.43	10%	-2			1	1	1		1			1	
28175	Radical resection of tumor; pl	090	205	223	18	9%	8.29	9.37	1.08	13%	-2			1	1	1					0.5	
28190	Removal of foreign body, foo	010	64	66	2	3%	2.01	2.23	0.22	11%	0			1								
28192	Removal of foreign body, foo	090	141	147	6	4%	4.78	5.44	0.66	14%	0			3								

28193	Removal of foreign body, foo	090	189	196	7	4%	5.90	6.78	0.88	15%	0			3.5							0.5	
28200	Repair, tendon, flexor, foot; p	090	149	155	6	4%	4.74	5.40	0.66	14%	0			3								
28202	Repair, tendon, flexor, foot; s	090	240	249.5	9.5	4%	7.07	8.18	1.11	16%	0			3.5				0.5			1	
28208	Repair, tendon, extensor, foo	090	154	160	6	4%	4.51	5.28	0.77	17%	0			3							0.5	
28210	Repair, tendon, extensor, foo	090	209	216	7	3%	6.52	7.51	0.99	15%	0			3.5							1	
28220	Tenolysis, flexor, foot; single	090	149	155	6	4%	4.67	5.44	0.77	16%	0			3							0.5	
28222	Tenolysis, flexor, foot; multip	090	175	181	6	3%	5.76	6.53	0.77	13%	0			3							0.5	
28225	Tenolysis, extensor, foot; sing	090	133	138	5	4%	3.78	4.44	0.66	17%	0			2.5							0.5	
28226	Tenolysis, extensor, foot; mul	090	162	168	6	4%	4.67	5.44	0.77	16%	0			3							0.5	
28230	Tenotomy, open, tendon flex	090	143	148	5	3%	4.36	5.02	0.66	15%	0			2.5							0.5	
28232	Tenotomy, open, tendon flex	090	107	112	5	5%	3.51	4.06	0.55	16%	0			2.5								
28234	Tenotomy, open, extensor, fo	090	122	129	7	6%	3.54	4.31	0.77	22%	0			3.5								
28238	Reconstruction (advancemen	090	248	257.5	9.5	4%	7.96	9.07	1.11	14%	0			3.5				0.5			1	
28240	Tenotomy, lengthening, or re	090	139	144	5	4%	4.48	5.14	0.66	15%	0			2.5							0.5	
28250	Division of plantar fascia and	090	164	170	6	4%	6.06	6.83	0.77	13%	0			3							0.5	
28260	Capsulotomy, midfoot; media	090	225	234.5	9.5	4%	8.19	9.30	1.11	14%	0			3.5				0.5			1	
28261	Capsulotomy, midfoot; with t	090	343	376	33	10%	13.11	14.89	1.78	14%	0				4			1			1	
28262	Capsulotomy, midfoot; exten	090	380	413	33	9%	17.21	18.99	1.78	10%	0				4			1			1	
28264	Capsulotomy, midtarsal (eg, H	090	269	282	13	5%	10.65	11.99	1.34	13%	0			4				1			1	
28270	Capsulotomy; metatarsophala	090	145	152	7	5%	4.93	5.70	0.77	16%	0			3.5								
28272	Capsulotomy; interphalangea	090	113	118	5	4%	3.92	4.47	0.55	14%	0			2.5								
28280	Syndactylization, toes (eg, we	090	167	173	6	4%	5.33	6.10	0.77	14%	0			3							0.5	
28285	Correction, hammertoe (eg, i	090	190	208	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	
28286	Correction, cock-up fifth toe,	090	145	151	6	4%	4.70	5.36	0.66	14%	0			3								
28288	Ostectomy, partial, exostecto	090	169	197	28	17%	6.02	7.34	1.32	22%	-2		1		4							
28289	Hallux rigidus correction with	090	210	228	18	9%	6.90	8.11	1.21	18%	0			2	2						0.5	
28291	Hallux rigidus correction with	090	215	233	18	8%	8.01	9.22	1.21	15%	0			2	2						0.5	
28292	Correction, hallux valgus (bur	090	226	246	20	9%	7.44	8.87	1.43	19%	0			3	2						0.5	
28295	Correction, hallux valgus (bur	090	241	261	20	8%	8.57	10.00	1.43	17%	0			3	2						0.5	
28296	Correction, hallux valgus (bur	090	241	261	20	8%	8.25	9.68	1.43	17%	0			3	2						0.5	
28297	Correction, hallux valgus (bur	090	256	276	20	8%	9.29	10.72	1.43	15%	0			3	2						0.5	
28298	Correction, hallux valgus (bur	090	225	243	18	8%	7.75	8.96	1.21	16%	0			2	2						0.5	
28299	Correction, hallux valgus (bur	090	256	276	20	8%	9.29	10.72	1.43	15%	0			3	2						0.5	
28300	Osteotomy; calcaneus (eg, Dv	090	218	226	8	4%	9.73	10.72	0.99	10%	0			4							0.5	
28302	Osteotomy; talus	090	234	242	8	3%	9.74	10.84	1.10	11%	0			4							1	
28304	Osteotomy, tarsal bones, oth	090	239	249.5	10.5	4%	9.41	10.63	1.22	13%	0			4				0.5			1	
28305	Osteotomy, tarsal bones, oth	090	283	294.5	11.5	4%	10.77	12.10	1.33	12%	0			4.5				0.5			1	
28306	Osteotomy, with or without l	090	163	169	6	4%	6.00	6.66	0.66	11%	0			3								
28307	Osteotomy, with or without l	090	213	220	7	3%	6.50	7.38	0.88	14%	0			3.5							0.5	
28308	Osteotomy, with or without l	090	165	173	8	5%	5.48	6.36	0.88	16%	0			4								
28309	Osteotomy, with or without l	090	350	383	33	9%	14.16	15.94	1.78	13%	0				4			1			1	
28310	Osteotomy, shortening, angu	090	165	171	6	4%	5.57	6.34	0.77	14%	0			3							0.5	
28312	Osteotomy, shortening, angu	090	160	166	6	4%	4.69	5.46	0.77	16%	0			3							0.5	
28313	Reconstruction, angular defo	090	151	157	6	4%	5.15	5.92	0.77	15%	0			3							0.5	
28315	Sesamoidectomy, first toe (se	090	156	162	6	4%	5.00	5.77	0.77	15%	0			3							0.5	
28320	Repair, nonunion or malunion	090	254	262	8	3%	9.37	10.47	1.10	12%	0			4							1	
28322	Repair, nonunion or malunion	090	221	229	8	4%	8.53	9.52	0.99	12%	0			4							0.5	
28340	Reconstruction, toe, macroda	090	230	237	7	3%	7.15	8.14	0.99	14%	0			3.5							1	
28341	Reconstruction, toe, macroda	090	298	311	13	4%	8.72	10.06	1.34	15%	0			4				1			1	
28344	Reconstruction, toe(s); polyda	090	185	191	6	3%	4.40	5.28	0.88	20%	0			3							1	
28345	Reconstruction, toe(s); synda	090	222	229	7	3%	6.09	7.08	0.99	16%	0			3.5							1	
28360	Reconstruction, cleft foot	090	395	430	35	9%	14.92	16.57	1.65	11%	0				5							
28400	Closed treatment of calcanea	090	97	103	6	6%	2.31	2.97	0.66	29%	0			3								
28405	Closed treatment of calcanea	090	164	171	7	4%	4.74	5.62	0.88	19%	0			3.5							0.5	
28406	Percutaneous skeletal fixation	090	229	239.5	10.5	5%	6.56	7.78	1.22	19%	0			4				0.5			1	
28415	Open treatment of calcaneal	090	441	472	31	7%	16.19	18.39	2.20	14%	0			1	4			1	1		1	
28420	Open treatment of calcaneal	090	481	512	31	6%	17.52	19.72	2.20	13%	0			1	4			1	1		1	
28430	Closed treatment of talus fra	090	89	94	5	6%	2.22	2.77	0.55	25%	0			2.5								
28435	Closed treatment of talus fra	090	116	122	6	5%	3.54	4.20	0.66	19%	0			3								
28436	Percutaneous skeletal fixation	090	190	198	8	4%	4.90	5.89	0.99	20%	0			4							0.5	
28445	Open treatment of talus fract	090	444	475	31	7%	15.76	17.96	2.20	14%	0			1	4			1	1		1	
28446	Open osteochondral autograf	090	339	364	25	7%	17.71	19.36	1.65	9%	0			2	3						1	
28450	Treatment of tarsal bone frac	090	87	92	5	6%	2.03	2.58	0.55	27%	0			2.5								
28455	Treatment of tarsal bone frac	090	113	119	6	5%	3.24	3.90	0.66	20%	0			3								
28456	Percutaneous skeletal fixation	090	182	189	7	4%	2.86	3.74	0.88	31%	0			3.5							0.5	
28465	Open treatment of tarsal bon	090	257	275	18	7%	8.80	10.01	1.21	14%	0			2	2						0.5	

28470	Closed treatment of metatars	090	77	83	6	8%	2.03	2.69	0.66	33%	0			3								
28475	Closed treatment of metatars	090	80.5	80.5	0	0%	3.01	3.01	-	0%	-7		3.5									
28476	Percutaneous skeletal fixatior	090	168	177	9	5%	3.60	4.59	0.99	28%	0			4.5								
28485	Open treatment of metatarsa	090	242	260	18	7%	7.44	8.65	1.21	16%	0			2	2						0.5	
28490	Closed treatment of fracture	090	64	67	3	5%	1.17	1.50	0.33	28%	0			1.5								
28495	Closed treatment of fracture	090	89	93	4	4%	1.68	2.12	0.44	26%	0			2								
28496	Percutaneous skeletal fixatior	090	142	148	6	4%	2.48	3.14	0.66	27%	0			3								
28505	Open treatment of fracture, g	090	227	245	18	8%	7.44	8.65	1.21	16%	0			2	2						0.5	
28510	Closed treatment of fracture,	090	53	56	3	6%	1.17	1.50	0.33	28%	0			1.5								
28515	Closed treatment of fracture,	090	71	75	4	6%	1.56	2.00	0.44	28%	0			2								
28525	Open treatment of fracture, g	090	207	225	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	
28530	Closed treatment of sesamoic	090	56	58	2	4%	1.11	1.33	0.22	20%	0			1								
28531	Open treatment of sesamoid	090	225	234	9	4%	2.57	3.47	0.90	35%	0			2				1			1	
28540	Closed treatment of tarsal bo	090	106	112	6	6%	2.19	2.85	0.66	30%	0			3								
28545	Closed treatment of tarsal bo	090	142	148	6	4%	2.60	3.37	0.77	30%	0			3							0.5	
28546	Percutaneous skeletal fixatior	090	184	192	8	4%	3.40	4.39	0.99	29%	0			4							0.5	
28555	Open treatment of tarsal bon	090	281	304	23	8%	9.65	11.21	1.56	16%	0			2	2			1			1	
28570	Closed treatment of talotarsa	090	92	96	4	4%	1.76	2.20	0.44	25%	0			2								
28575	Closed treatment of talotarsa	090	178	185	7	4%	3.49	4.48	0.99	28%	0			3.5							1	
28576	Percutaneous skeletal fixatior	090	277	295	18	6%	4.60	6.18	1.58	34%	0			4				2			1	
28585	Open treatment of talotarsal	090	324	354	30	9%	11.13	13.02	1.89	17%	0			2	3			1			1	
28600	Closed treatment of tarsomet	090	105	110	5	5%	2.02	2.57	0.55	27%	0			2.5								
28605	Closed treatment of tarsomet	090	156	163	7	4%	2.89	3.77	0.88	30%	0			3.5							0.5	
28606	Percutaneous skeletal fixatior	090	224	232	8	4%	5.09	6.19	1.10	22%	0			4							1	
28615	Open treatment of tarsometa	090	323	355	32	10%	10.70	12.81	2.11	20%	0			3	3			1			1	
28630	Closed treatment of metatars	010	55	57	2	4%	1.75	1.97	0.22	13%	0			1								
28635	Closed treatment of metatars	010	61	63	2	3%	1.96	2.18	0.22	11%	0			1								
28645	Open treatment of metatarsa	090	217	235	18	8%	7.44	8.65	1.21	16%	0			2	2						0.5	
28660	Closed treatment of interpha	010	49	51	2	4%	1.28	1.50	0.22	17%	0			1								
28665	Closed treatment of interpha	010	53	55	2	4%	1.97	2.19	0.22	11%	0			1								
28675	Open treatment of interphala	090	197	215	18	9%	5.62	6.83	1.21	22%	0			2	2						0.5	
28705	Arthrodesis; pantalar	090	490	516	26	5%	20.33	22.29	1.96	10%	-2			1	2	1		1	1		1	
28715	Arthrodesis; triple	090	366	398	32	9%	13.42	15.29	1.87	14%	0			2	4						0.5	
28725	Arthrodesis; subtalar	090	298	323	25	8%	11.22	12.76	1.54	14%	0			2	3						0.5	
28730	Arthrodesis, midtarsal or tars	090	308	333	25	8%	10.70	12.24	1.54	14%	0			2	3						0.5	
28735	Arthrodesis, midtarsal or tars	090	360	393	33	9%	12.23	14.01	1.78	15%	0				4			1			1	
28737	Arthrodesis, with tendon leng	090	340	373	33	10%	11.03	12.81	1.78	16%	0				4			1			1	
28740	Arthrodesis, midtarsal or tars	090	266	294	28	11%	9.29	10.72	1.43	15%	0				4						0.5	
28750	Arthrodesis, great toe; metat	090	237	265	28	12%	8.57	9.89	1.32	15%	0				4							
28755	Arthrodesis, great toe; interp	090	172	178	6	3%	4.88	5.65	0.77	16%	0			3							0.5	
28760	Arthrodesis, with extensor ha	090	330	363	33	10%	9.14	10.92	1.78	19%	0				4			1			1	
28800	Amputation, foot; midtarsal (	090	306	330	24	8%	8.79	10.72	1.93	22%	0			4.5				3			1	
28805	Amputation, foot; transmetat	090	376	424	48	13%	12.71	15.47	2.76	22%	0			2	2			6			1	
28810	Amputation, metatarsal, with	090	251	269	18	7%	6.64	8.22	1.58	24%	0			4				2			1	
28890	Extracorporeal shock wave, h	090	140	146	6	4%	3.45	4.22	0.77	22%	0			3							0.5	
29800	Arthroscopy, temporomandib	090	161	172	11	7%	6.84	7.72	0.88	13%	0			2	1						0.5	
29804	Arthroscopy, temporomandib	090	206	224	18	9%	8.87	10.08	1.21	14%	0			2	2						0.5	
29805	Arthroscopy, shoulder, diagn	090	154	160	6	4%	6.03	6.69	0.66	11%	0			3								
29806	Arthroscopy, shoulder, surgic	090	298	318	20	7%	15.14	16.57	1.43	9%	0			3	2						0.5	
29807	Arthroscopy, shoulder, surgic	090	288	308	20	7%	14.67	16.10	1.43	10%	0			3	2						0.5	
29819	Arthroscopy, shoulder, surgic	090	196	203	7	4%	7.79	8.67	0.88	11%	0			3.5							0.5	
29820	Arthroscopy, shoulder, surgic	090	189	195	6	3%	7.21	7.98	0.77	11%	0			3							0.5	
29821	Arthroscopy, shoulder, surgic	090	223	230	7	3%	7.89	8.77	0.88	11%	0			3.5							0.5	
29822	Arthroscopy, shoulder, surgic	090	191	207	16	8%	7.03	8.02	0.99	14%	0			1	2						0.5	
29823	Arthroscopy, shoulder, surgic	090	211	227	16	8%	7.98	8.97	0.99	12%	0			1	2						0.5	
29824	Arthroscopy, shoulder, surgic	090	225	243	18	8%	8.98	10.19	1.21	13%	0			2	2						0.5	
29825	Arthroscopy, shoulder, surgic	090	212	219	7	3%	7.79	8.67	0.88	11%	0			3.5							0.5	
29827	Arthroscopy, shoulder, surgic	090	334	344	10	3%	15.59	16.80	1.21	8%	0			5							0.5	
29828	Arthroscopy, shoulder, surgic	090	252	270	18	7%	13.16	14.37	1.21	9%	0			2	2						0.5	
29830	Arthroscopy, elbow, diagnost	090	132	137	5	4%	5.88	6.43	0.55	9%	0			2.5								
29834	Arthroscopy, elbow, surgical;	090	153	159	6	4%	6.42	7.08	0.66	10%	0			3								
29835	Arthroscopy, elbow, surgical;	090	160	166	6	4%	6.62	7.28	0.66	10%	0			3								
29836	Arthroscopy, elbow, surgical;	090	196	203	7	4%	7.72	8.49	0.77	10%	0			3.5								
29837	Arthroscopy, elbow, surgical;	090	165	171	6	4%	7.01	7.67	0.66	9%	0			3								
29838	Arthroscopy, elbow, surgical;	090	220	227	7	3%	7.88	8.76	0.88	11%	0			3.5							0.5	
29840	Arthroscopy, wrist, diagnostic	090	146	152	6	4%	5.68	6.34	0.66	12%	0			3								

29843	Arthroscopy, wrist, surgical; f	090	157	163	6	4%	6.15	6.81	0.66	11%	0			3								
29844	Arthroscopy, wrist, surgical; s	090	160	166	6	4%	6.51	7.17	0.66	10%	0			3								
29845	Arthroscopy, wrist, surgical; s	090	199	206	7	4%	7.69	8.46	0.77	10%	0			3.5								
29846	Arthroscopy, wrist, surgical; e	090	179	185	6	3%	6.89	7.55	0.66	10%	0			3								
29847	Arthroscopy, wrist, surgical; i	090	190	196	6	3%	7.22	7.88	0.66	9%	0			3								
29848	Endoscopy, wrist, surgical, wi	090	179	200	21	12%	6.39	7.38	0.99	15%	0				3							
29850	Arthroscopically aided treatm	090	192	198	6	3%	8.27	9.04	0.77	9%	0			3							0.5	
29851	Arthroscopically aided treatm	090	274	297	23	8%	13.26	14.58	1.32	10%	0			1	3						0.5	
29855	Arthroscopically aided treatm	090	255	273	18	7%	10.76	11.97	1.21	11%	0			2	2						0.5	
29856	Arthroscopically aided treatm	090	314	332	18	6%	14.28	15.60	1.32	9%	0			2	2						1	
29860	Arthroscopy, hip, diagnostic v	090	244	265	21	9%	9.00	9.99	0.99	11%	0				3							
29861	Arthroscopy, hip, surgical; wit	090	254	275	21	8%	10.10	11.09	0.99	10%	0				3							
29862	Arthroscopy, hip, surgical; wit	090	297	325	28	9%	11.17	12.49	1.32	12%	0				4							
29863	Arthroscopy, hip, surgical; wit	090	297	325	28	9%	11.17	12.49	1.32	12%	0				4							
29866	Arthroscopy, knee, surgical; d	090	308	328	20	6%	14.67	16.10	1.43	10%	0			3	2						0.5	
29867	Arthroscopy, knee, surgical; d	090	404	425	21	5%	18.39	20.24	1.85	10%	0			2	3					1	1	
29868	Arthroscopy, knee, surgical; m	090	484	510	26	5%	25.10	27.19	2.09	8%	0			2	3				1	1	1	
29870	Arthroscopy, knee, diagnostic	090	129	134	5	4%	5.19	5.74	0.55	11%	0			2.5								
29871	Arthroscopy, knee, surgical; fi	090	184	190	6	3%	6.69	7.46	0.77	12%	0			3							0.5	
29873	Arthroscopy, knee, surgical; w	090	249	259	10	4%	6.24	7.45	1.21	19%	0			5							0.5	
29874	Arthroscopy, knee, surgical; fi	090	181	187	6	3%	7.19	7.96	0.77	11%	0			3							0.5	
29875	Arthroscopy, knee, surgical; s	090	168	174	6	4%	6.45	7.11	0.66	10%	0			3								
29876	Arthroscopy, knee, surgical; s	090	233	254	21	9%	8.87	9.97	1.10	12%	0				3						0.5	
29877	Arthroscopy, knee, surgical; d	090	197	218	21	11%	8.30	9.29	0.99	12%	0				3							
29879	Arthroscopy, knee, surgical; a	090	217	238	21	10%	8.99	10.09	1.10	12%	0				3						0.5	
29880	Arthroscopy, knee, surgical; w	090	199	215	16	8%	7.39	8.38	0.99	13%	0			1	2						0.5	
29881	Arthroscopy, knee, surgical; w	090	194	210	16	8%	7.03	8.02	0.99	14%	0			1	2						0.5	
29882	Arthroscopy, knee, surgical; w	090	244	265	21	9%	9.60	10.70	1.10	11%	0				3						0.5	
29883	Arthroscopy, knee, surgical; w	090	311	329	18	6%	11.77	13.09	1.32	11%	0			2	2						1	
29884	Arthroscopy, knee, surgical; w	090	208	229	21	10%	8.28	9.38	1.10	13%	0				3						0.5	
29885	Arthroscopy, knee, surgical; d	090	250.5	275	24.5	10%	10.21	11.48	1.27	12%	0				3.5						0.5	
29886	Arthroscopy, knee, surgical; d	090	221	242	21	10%	8.49	9.59	1.10	13%	0				3						0.5	
29887	Arthroscopy, knee, surgical; d	090	261.5	286	24.5	9%	10.16	11.43	1.27	12%	0				3.5						0.5	
29888	Arthroscopically aided anteric	090	295	313	18	6%	14.30	15.51	1.21	8%	0			2	2						0.5	
29889	Arthroscopically aided poster	090	433	465	32	7%	17.41	19.26	1.85	11%	-2			1	3	1					1	
29891	Arthroscopy, ankle, surgical, e	090	227	255	28	12%	9.67	10.99	1.32	14%	0				4							
29892	Arthroscopically aided repair	090	272	300	28	10%	10.27	11.59	1.32	13%	0				4							
29893	Endoscopic plantar fasciotom	090	247	274	27	11%	6.32	7.97	1.65	26%	0			3	3							
29894	Arthroscopy, ankle (tibiotalar	090	179	185	6	3%	7.35	8.12	0.77	10%	0			3							0.5	
29895	Arthroscopy, ankle (tibiotalar	090	178	184	6	3%	7.13	7.90	0.77	11%	0			3							0.5	
29897	Arthroscopy, ankle (tibiotalar	090	186	192	6	3%	7.32	8.09	0.77	11%	0			3							0.5	
29898	Arthroscopy, ankle (tibiotalar	090	222	229	7	3%	8.49	9.37	0.88	10%	0			3.5							0.5	
29899	Arthroscopy, ankle (tibiotalar	090	395	433	38	10%	15.41	17.43	2.02	13%	0				4				2		1	
29900	Arthroscopy, metacarpophala	090	220	233	13	6%	5.88	6.98	1.10	19%	0			3	1						0.5	
29901	Arthroscopy, metacarpophala	090	235	248	13	6%	6.59	7.69	1.10	17%	0			3	1						0.5	
29902	Arthroscopy, metacarpophala	090	250	263	13	5%	7.16	8.26	1.10	15%	0			3	1						0.5	
29904	Arthroscopy, subtalar joint, su	090	228	249	21	9%	8.65	9.75	1.10	13%	0				3						0.5	
29905	Arthroscopy, subtalar joint, su	090	244	267	23	9%	9.18	10.50	1.32	14%	0			1	3						0.5	
29906	Arthroscopy, subtalar joint, su	090	244	267	23	9%	9.65	10.97	1.32	14%	0			1	3						0.5	
29907	Arthroscopy, subtalar joint, su	090	293	316	23	8%	12.18	13.61	1.43	12%	0			1	3						1	
29914	Arthroscopy, hip, surgical; wit	090	280	298	18	6%	14.67	15.88	1.21	8%	0			2	2						0.5	
29915	Arthroscopy, hip, surgical; wit	090	270	288	18	7%	15.00	16.21	1.21	8%	0			2	2						0.5	
29916	Arthroscopy, hip, surgical; wit	090	270	288	18	7%	15.00	16.21	1.21	8%	0			2	2						0.5	
30000	Drainage abscess or hematon	010	56	58	2	4%	1.48	1.70	0.22	15%	0			1								
30020	Drainage abscess or hematon	010	57	59	2	4%	1.48	1.70	0.22	15%	0			1								
30110	Excision, nasal polyp(s), simpl	010	62	64	2	3%	1.68	1.90	0.22	13%	0			1								
30115	Excision, nasal polyp(s), exter	090	120	124	4	3%	4.44	4.88	0.44	10%	0			2								
30117	Excision or destruction (eg, la	090	110	114	4	4%	3.26	3.70	0.44	13%	0			2								
30118	Excision or destruction (eg, la	090	288	297.5	9.5	3%	9.92	11.03	1.11	11%	0			3.5					0.5		1	
30120	Excision or surgical planing of	090	160	165	5	3%	5.39	5.94	0.55	10%	0			2.5								
30124	Excision dermoid cyst, nose; s	090	101	105	4	4%	3.20	3.64	0.44	14%	0			2								
30125	Excision dermoid cyst, nose; c	090	252	258	6	2%	7.30	8.18	0.88	12%	0			3							1	
30130	Excision inferior turbinate, pa	090	122	126	4	3%	3.47	4.02	0.55	16%	0			2							0.5	
30150	Rhinectomy; partial	090	267	284	17	6%	9.55	11.02	1.47	15%	0			3.5					2		1	
30160	Rhinectomy; total	090	302	319	17	6%	9.99	11.46	1.47	15%	0			3.5					2		1	
30210	Displacement therapy (Proetz	010	39	41	2	5%	1.13	1.35	0.22	19%	0			1								

30220	Insertion, nasal septal prosth	010	51	53	2	4%	1.59	1.81	0.22	14%	0			1								
30300	Removal foreign body, intran	010	46	48	2	4%	1.09	1.31	0.22	20%	0			1								
30310	Removal foreign body, intran	010	68	70	2	3%	2.01	2.23	0.22	11%	0			1								
30320	Removal foreign body, intran	090	151	156	5	3%	4.64	5.19	0.55	12%	0			2.5								
30400	Rhinoplasty, primary; lateral a	090	312	338	26	8%	10.86	12.58	1.72	16%	-4			4		2						
30410	Rhinoplasty, primary; comple	090	362	388	26	7%	14.00	15.72	1.72	12%	-4			4		2						
30420	Rhinoplasty, primary; includir	090	399	425	26	7%	16.90	18.62	1.72	10%	-4			4		2						
30430	Rhinoplasty, secondary; mino	090	274	300	26	9%	8.24	9.96	1.72	21%	-4			4		2						
30435	Rhinoplasty, secondary; inter	090	354	380	26	7%	12.73	14.45	1.72	14%	-4			4		2						
30450	Rhinoplasty, secondary; majo	090	414	440	26	6%	19.66	21.38	1.72	9%	-4			4		2						
30460	Rhinoplasty for nasal deformi	090	232	241	9	4%	10.32	10.87	0.55	5%	0			1	1							
30462	Rhinoplasty for nasal deformi	090	388	406	18	5%	20.28	21.38	1.10	5%	0			2	2							
30465	Repair of nasal vestibular ste	090	277	295	18	6%	12.36	13.57	1.21	10%	0			2	2						0.5	
30520	Septoplasty or submucous re	090	210.5	228.5	18	9%	7.01	8.22	1.21	17%	0			2	2						0.5	
30540	Repair choanal atresia; intran	090	196	203	7	4%	7.92	8.80	0.88	11%	0			3.5							0.5	
30545	Repair choanal atresia; transp	090	305	315.5	10.5	3%	11.62	12.84	1.22	10%	0			4				0.5			1	
30560	Lysis intranasal synechia	010	46	48	2	4%	1.31	1.53	0.22	17%	0			1								
30580	Repair fistula; oromaxillary (c	090	204	212	8	4%	6.88	7.76	0.88	13%	0			4								
30600	Repair fistula; oronasal	090	167	173	6	4%	6.16	6.82	0.66	11%	0			3								
30620	Septal or other intranasal der	090	234	242	8	3%	6.16	7.26	1.10	18%	0			4							1	
30630	Repair nasal septal perforatio	090	260	267	7	3%	7.29	8.17	0.88	12%	0			3.5							0.5	
30801	Ablation, soft tissue of inferio	010	46	48	2	4%	1.14	1.36	0.22	19%	0			1								
30802	Ablation, soft tissue of inferio	010	56	58	2	4%	2.08	2.30	0.22	11%	0			1								
30915	Ligation arteries; ethmoidal	090	242	252	10	4%	7.44	8.45	1.01	14%	0			2.5				1			1	
30920	Ligation arteries; internal ma	090	428	441	13	3%	11.14	13.01	1.87	17%	0			2	1			2	2		1	
30930	Fracture nasal inferior turbina	010	56	58	2	4%	1.31	1.53	0.22	17%	0			1								
31000	Lavage by cannulation; maxill	010	52	54	2	4%	1.20	1.42	0.22	18%	0			1								
31002	Lavage by cannulation; sphen	010	62	64	2	3%	1.96	2.18	0.22	11%	0			1								
31020	Sinusotomy, maxillary (antrot	090	105	110	5	5%	3.07	3.62	0.55	18%	0			2.5								
31030	Sinusotomy, maxillary (antrot	090	167	171	4	2%	6.01	6.67	0.66	11%	0			2							1	
31032	Sinusotomy, maxillary (antrot	090	211	216	5	2%	6.69	7.46	0.77	12%	0			2.5							1	
31040	Pterygomaxillary fossa surger	090	300	314.5	14.5	5%	9.77	11.12	1.35	14%	0			3.5				1.5			1	
31050	Sinusotomy, sphenoid, with o	090	147	151	4	3%	5.37	5.92	0.55	10%	0			2							0.5	
31051	Sinusotomy, sphenoid, with o	090	179	185	6	3%	7.25	8.02	0.77	11%	0			3							0.5	
31070	Sinusotomy frontal; external,	090	144	149	5	3%	4.40	5.06	0.66	15%	0			2.5							0.5	
31075	Sinusotomy frontal; transorbi	090	263	277.5	14.5	6%	9.51	10.86	1.35	14%	0			3.5				1.5			1	
31080	Sinusotomy frontal; obliterati	090	343	373.5	30.5	9%	12.74	14.40	1.66	13%	0				4			0.5			1	
31081	Sinusotomy frontal; obliterati	090	365	400.5	35.5	10%	14.19	16.09	1.90	13%	0				4			1.5			1	
31084	Sinusotomy frontal; obliterati	090	387	422.5	35.5	9%	14.95	16.85	1.90	13%	0				4			1.5			1	
31085	Sinusotomy frontal; obliterati	090	400	435.5	35.5	9%	15.64	17.54	1.90	12%	0				4			1.5			1	
31086	Sinusotomy frontal; nonoblite	090	370	408	38	10%	14.36	16.38	2.02	14%	0				4			2			1	
31087	Sinusotomy frontal; nonoblite	090	423.5	463	39.5	9%	14.57	16.67	2.10	14%	0				3.5			3			1	
31090	Sinusotomy, unilateral, 3 or n	090	425	464	39	9%	11.17	13.35	2.18	20%	-4			1	2	2		1			1	
31200	Ethmoidectomy; intranasal, a	090	186	193	7	4%	5.14	6.02	0.88	17%	0			3.5							0.5	
31201	Ethmoidectomy; intranasal, t	090	237	246.5	9.5	4%	8.60	9.71	1.11	13%	0			3.5				0.5			1	
31205	Ethmoidectomy; extranasal, t	090	258	272.5	14.5	6%	10.58	11.93	1.35	13%	0			3.5				1.5			1	
31225	Maxillectomy; without orbital	090	608	634	26	4%	26.70	29.59	2.89	11%	-2			1	3	1		1	2	1	1	
31230	Maxillectomy; with orbital ex	090	688	719	31	5%	30.82	33.95	3.13	10%	-2			1	3	1		2	2	1	1	
31239	Nasal/sinus endoscopy, surgi	010	168	175	7	4%	9.04	9.48	0.44	5%	0				1						0.5	
31241	Nasal/sinus endoscopy, surgi	000	142	142	0	0%	8.00	8.11	0.11	1%	0										0.5	
31290	Nasal/sinus endoscopy, surgi	010	578	600	22	4%	18.61	20.64	2.03	11%	-1						1	3	2		1	
31291	Nasal/sinus endoscopy, surgi	010	581	603	22	4%	19.56	21.59	2.03	10%	-1						1	3	2		1	
31292	Nasal/sinus endoscopy, surgi	010	453	465	12	3%	15.90	17.45	1.55	10%	-1						1	1	2		1	
31293	Nasal/sinus endoscopy, surgi	010	528	545	17	3%	17.47	19.26	1.79	10%	-1						1	2	2		1	
31294	Nasal/sinus endoscopy, surgi	010	563	580	17	3%	20.31	22.10	1.79	9%	-1						1	2	2		1	
31300	Laryngotomy (thyrotomy, lary	090	414	457	43	10%	15.91	18.17	2.26	14%	0				4			3			1	
31360	Laryngectomy; total, without	090	768	809	41	5%	29.91	33.90	3.99	13%	-4			1	3	2		3	3	1	1	
31365	Laryngectomy; total, with rad	090	893	939	46	5%	38.81	43.04	4.23	11%	-4			1	3	2		4	3	1	1	
31367	Laryngectomy; subtotal supra	090	728	764	36	5%	30.57	34.32	3.75	12%	-4			1	3	2		2	3	1	1	
31368	Laryngectomy; subtotal supra	090	858	899	41	5%	34.19	38.18	3.99	12%	-4			1	3	2		3	3	1	1	
31370	Partial laryngectomy (hemilar	090	728	764	36	5%	27.57	31.32	3.75	14%	-4			1	3	2		2	3	1	1	
31375	Partial laryngectomy (hemilar	090	698	734	36	5%	26.07	29.82	3.75	14%	-4			1	3	2		2	3	1	1	
31380	Partial laryngectomy (hemilar	090	708	744	36	5%	25.57	29.32	3.75	15%	-4			1	3	2		2	3	1	1	
31382	Partial laryngectomy (hemilar	090	728	764	36	5%	28.57	32.32	3.75	13%	-4			1	3	2		2	3	1	1	
31390	Pharyngolaryngectomy, with	090	988	1026	38	4%	42.51	46.90	4.39	10%	-4			1	3	2		3	3	2	1	
31395	Pharyngolaryngectomy, with	090	1048	1091	43	4%	43.80	48.43	4.63	11%	-4			1	3	2		4	3	2	1	

31400	Arytenoidectomy or arytenoi	090	481	514	33	7%	11.60	13.90	2.30	20%	0			4				5			1	
31420	Epiglottidectomy	090	436	465.5	29.5	7%	11.43	13.50	2.07	18%	0			3.5				4.5			1	
31545	Laryngoscopy, direct, operati	000	154	154	0	0%	6.30	6.41	0.11	2%	0										0.5	
31546	Laryngoscopy, direct, operati	000	189	189	0	0%	9.73	9.84	0.11	1%	0										0.5	
31551	Laryngoplasty; for laryngeal s	090	658	684	26	4%	21.50	24.43	2.93	14%	0				3			3	1	2	1	
31552	Laryngoplasty; for laryngeal s	090	505	527	22	4%	20.50	22.15	1.65	8%	0				3			1	1		1	
31553	Laryngoplasty; for laryngeal s	090	718	717	-1	0%	22.00	24.81	2.81	13%	0				3				4	2	1	
31554	Laryngoplasty; for laryngeal s	090	540	567	27	5%	22.00	23.89	1.89	9%	0				3			2	1		1	
31561	Laryngoscopy, direct, operati	000	218	218	0	0%	5.99	6.21	0.22	4%	0										1	
31571	Laryngoscopy, direct, with inj	000	129	129	0	0%	4.26	4.37	0.11	3%	0										0.5	
31580	Laryngoplasty; for laryngeal v	090	405	431	26	6%	14.60	16.05	1.45	10%	0				3			1			1	
31584	Laryngoplasty; with open red	090	445	467	22	5%	17.58	19.23	1.65	9%	0				3			1	1		1	
31587	Laryngoplasty, cricoid split, w	090	445	474	29	7%	15.27	17.80	2.53	17%	0				3			3	1	1	1	
31590	Laryngeal reinnervation by ne	090	291	313	22	8%	7.85	9.26	1.41	18%	-2			3	1	1						
31591	Laryngoplasty, medialization,	090	275	296	21	8%	13.56	14.66	1.10	8%	0				3						0.5	
31592	Cricotracheal resection	090	738	741	3	0%	25.00	27.61	2.61	10%	0				3				3	2	1	
31610	Tracheostomy, fenestration p	090	367	391	24	7%	12.00	14.29	2.29	19%	0				3			2	1	1	1	
31611	Construction of tracheoesoph	090	164	169	5	3%	6.00	6.66	0.66	11%	0			2.5							0.5	
31613	Tracheostoma revision; simpl	090	155	160	5	3%	4.71	5.48	0.77	16%	0			2.5							1	
31614	Tracheostoma revision; comp	090	346	361	15	4%	8.63	10.59	1.96	23%	0			2	2			1	2		1	
31750	Tracheoplasty; cervical	090	540	561	21	4%	15.39	17.77	2.38	15%	0				4			1	3		1	
31755	Tracheoplasty; tracheopharyr	090	414	452	38	9%	17.54	19.70	2.16	12%	-4			3	2	2						
31760	Tracheoplasty; intrathoracic	090	623	671	48	8%	23.48	26.50	3.02	13%	0			4				8			1	
31766	Carinal reconstruction	090	788	841.5	53.5	7%	31.67	34.83	3.16	10%	0			3				9.5			1	
31770	Bronchoplasty; graft repair	090	544	588	44	8%	23.54	26.12	2.58	11%	0			2				8			1	
31775	Bronchoplasty; excision stend	090	557	602	45	8%	24.59	27.28	2.69	11%	0			2.5				8			1	
31780	Excision tracheal stenosis and	090	619	631	12	2%	19.84	22.57	2.73	14%	0			3	1			3	4		1	
31781	Excision tracheal stenosis and	090	602	637	35	6%	24.85	27.06	2.21	9%	0			2.5				6			1	
31785	Excision of tracheal tumor or	090	524	550.5	26.5	5%	18.35	20.09	1.74	9%	0			2				4.5			1	
31786	Excision of tracheal tumor or	090	722	762	40	6%	25.42	27.87	2.45	10%	0			2.5				7			1	
31800	Suture of tracheal wound or i	090	301	311	10	3%	8.18	9.19	1.01	12%	0			2.5				1			1	
31805	Suture of tracheal wound or i	090	382	394.5	12.5	3%	13.42	14.55	1.13	8%	0			2.5				1.5			1	
31820	Surgical closure tracheostom	090	168	174.5	6.5	4%	4.64	5.42	0.78	17%	0			2				0.5			1	
31825	Surgical closure tracheostom	090	230	241	11	5%	7.07	8.19	1.12	16%	0			3				1			1	
31830	Revision of tracheostomy sca	090	153	158	5	3%	4.62	5.28	0.66	14%	0			2.5							0.5	
32035	Thoracostomy; with rib resec	090	667	723	56	8%	11.29	14.57	3.28	29%	0			3				10			1	
32036	Thoracostomy; with open flap	090	674	730	56	8%	12.30	15.58	3.28	27%	0			3				10			1	
32096	Thoracotomy, with diagnostic	090	436	434	-2	0%	13.75	15.74	1.99	14%	0				1			1	2	2	1	
32097	Thoracotomy, with diagnostic	090	401	402	1	0%	13.75	15.34	1.59	12%	0				1			1	2	1	1	
32098	Thoracotomy, with biopsy(ies	090	341	346	5	1%	12.91	14.30	1.39	11%	0				1			1	1	1	1	
32100	Thoracotomy; with exploratic	090	411	412	1	0%	13.75	15.34	1.59	12%	0				1			1	2	1	1	
32110	Thoracotomy; with control of	090	561	580	19	3%	25.28	27.33	2.05	8%	-2				1	1		2	1	1	1	
32120	Thoracotomy; for postoperat	090	647	700.5	53.5	8%	14.39	17.16	2.77	19%	-3					1.5		8			1	
32124	Thoracotomy; with open intra	090	696	744.5	48.5	7%	15.45	17.98	2.53	16%	-3					1.5		7			1	
32140	Thoracotomy; with cyst(s) ren	090	664	712.5	48.5	7%	16.66	19.19	2.53	15%	-3					1.5		7			1	
32141	Thoracotomy; with resection-	090	673	662	-11	-2%	27.18	30.19	3.01	11%	0			1	1			1	4	3	1	
32150	Thoracotomy; with removal o	090	626	672	46	7%	16.82	19.23	2.41	14%	-3					1.5		6.5			1	
32151	Thoracotomy; with removal o	090	656	704.5	48.5	7%	16.94	19.47	2.53	15%	-3					1.5		7			1	
32160	Thoracotomy; with cardiac m	090	788	832	44	6%	13.10	15.42	2.32	18%	-2					1		7			1	
32200	Pneumonostomy, with open d	090	691	758.5	67.5	10%	18.68	22.11	3.43	18%	-5					2.5		9			1	
32215	Pleural scarification for repea	090	471	509.5	38.5	8%	13.05	15.10	2.05	16%	-3					1.5		5			1	
32220	Decortication, pulmonary (se	090	722	756	34	5%	26.65	29.51	2.86	11%	-2			2	2	1		3	2		1	
32225	Decortication, pulmonary (se	090	716	767	51	7%	16.75	19.40	2.65	16%	-3					1.5		7.5			1	
32310	Pleurectomy, parietal (separa	090	516	559.5	43.5	8%	15.28	17.57	2.29	15%	-3					1.5		6			1	
32320	Decortication and parietal ple	090	735	765	30	4%	27.25	30.49	3.24	12%	-2			1	2	1		3	1	2	1	
32440	Removal of lung, pneumonec	090	628	638	10	2%	27.28	29.55	2.27	8%	0			2	1			2	2	1	1	
32442	Removal of lung, pneumonec	090	1035	1020	-15	-1%	56.47	60.79	4.32	8%	0				2			1	4	6	1	
32445	Removal of lung, pneumonec	090	1182	1180	-2	0%	63.84	68.89	5.05	8%	-4			1	1	2		1	4	6	1	
32480	Removal of lung, other than p	090	593	612	19	3%	25.82	28.13	2.31	9%	0			2	1			3	1	1	1	
32482	Removal of lung, other than p	090	680	706	26	4%	27.44	29.95	2.51	9%	-2			1	1	1		3	1	1	1	
32484	Removal of lung, other than p	090	561	561	0	0%	25.38	27.59	2.21	9%	0			1	1			1	2	2	1	
32486	Removal of lung, other than p	090	812	802	-10	-1%	42.88	46.09	3.21	7%	0			1	1			1	3	4	1	
32488	Removal of lung, other than p	090	836	839	3	0%	42.99	46.42	3.43	8%	-2			1	1	1		1	2	4	1	
32491	Removal of lung, other than p	090	887	1000	113	13%	25.24	31.65	6.41	25%	0				3			20	2		1	
32503	Resection of apical lung tumo	090	645	687	42	7%	31.74	34.48	2.74	9%	0			1	2			6	1		1	
32504	Resection of apical lung tumo	090	705	747	42	6%	36.54	39.28	2.74	7%	0			1	2			6	1		1	

32505	Thoracotomy; with therapeut	090	427	430	3	1%	15.75	17.56	1.81	11%	0			1	1			1	2	1	1	
32540	Extrapleural enucleation of e	090	740	732	-8	-1%	30.35	33.89	3.54	12%	0			1	2			1	5	3	1	
32552	Removal of indwelling tunnel	010	82	84	2	2%	2.53	2.86	0.33	13%	0			1							0.5	
32601	Thoracoscopy, diagnostic (sep	000	193	189	-4	-2%	5.50	5.70	0.20	4%	0								1			
32607	Thoracoscopy; with diagnosti	000	178	174	-4	-2%	5.50	5.70	0.20	4%	0								1			
32608	Thoracoscopy; with diagnosti	000	195	191	-4	-2%	6.84	7.04	0.20	3%	0								1			
32609	Thoracoscopy; with biopsy(ie	000	178	174	-4	-2%	4.58	4.78	0.20	4%	0								1			
32650	Thoracoscopy, surgical; with p	090	290	304	14	5%	10.83	11.97	1.14	11%	0			2				2			1	
32651	Thoracoscopy, surgical; with p	090	502	496	-6	-1%	18.78	20.79	2.01	11%	0			1	1			1	5		1	
32652	Thoracoscopy, surgical; with t	090	645	648	3	0%	29.13	31.87	2.74	9%	0			1	2			1	3	2	1	
32653	Thoracoscopy, surgical; with r	090	509	503	-6	-1%	18.17	20.18	2.01	11%	0			1	1			1	5		1	
32654	Thoracoscopy, surgical; with d	090	515	507	-8	-2%	20.52	23.13	2.61	13%	0			1	1			1	4	2	1	
32655	Thoracoscopy, surgical; with r	090	425	427	2	0%	16.17	17.78	1.61	10%	0			1	1			1	3		1	
32656	Thoracoscopy, surgical; with p	090	377	401	24	6%	13.26	14.75	1.49	11%	0			1	1			3			1	
32658	Thoracoscopy, surgical; with r	090	330	339	9	3%	11.71	12.61	0.90	8%	0			2				1			1	
32659	Thoracoscopy, surgical; with d	090	357	376	19	5%	11.94	13.19	1.25	10%	0			1	1			2			1	
32661	Thoracoscopy, surgical; with e	090	300	309	9	3%	13.33	14.23	0.90	7%	0			2				1			1	
32662	Thoracoscopy, surgical; with e	090	350	355	5	1%	14.99	15.96	0.97	6%	0			1	1				1		1	
32663	Thoracoscopy, surgical; with l	090	507	511	4	1%	24.64	26.65	2.01	8%	0			1	1			1	1	2	1	
32664	Thoracoscopy, surgical; with t	090	330	339	9	3%	14.28	15.18	0.90	6%	0			2				1			1	
32665	Thoracoscopy, surgical; with e	090	512	511	-1	0%	21.53	23.54	2.01	9%	0			1	1			1	3	1	1	
32666	Thoracoscopy, surgical; with t	090	332	343	11	3%	14.50	15.91	1.41	10%	0			1	1			1		1	1	
32669	Thoracoscopy, surgical; with r	090	502	506	4	1%	23.53	25.54	2.01	9%	0			1	1			1	1	2	1	
32670	Thoracoscopy, surgical; with r	090	532	536	4	1%	28.52	30.53	2.01	7%	0			1	1			1	1	2	1	
32671	Thoracoscopy, surgical; with r	090	602	606	4	1%	31.92	33.93	2.01	6%	0			1	1			1	1	2	1	
32672	Thoracoscopy, surgical; with r	090	567	564	-3	-1%	27.00	29.61	2.61	10%	0			1	1			1	2	3	1	
32673	Thoracoscopy, surgical; with r	090	447	454	7	2%	21.13	22.74	1.61	8%	0			1	1			1	1	1	1	
32800	Repair lung hernia through ch	090	578	629	51	9%	15.71	18.36	2.65	17%	-3					1.5		7.5			1	
32810	Closure of chest wall followin	090	523	569	46	9%	14.95	17.36	2.41	16%	-3					1.5		6.5			1	
32815	Open closure of major bronch	090	1147	1133	-14	-1%	50.03	55.68	5.65	11%	-4			1	1	2		1	7	6	1	
32820	Major reconstruction, chest w	090	854	894.5	40.5	5%	22.51	24.65	2.14	10%	-2				2	1		3.5			1	
32851	Lung transplant, single; witho	090	1165	1182	17	1%	59.64	63.04	3.40	6%	-3					1	1	1	3	3		1
32852	Lung transplant, single; with d	090	1320	1330	10	1%	65.50	69.50	4.00	6%	-3					1	1	1	4	4		1
32853	Lung transplant, double (bilat	090	1440	1447	7	0%	84.48	88.88	4.40	5%	-3					1	1	1	4	5		1
32854	Lung transplant, double (bilat	090	1600	1596	-4	0%	90.00	95.20	5.20	6%	-3					1	1	1	6	6		1
32900	Resection of ribs, extrapleura	090	821	872	51	6%	23.81	26.46	2.65	11%	-3					1.5		7.5			1	
32905	Thoracoplasty, Schede type o	090	721	762	41	6%	23.29	25.46	2.17	9%	-3					1.5		5.5			1	
32906	Thoracoplasty, Schede type o	090	751	792	41	5%	29.30	31.47	2.17	7%	-3					1.5		5.5			1	
32940	Pneumonolysis, extraperioste	090	546	582	36	7%	21.34	23.27	1.93	9%	-3					1.5		4.5			1	
32997	Total lung lavage (unilateral)	000	424	435	11	3%	7.31	8.83	1.52	21%	0				2			1	2		1	
33020	Pericardiotomy for removal o	090	321	326	5	2%	14.31	15.70	1.39	10%	0				1			1	1	1	1	
33025	Creation of pericardial windo	090	301	310	9	3%	13.20	14.39	1.19	9%	0				1			1		1	1	
33030	Pericardiectomy, subtotal or d	090	739	746	7	1%	36.00	38.41	2.41	7%	-2				1	1		1	2	2	1	
33031	Pericardiectomy, subtotal or d	090	839	852	13	2%	45.00	47.84	2.84	6%	-2				1	1		1	2	3		1
33050	Resection of pericardial cyst o	090	623	666.5	43.5	7%	16.97	19.26	2.29	13%	-3					1.5		6			1	
33120	Excision of intracardiac tumor	090	686	686	0	0%	38.45	40.53	2.08	5%	-2					1		1	2	2	1	
33130	Resection of external cardiac	090	719	770	51	7%	24.17	26.82	2.65	11%	-3					1.5		7.5			1	
33140	Transmyocardial laser revascu	090	621	622	1	0%	28.34	30.62	2.28	8%	-2					1		1	1	3	1	
33141	Transmyocardial laser revascu	ZZZ	32.2	31.9	-0.3	-1%	2.54	2.58	0.04	2%	0									0.1		
33202	Insertion of epicardial electro	090	301	309	8	3%	13.20	14.19	0.99	8%	0				1			1	1		1	
33203	Insertion of epicardial electro	090	326	334	8	2%	13.97	14.96	0.99	7%	0				1			1	1		1	
33206	Insertion of new or replacem	090	248.5	269	20.5	8%	7.14	8.34	1.20	17%	0				1.5			2			1	
33207	Insertion of new or replacem	090	233.5	236.5	3	1%	7.80	8.55	0.75	10%	0				1				1		1	
33208	Insertion of new or replacem	090	231	234	3	1%	8.52	9.27	0.75	9%	0				1				1		1	
33212	Insertion of pacemaker pulse	090	124	131	7	6%	5.01	5.45	0.44	9%	0				1						0.5	
33213	Insertion of pacemaker pulse	090	125	132	7	6%	5.28	5.72	0.44	8%	0				1						0.5	
33214	Upgrade of implanted pacem	090	262	266	4	2%	7.59	8.03	0.44	6%	0			2								
33215	Repositioning of previously in	090	179	186	7	4%	4.92	5.60	0.68	14%	0			1				1			1	
33216	Insertion of a single transven	090	262	266	4	2%	5.62	6.06	0.44	8%	0			2								
33217	Insertion of 2 transvenous ele	090	262	266	4	2%	5.59	6.03	0.44	8%	0			2								
33218	Repair of single transvenous e	090	246	260	14	6%	5.82	6.48	0.66	11%	0				2							
33220	Repair of 2 transvenous elect	090	276	290	14	5%	5.90	6.56	0.66	11%	0				2							
33221	Insertion of pacemaker pulse	090	129	136	7	5%	5.55	5.99	0.44	8%	0				1						0.5	
33222	Relocation of skin pocket for	090	275	281	6	2%	4.85	5.51	0.66	14%	0			3								
33223	Relocation of skin pocket for	090	230	234	4	2%	6.30	6.74	0.44	7%	0			2								
33224	Insertion of pacing electrode,	000	204	204	0	0%	9.04	9.15	0.11	1%	0										0.5	

33226	Repositioning of previously in	000	189	189	0	0%	8.68	8.79	0.11	1%	0										0.5	
33227	Removal of permanent pacen	090	124	131	7	6%	5.25	5.69	0.44	8%	0				1						0.5	
33228	Removal of permanent pacen	090	129	136	7	5%	5.52	5.96	0.44	8%	0				1						0.5	
33229	Removal of permanent pacen	090	139	146	7	5%	5.79	6.23	0.44	8%	0				1						0.5	
33230	Insertion of implantable defib	090	150	157	7	5%	6.07	6.51	0.44	7%	0				1						0.5	
33231	Insertion of implantable defib	090	150	157	7	5%	6.34	6.78	0.44	7%	0				1						0.5	
33233	Removal of permanent pacen	090	150	154	4	3%	3.14	3.58	0.44	14%	0			2								
33234	Removal of transvenous pace	090	292	296	4	1%	7.66	8.10	0.44	6%	0			2								
33235	Removal of transvenous pace	090	390	420	30	8%	9.90	11.28	1.38	14%	-2						2					
33236	Removal of permanent epicar	090	346	372	26	8%	12.73	14.57	1.84	14%	0			3				4			1	
33237	Removal of permanent epicar	090	456	487	31	7%	13.84	15.92	2.08	15%	0			3				5			1	
33238	Removal of permanent transv	090	472	505	33	7%	15.40	17.70	2.30	15%	0			4				5			1	
33240	Insertion of implantable defib	090	135	142	7	5%	5.80	6.24	0.44	8%	0				1						0.5	
33241	Removal of implantable defib	090	171	173	2	1%	3.04	3.26	0.22	7%	0			1								
33243	Removal of single or dual cha	090	537	583	46	9%	23.57	25.98	2.41	10%	0				3			5			1	
33244	Removal of single or dual cha	090	310	320	10	3%	13.74	14.84	1.10	8%	0			5								
33249	Insertion or replacement of p	090	239	260	21	9%	14.92	15.91	0.99	7%	0				3							
33250	Operative ablation of suprave	090	983	1034	51	5%	25.90	28.55	2.65	10%	-3					1.5		7.5			1	
33251	Operative ablation of suprave	090	1001	1052	51	5%	28.92	31.57	2.65	9%	-3					1.5		7.5			1	
33254	Operative tissue ablation and	090	416	433	17	4%	23.71	25.12	1.41	6%	-2				1	1		1	1		1	
33255	Operative tissue ablation and	090	516	529	13	3%	29.04	30.65	1.61	6%	-2				1	1		1	2		1	
33256	Operative tissue ablation and	090	646	655	9	1%	34.90	36.71	1.81	5%	-2				1	1		1	3		1	
33257	Operative tissue ablation and	ZZZ	180.35	185.52	5.17	3%	9.63	10.31	0.68	7%	0				1					0.61	0.5	
33258	Operative tissue ablation and	ZZZ	190.3	196.28	5.98	3%	11.00	11.58	0.58	5%	0				1					0.34	0.5	
33259	Operative tissue ablation and	ZZZ	222.75	234.92	12.17	5%	14.14	15.15	1.01	7%	0				2					0.61	0.5	
33261	Operative ablation of ventricu	090	1004	1055	51	5%	28.92	31.57	2.65	9%	-3					1.5		7.5			1	
33262	Removal of implantable defib	090	150	157	7	5%	5.81	6.25	0.44	8%	0				1						0.5	
33263	Removal of implantable defib	090	150	157	7	5%	6.08	6.52	0.44	7%	0				1						0.5	
33264	Removal of implantable defib	090	150	157	7	5%	6.35	6.79	0.44	7%	0				1						0.5	
33265	Endoscopy, surgical; operativ	090	446	463	17	4%	23.71	25.12	1.41	6%	-2				1	1		1	1		1	
33266	Endoscopy, surgical; operativ	090	536	549	13	2%	33.04	34.65	1.61	5%	-2				1	1		1	2		1	
33267	Exclusion of left atrial append	090	401	400	-1	0%	18.50	19.45	0.95	5%	0				1				2		1	
33269	Exclusion of left atrial append	090	323	323	0	0%	14.31	15.46	1.15	8%	0				1				1	1	1	
33270	Insertion or replacement of p	090	232	241	9	4%	9.10	9.74	0.64	7%	-2					1					1	
33271	Insertion of subcutaneous im	090	202	211	9	4%	7.50	8.14	0.64	9%	-2					1					1	
33272	Removal of subcutaneous imp	090	151	158	7	5%	5.42	5.86	0.44	8%	0				1						0.5	
33273	Repositioning of previously in	090	202	211	9	4%	6.50	7.14	0.64	10%	-2					1					1	
33274	Transcatheter insertion or rep	090	173	180	7	4%	7.80	8.24	0.44	6%	0				1						0.5	
33275	Transcatheter removal of per	090	188	195	7	4%	8.59	9.03	0.44	5%	0				1						0.5	
33300	Repair of cardiac wound; with	090	859	853	-6	-1%	44.97	47.85	2.88	6%	-2					1		1	2	4	1	
33305	Repair of cardiac wound; with	090	1251	1245	-6	0%	76.93	79.81	2.88	4%	-2					1		1	2	4	1	
33310	Cardiotomy, exploratory (incl	090	532	575.5	43.5	8%	20.34	22.63	2.29	11%	-3					1.5		6			1	
33315	Cardiotomy, exploratory (incl	090	621	625	4	1%	35.00	36.88	1.88	5%	-2					1		1	1	2	1	
33320	Suture repair of aorta or grea	090	516.5	559.5	43	8%	18.54	20.82	2.28	12%	0				1.5			6.5			1	
33321	Suture repair of aorta or grea	090	754	808	54	7%	20.81	23.61	2.80	13%	0				2			8			1	
33322	Suture repair of aorta or grea	090	884	935	51	6%	24.42	27.07	2.65	11%	-3					1.5		7.5			1	
33330	Insertion of graft, aorta or gre	090	916	969.5	53.5	6%	25.29	28.06	2.77	11%	-3					1.5		8			1	
33335	Insertion of graft, aorta or gre	090	963	1019	56	6%	33.91	36.80	2.89	9%	-3					1.5		8.5			1	
33361	Transcatheter aortic valve rep	000	275	275	0	0%	22.47	22.47	-	0%	0											
33362	Transcatheter aortic valve rep	000	303	303	0	0%	24.54	24.54	-	0%	0											
33363	Transcatheter aortic valve rep	000	300	300	0	0%	25.47	25.47	-	0%	0											
33364	Transcatheter aortic valve rep	000	294	294	0	0%	25.97	25.97	-	0%	0											
33365	Transcatheter aortic valve rep	000	320	320	0	0%	26.59	26.59	-	0%	0											
33366	Transcatheter aortic valve rep	000	320	320	0	0%	29.35	29.35	-	0%	0											
33390	Valvuloplasty, aortic valve, op	090	622	625	3	0%	35.00	36.81	1.81	5%	0			1	1			1	2	1	1	
33391	Valvuloplasty, aortic valve, op	090	676	686	10	1%	41.50	43.51	2.01	5%	-2				1	1		1	2	1	1	
33404	Construction of apical-aortic c	090	846	899.5	53.5	6%	31.37	34.14	2.77	9%	-3					1.5		8			1	
33405	Replacement, aortic valve, op	090	768	772	4	1%	41.32	44.13	2.81	7%	-2				1	1		1	2	3	1	
33406	Replacement, aortic valve, op	090	853	857	4	0%	52.68	55.49	2.81	5%	-2				1	1		1	2	3	1	
33410	Replacement, aortic valve, op	090	800	804	4	0%	46.41	49.22	2.81	6%	-2				1	1		1	2	3	1	
33411	Replacement, aortic valve; wi	090	1059	1052	-7	-1%	62.07	65.68	3.61	6%	-2				1	1		1	4	4	1	
33412	Replacement, aortic valve; wi	090	866	867	1	0%	59.00	61.28	2.28	4%	-2					1		1	1	3	1	
33413	Replacement, aortic valve; by	090	898	906	8	1%	59.87	62.48	2.61	4%	-2				1	1		1	1	3	1	
33414	Repair of left ventricular outf	090	763	764	1	0%	39.37	41.65	2.28	6%	-2					1		1	1	3	1	
33415	Resection or incision of subva	090	679	679	0	0%	37.27	39.35	2.08	6%	-2					1		1	2	2	1	
33416	Ventriculomyotomy (-myecto	090	664	683	19	3%	36.56	38.61	2.05	6%	-2				1	1		2	1	1	1	

33417	Aortoplasty (gusset) for supra	090	750	780.5	30.5	4%	29.33	30.99	1.66	6%	-4					2		2.5			1	
33418	Transcatheter mitral valve re	090	561	580	19	3%	32.25	33.74	1.49	5%	-4					2			2			1
33420	Valvotomy, mitral valve; close	090	761	814.5	53.5	7%	25.79	28.56	2.77	11%	-3					1.5		8			1	
33422	Valvotomy, mitral valve; oper	090	892	943	51	6%	29.73	32.38	2.65	9%	-3					1.5		7.5			1	
33425	Valvuloplasty, mitral valve, w	090	880	881	1	0%	49.96	53.17	3.21	6%	-2				1	1		1	2	4	1	
33426	Valvuloplasty, mitral valve, w	090	776	780	4	1%	43.28	46.09	2.81	6%	-2				1	1		1	2	3	1	
33427	Valvuloplasty, mitral valve, w	090	737	744	7	1%	44.83	47.24	2.41	5%	-2				1	1		1	2	2	1	
33430	Replacement, mitral valve, wi	090	913	933	20	2%	50.93	54.10	3.17	6%	-2				2	1		1	2	3		1
33440	Replacement, aortic valve; by	090	998	996	-2	0%	64.00	66.92	2.92	5%	-2					1		2	3	3	1	
33460	Valvectomy, tricuspid valve, v	090	877	867	-10	-1%	44.70	47.78	3.08	7%	-2					1		1	3	4	1	
33463	Valvuloplasty, tricuspid valve,	090	1127	1108	-19	-2%	57.08	61.29	4.21	7%	-2				1	1		1	7	4	1	
33464	Valvuloplasty, tricuspid valve,	090	871	868	-3	0%	44.62	48.03	3.41	8%	-2				1	1		1	3	4	1	
33465	Replacement, tricuspid valve,	090	972	964	-8	-1%	50.72	54.13	3.41	7%	-2				1	1		1	5	3	1	
33468	Tricuspid valve repositioning	090	806	807	1	0%	45.13	47.41	2.28	5%	-2					1		1	1	3	1	
33471	Valvotomy, pulmonary valve,	090	572	608	36	6%	22.96	24.89	1.93	8%	-2				1	1		4			1	
33474	Valvotomy, pulmonary valve,	090	738	745	7	1%	39.40	41.81	2.41	6%	-2				1	1		1	2	2	1	
33475	Replacement, pulmonary valv	090	750	757	7	1%	42.40	44.81	2.41	6%	-2				1	1		1	2	2	1	
33476	Right ventricular resection fo	090	859	877	18	2%	26.57	27.63	1.06	4%	-4					2					1	
33478	Outflow tract augmentation (	090	882	900	18	2%	27.54	28.60	1.06	4%	-4					2					1	
33496	Repair of non-structural prost	090	881	887	6	1%	29.84	32.29	2.45	8%	-2				1	1		2	5		1	
33500	Repair of coronary arterioven	090	690	736	46	7%	27.94	30.35	2.41	9%	-3					1.5		6.5			1	
33501	Repair of coronary arterioven	090	411	419	8	2%	19.51	21.56	2.05	11%	0			1	1			2	2	1	1	
33502	Repair of anomalous coronar	090	688	718.5	30.5	4%	21.85	23.51	1.66	8%	-4					2		2.5			1	
33503	Repair of anomalous coronar	090	838	895.5	57.5	7%	22.51	25.43	2.92	13%	-2						2	5.5			1	
33504	Repair of anomalous coronar	090	789	829.5	40.5	5%	25.46	27.60	2.14	8%	-4					2		4.5			1	
33505	Repair of anomalous coronar	090	678	727	49	7%	38.40	41.51	3.11	8%	0				1			9		1	1	
33506	Repair of anomalous coronar	090	678	727	49	7%	37.85	40.96	3.11	8%	0				1			9		1	1	
33507	Repair of anomalous (eg, intr	090	563.5	576.5	13	2%	31.40	32.63	1.23	4%	0				1			2	1		1	
33510	Coronary artery bypass, vein	090	718	717	-1	0%	34.98	37.68	2.70	8%	-2			1		1		1	2	3	1	
33511	Coronary artery bypass, vein	090	750	749	-1	0%	38.45	41.15	2.70	7%	-2			1		1		1	2	3	1	
33512	Coronary artery bypass, vein	090	832	828	-4	0%	43.98	47.08	3.10	7%	-2			1		1		1	2	4	1	
33513	Coronary artery bypass, vein	090	850	846	-4	0%	45.37	48.47	3.10	7%	-2			1		1		1	2	4	1	
33514	Coronary artery bypass, vein	090	867	863	-4	0%	48.08	51.18	3.10	6%	-2			1		1		1	2	4	1	
33516	Coronary artery bypass, vein	090	883	879	-4	0%	49.76	52.86	3.10	6%	-2			1		1		1	2	4	1	
33517	Coronary artery bypass, using	ZZZ	53.5	52.6	-0.9	-2%	3.61	3.73	0.12	3%	0									0.3		
33518	Coronary artery bypass, using	ZZZ	112.6	110.56	-2.04	-2%	7.93	8.20	0.27	3%	0									0.68		
33519	Coronary artery bypass, using	ZZZ	139.8	137.52	-2.28	-2%	10.49	10.79	0.30	3%	0									0.76		
33521	Coronary artery bypass, using	ZZZ	158.05	155.68	-2.37	-1%	12.59	12.91	0.32	3%	0									0.79		
33522	Coronary artery bypass, using	ZZZ	174.45	171.72	-2.73	-2%	14.14	14.50	0.36	3%	0									0.91		
33523	Coronary artery bypass, using	ZZZ	193	190	-3	-2%	16.08	16.48	0.40	2%	0									1		
33530	Reoperation, coronary artery	ZZZ	112.4	111.08	-1.32	-1%	10.13	10.31	0.18	2%	0									0.44		
33533	Coronary artery bypass, using	090	682	685	3	0%	33.75	36.25	2.50	7%	-2			1		1		1	1	3	1	
33534	Coronary artery bypass, using	090	717	720	3	0%	39.88	42.38	2.50	6%	-2			1		1		1	1	3	1	
33535	Coronary artery bypass, using	090	755	758	3	0%	44.75	47.25	2.50	6%	-2			1		1		1	1	3	1	
33536	Coronary artery bypass, using	090	783	786	3	0%	48.43	50.93	2.50	5%	-2			1		1		1	1	3	1	
33542	Myocardial resection (eg, ven	090	848	852	4	0%	48.21	51.02	2.81	6%	-2				1	1		1	2	3	1	
33545	Repair of postinfarction ventr	090	939	953	14	1%	57.06	60.10	3.04	5%	-2				1	1		1	1	4		1
33548	Surgical ventricular restoratio	090	928	948	20	2%	54.14	57.31	3.17	6%	-2				2	1		1	2	3		1
33600	Closure of atrioventricular va	090	628	676	48	8%	30.31	32.81	2.50	8%	-4					2		6			1	
33602	Closure of semilunar valve (a	090	628	676	48	8%	29.34	31.84	2.50	9%	-4					2		6			1	
33606	Anastomosis of pulmonary ar	090	728	786	58	8%	31.53	34.51	2.98	9%	-4					2		8			1	
33608	Repair of complex cardiac and	090	668	711	43	6%	31.88	34.14	2.26	7%	-4					2		5			1	
33610	Repair of complex cardiac and	090	648	701	53	8%	31.40	34.14	2.74	9%	-4					2		7			1	
33611	Repair of double outlet right v	090	673	732	59	9%	35.57	38.61	3.04	9%	-2					1		10			1	
33612	Repair of double outlet right v	090	673	732	59	9%	36.57	39.61	3.04	8%	-2					1		10			1	
33615	Repair of complex cardiac and	090	696	762	66	9%	35.89	39.26	3.37	9%	-2				1	1		10			1	
33617	Repair of complex cardiac and	090	811	868	57	7%	39.09	42.42	3.33	9%	-2				1	1		9	1		1	
33619	Repair of single ventricle with	090	1039	1058	19	2%	48.76	52.90	4.14	8%	-12		5	1		1		7	6	1	1	
33620	Application of right and left p	090	609	630	21	3%	30.00	32.55	2.55	9%	0				1			5	2	1	1	
33621	Transthoracic insertion of cat	090	363.5	385.5	22	6%	16.18	17.23	1.05	6%	0				1			3				
33622	Reconstruction of complex ca	090	986	1017	31	3%	64.00	67.72	3.72	6%	-2					1		7	1	3	1	
33641	Repair atrial septal defect, se	090	562	569	7	1%	29.58	31.06	1.48	5%	-2					1		1	1	1	1	
33645	Direct or patch closure, sinus	090	546	553	7	1%	31.30	32.78	1.48	5%	-2					1		1	1	1	1	
33647	Repair of atrial septal defect a	090	614	618	4	1%	33.00	34.88	1.88	6%	-2					1		1	1	2	1	
33660	Repair of incomplete or partia	090	613	620	7	1%	31.83	33.31	1.48	5%	-2					1		1	1	1	1	
33665	Repair of intermediate or trar	090	613	620	7	1%	34.85	36.33	1.48	4%	-2					1		1	1	1	1	

33670	Repair of complete atrioventr	090	626	645	19	3%	36.63	38.30	1.67	5%	0				1			3		1	1	
33675	Closure of multiple ventricula	090	628	644	16	3%	35.95	37.71	1.76	5%	-2					1		3	2		1	
33676	Closure of multiple ventricula	090	658	674	16	2%	36.95	38.71	1.76	5%	-2					1		3	2		1	
33677	Closure of multiple ventricula	090	688	704	16	2%	38.45	40.21	1.76	5%	-2					1		3	2		1	
33681	Closure of single ventricular s	090	506.5	559.5	53	10%	32.34	35.08	2.74	8%	-2				2	1		6			1	
33684	Closure of single ventricular s	090	616	623	7	1%	34.37	35.85	1.48	4%	-2					1		1	1	1	1	
33688	Closure of single ventricular s	090	628	635	7	1%	34.75	36.23	1.48	4%	-2					1		1	1	1	1	
33690	Banding of pulmonary artery	090	636	666.5	30.5	5%	20.36	22.02	1.66	8%	-4					2		2.5			1	
33692	Complete repair tetralogy of	090	684	697	13	2%	36.15	38.31	2.16	6%	-2					1		3	2	1	1	
33694	Complete repair tetralogy of	090	718	777	59	8%	35.57	38.61	3.04	9%	-2					1		10			1	
33697	Complete repair tetralogy of	090	693	752	59	9%	37.57	40.61	3.04	8%	-2					1		10			1	
33702	Repair sinus of Valsalva fistul	090	751	769.5	18.5	2%	27.24	28.33	1.09	4%	-2				1	1		0.5			1	
33710	Repair sinus of Valsalva fistul	090	656	663	7	1%	37.50	38.98	1.48	4%	-2					1		1	1	1	1	
33720	Repair sinus of Valsalva aneu	090	770	786	16	2%	27.26	28.23	0.97	4%	-2				1	1					1	
33724	Repair of isolated partial ano	090	559	574	15	3%	27.63	28.95	1.32	5%	-2					1		2	1		1	
33726	Repair of pulmonary venous s	090	643	663	20	3%	37.12	38.68	1.56	4%	-2					1		3	1		1	
33730	Complete repair of anomalou	090	671	737	66	10%	36.14	39.51	3.37	9%	-2				1	1		10			1	
33732	Repair of cor triatriatum or su	090	578	621	43	7%	28.96	31.22	2.26	8%	-4					2		5			1	
33735	Atrial septectomy or septosto	090	770	800.5	30.5	4%	22.20	23.86	1.66	7%	-4					2		2.5			1	
33736	Atrial septectomy or septosto	090	548	591	43	8%	24.32	26.58	2.26	9%	-4					2		5			1	
33737	Atrial septectomy or septosto	090	706	732	26	4%	22.47	23.92	1.45	6%	-2				1	1		2			1	
33750	Shunt; subclavian to pulmona	090	722	750	28	4%	22.22	23.76	1.54	7%	-4					2		2			1	
33755	Shunt; ascending aorta to pul	090	750	775.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33762	Shunt; descending aorta to pu	090	755	780.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33764	Shunt; central, with prostheti	090	750	775.5	25.5	3%	22.60	24.02	1.42	6%	-4					2		1.5			1	
33766	Shunt; superior vena cava to	090	756	781.5	25.5	3%	23.57	24.99	1.42	6%	-4					2		1.5			1	
33767	Shunt; superior vena cava to	090	608	651	43	7%	25.30	27.56	2.26	9%	-4					2		5			1	
33770	Repair of transposition of the	090	696	716	20	3%	39.07	41.18	2.11	5%	0				1			4	1	1	1	
33771	Repair of transposition of the	090	716	736	20	3%	40.63	42.74	2.11	5%	0				1			4	1	1	1	
33774	Repair of transposition of the	090	998	1024.5	26.5	3%	31.73	33.18	1.45	5%	-3					1	1	0.5			1	
33775	Repair of transposition of the	090	1043	1063.5	20.5	2%	32.99	34.17	1.18	4%	-4					2		0.5			1	
33776	Repair of transposition of the	090	1096	1133.5	37.5	3%	34.75	36.71	1.96	6%	-2						2	1.5			1	
33777	Repair of transposition of the	090	993	1040.5	47.5	5%	34.17	36.61	2.44	7%	-2						2	3.5			1	
33778	Repair of transposition of the	090	838.5	887.5	49	6%	42.75	46.48	3.73	9%	-2				1	1		9	3		1	
33779	Repair of transposition of the	090	733	755	22	3%	43.23	45.43	2.20	5%	-2					1		4	1	1	1	
33780	Repair of transposition of the	090	731	760	29	4%	43.90	46.29	2.39	5%	0				1			6	2		1	
33781	Repair of transposition of the	090	738	767	29	4%	43.21	45.60	2.39	6%	0				1			6	2		1	
33782	Aortic root translocation with	090	866	867	1	0%	60.08	62.36	2.28	4%	-2					1		1	1	3	1	
33783	Aortic root translocation with	090	926	927	1	0%	65.08	67.36	2.28	4%	-2					1		1	1	3	1	
33786	Total repair, truncus arteriosu	090	838.5	892.5	54	6%	41.87	45.84	3.97	9%	-2				1	1		10	3		1	
33788	Reimplantation of an anomal	090	736	766.5	30.5	4%	27.42	29.08	1.66	6%	-4					2		2.5			1	
33800	Aortic suspension (aortopexy	090	375	386	11	3%	17.28	18.61	1.33	8%	0				1			2	1.5		1	
33802	Division of aberrant vessel (va	090	556	584.5	28.5	5%	18.37	19.94	1.57	9%	-2				1	1		2.5			1	
33803	Division of aberrant vessel (va	090	586	614.5	28.5	5%	20.31	21.88	1.57	8%	-2				1	1		2.5			1	
33813	Obliteration of aortopulmona	090	664	685	21	3%	21.36	22.57	1.21	6%	-2				1	1		1			1	
33814	Obliteration of aortopulmona	090	838	856	18	2%	26.57	27.63	1.06	4%	-4					2					1	
33820	Repair of patent ductus arteri	090	414	428	14	3%	16.69	17.57	0.88	5%	-2					1		1			1	
33822	Repair of patent ductus arteri	090	463	472	9	2%	17.71	18.35	0.64	4%	-2					1					1	
33824	Repair of patent ductus arteri	090	615	633.5	18.5	3%	20.23	21.32	1.09	5%	-2				1	1		0.5			1	
33840	Excision of coarctation of aort	090	639	662.5	23.5	4%	21.34	22.67	1.33	6%	-2				1	1		1.5			1	
33845	Excision of coarctation of aort	090	726	749	23	3%	22.93	24.23	1.30	6%	-4					2		1			1	
33851	Excision of coarctation of aort	090	700	726	26	4%	21.98	23.43	1.45	7%	-2				1	1		2			1	
33852	Repair of hypoplastic or inter	090	719	745	26	4%	24.41	25.86	1.45	6%	-2				1	1		2			1	
33853	Repair of hypoplastic or inter	090	668	726	58	9%	32.51	35.49	2.98	9%	-4					2		8			1	
33858	Ascending aorta graft, with ca	090	911	922	11	1%	63.40	65.61	2.21	3%	-2				1	1		1	1	2	1	
33859	Ascending aorta graft, with ca	090	778	782	4	1%	45.13	47.01	1.88	4%	-2					1		1	1	2	1	
33863	Ascending aorta graft, with ca	090	838	842	4	0%	58.79	60.67	1.88	3%	-2					1		1	1	2	1	
33864	Ascending aorta graft, with ca	090	838	842	4	0%	60.08	61.96	1.88	3%	-2					1		1	1	2	1	
33871	Transverse aortic arch graft, v	090	901	905	4	0%	60.88	62.76	1.88	3%	-2					1		1	1	2	1	
33875	Descending thoracic aorta gra	090	993	1006	13	1%	50.72	53.56	2.84	6%	-2				1	1		1	2	3		1
33877	Repair of thoracoabdominal a	090	1110	1130	20	2%	69.03	72.20	3.17	5%	-2				2	1		1	2	3		1
33880	Endovascular repair of descer	090	599	611	12	2%	34.58	36.30	1.72	5%	0				2			1	1	1	1	
33881	Endovascular repair of descer	090	554	566	12	2%	29.58	31.30	1.72	6%	0				2			1	1	1	1	
33883	Placement of proximal extens	090	404	419	15	4%	21.09	22.41	1.32	6%	0				2			1	1		1	
33886	Placement of distal extension	090	379	394	15	4%	18.09	19.41	1.32	7%	0				2			1	1		1	
33910	Pulmonary artery embolector	090	889	893	4	0%	48.21	51.02	2.81	6%	-2				1	1		1	2	3	1	

33915	Pulmonary artery embolector	090	858	904	46	5%	24.95	27.36	2.41	10%	-3					1.5		6.5			1	
33916	Pulmonary endarterectomy, \	090	1259	1258	-1	0%	78.00	82.05	4.05	5%	-2				1	1		2	3	5	1	
33917	Repair of pulmonary artery st	090	608	651	43	7%	25.30	27.56	2.26	9%	-4					2		5			1	
33920	Repair of pulmonary atresia v	090	658	706	48	7%	32.74	35.24	2.50	8%	-4					2		6			1	
33922	Transection of pulmonary art	090	546	587	41	8%	24.22	26.39	2.17	9%	-2				1	1		5			1	
33925	Repair of pulmonary artery ar	090	641	665	24	4%	31.30	33.21	1.91	6%	0				1			4		1	1	
33926	Repair of pulmonary artery ar	090	846	891	45	5%	44.73	48.04	3.31	7%	0				1			9	1	1	1	
33935	Heart-lung transplant with re	090	1713	1708	-5	0%	91.78	97.71	5.93	6%	-3				1	1	1	1	8	6		1
33945	Heart transplant, with or with	090	1716	1745	29	2%	89.50	95.71	6.21	7%	-5				3	2	1	1	6	5		1
33951	Extracorporeal membrane ox	000	170	175	5	3%	8.15	8.39	0.24	3%	0							1				
33952	Extracorporeal membrane ox	000	158	163	5	3%	8.15	8.39	0.24	3%	0							1				
33953	Extracorporeal membrane ox	000	190	186	-4	-2%	9.11	9.31	0.20	2%	0								1			
33954	Extracorporeal membrane ox	000	178	174	-4	-2%	9.11	9.31	0.20	2%	0								1			
33955	Extracorporeal membrane ox	000	250	250	0	0%	16.00	16.00	-	0%	0											
33956	Extracorporeal membrane ox	000	250	250	0	0%	16.00	16.00	-	0%	0											
33957	Extracorporeal membrane ox	000	130	135	5	4%	3.51	3.75	0.24	7%	0							1				
33958	Extracorporeal membrane ox	000	118	123	5	4%	3.51	3.75	0.24	7%	0							1				
33959	Extracorporeal membrane ox	000	130	135	5	4%	4.47	4.71	0.24	5%	0							1				
33962	Extracorporeal membrane ox	000	118	123	5	4%	4.47	4.71	0.24	5%	0							1				
33963	Extracorporeal membrane ox	000	183	180	-3	-2%	9.00	9.40	0.40	4%	0									1		
33964	Extracorporeal membrane ox	000	195	192	-3	-2%	9.50	9.90	0.40	4%	0									1		
33965	Extracorporeal membrane ox	000	130	135	5	4%	3.51	3.75	0.24	7%	0							1				
33966	Extracorporeal membrane ox	000	133	138	5	4%	4.50	4.74	0.24	5%	0							1				
33969	Extracorporeal membrane ox	000	163	159	-4	-2%	5.22	5.42	0.20	4%	0								1			
33971	Removal of intra-aortic balloc	090	494	518	24	5%	11.99	13.35	1.36	11%	-2					1		3			1	
33974	Removal of intra-aortic balloc	090	314	333	19	6%	15.03	16.15	1.12	7%	0				2			1			1	
33984	Extracorporeal membrane ox	000	153	149	-4	-3%	5.46	5.66	0.20	4%	0								1			
33985	Extracorporeal membrane ox	000	200	197	-3	-2%	9.89	10.29	0.40	4%	0									1		
33986	Extracorporeal membrane ox	000	205	202	-3	-1%	10.00	10.40	0.40	4%	0									1		
33988	Insertion of left heart vent by	000	250	250	0	0%	15.00	15.00	-	0%	0											
33989	Removal of left heart vent by	000	205	202	-3	-1%	9.50	9.90	0.40	4%	0									1		
34001	Embolectomy or thrombector	090	384	386	2	1%	17.88	19.36	1.48	8%	0				2				3		1	
34051	Embolectomy or thrombector	090	594	636.5	42.5	7%	16.99	19.56	2.57	15%	0			2.5				7.5			1	
34101	Embolectomy or thrombector	090	322	337	15	5%	10.93	12.38	1.45	13%	0			1	1			2	1		1	
34111	Embolectomy or thrombector	090	307	322	15	5%	10.93	12.38	1.45	13%	0			1	1			2	1		1	
34151	Embolectomy or thrombector	090	508	531	23	5%	26.52	28.87	2.35	9%	0			2	1			4	2		1	
34201	Embolectomy or thrombector	090	422	438	16	4%	19.48	21.24	1.76	9%	0				2			2	2		1	
34203	Embolectomy or thrombector	090	413	440	27	7%	17.86	19.88	2.02	11%	0			1	2			3	1		1	
34401	Thrombectomy, direct or with	090	503	526	23	5%	26.52	28.87	2.35	9%	0			2	1			4	2		1	
34421	Thrombectomy, direct or with	090	412	428	16	4%	13.37	15.26	1.89	14%	0			1	1			3	2		1	
34451	Thrombectomy, direct or with	090	533	556	23	4%	28.52	30.87	2.35	8%	0			2	1			4	2		1	
34471	Thrombectomy, direct or with	090	453	475	22	5%	21.11	23.02	1.91	9%	0			2	1			3	1		1	
34490	Thrombectomy, direct or with	090	367	387	20	5%	10.91	12.60	1.69	15%	0			1	1			3	1		1	
34501	Valvuloplasty, femoral vein	090	393	405	12	3%	16.85	18.28	1.43	8%	0			2	1			1	1		1	
34502	Reconstruction of vena cava,	090	741	796	55	7%	28.07	30.90	2.83	10%	-4				1	2		6			1	
34510	Venous valve transposition, a	090	448	465	17	4%	19.91	21.58	1.67	8%	0			2	1			2	1		1	
34520	Cross-over vein graft to veno	090	443	465	22	5%	19.18	20.96	1.78	9%	0			1	2			2	1		1	
34530	Saphenopopliteal vein anasto	090	436	460	24	6%	17.93	19.93	2.00	11%	0			2	2			2	1		1	
34701	Endovascular repair of infrare	090	482	484	2	0%	23.71	25.08	1.37	6%	0			1	1				1	1	1	
34702	Endovascular repair of infrare	090	677	686	9	1%	36.00	38.63	2.63	7%	-2			1	1	1		1	2	2	1	
34703	Endovascular repair of infrare	090	507	509	2	0%	26.52	27.89	1.37	5%	0			1	1				1	1	1	
34704	Endovascular repair of infrare	090	737	746	9	1%	45.00	47.63	2.63	6%	-2			1	1	1		1	2	2	1	
34705	Endovascular repair of infrare	090	512	514	2	0%	29.58	30.95	1.37	5%	0			1	1				1	1	1	
34706	Endovascular repair of infrare	090	735	744	9	1%	45.00	47.63	2.63	6%	-2			1	1	1		1	2	2	1	
34707	Endovascular repair of iliac ar	090	482	484	2	0%	22.28	23.65	1.37	6%	0			1	1				1	1	1	
34708	Endovascular repair of iliac ar	090	677	686	9	1%	36.50	39.13	2.63	7%	-2			1	1	1		1	2	2	1	
34710	Delayed placement of distal c	090	397	407	10	3%	15.00	16.21	1.21	8%	0			1	1			1	1		1	
34712	Transcatheter delivery of enh	090	307	317	10	3%	12.00	13.21	1.21	10%	0			1	1			1	1		1	
34718	Endovascular repair of iliac ar	090	477	479	2	0%	24.00	25.37	1.37	6%	0			1	1				1	1	1	
34830	Open repair of infrarenal aort	090	665	682	17	3%	35.23	38.25	3.02	9%	0			1	2			3	2	2	1	
34831	Open repair of infrarenal aort	090	690	707	17	2%	37.98	41.00	3.02	8%	0			1	2			3	2	2	1	
34832	Open repair of infrarenal aort	090	710	727	17	2%	37.98	41.00	3.02	8%	0			1	2			3	2	2	1	
35001	Direct repair of aneurysm, ps	090	568	617.5	49.5	9%	20.81	23.84	3.03	15%	0			3.5				8.5			1	
35002	Direct repair of aneurysm, ps	090	592	644	52	9%	22.23	25.38	3.15	14%	0			3.5				9			1	
35005	Direct repair of aneurysm, ps	090	551	600.5	49.5	9%	19.29	22.32	3.03	16%	0			3.5				8.5			1	
35011	Direct repair of aneurysm, ps	090	357	376	19	5%	18.58	19.83	1.25	7%	0			1	1			2			1	

35013	Direct repair of aneurysm, ps	090	433	455	22	5%	23.23	25.01	1.78	8%	0			1	2			2	1		1	
35021	Direct repair of aneurysm, ps	090	745	797.5	52.5	7%	22.17	25.22	3.05	14%	0			2.5				9.5			1	
35022	Direct repair of aneurysm, ps	090	764	816.5	52.5	7%	25.70	28.75	3.05	12%	0			2.5				9.5			1	
35045	Direct repair of aneurysm, ps	090	329	342	13	4%	18.01	18.91	0.90	5%	0			0.5	1			1			1	
35081	Direct repair of aneurysm, ps	090	677	693	16	2%	33.53	35.80	2.27	7%	-2			1	1	1		2	3		1	
35082	Direct repair of aneurysm, ps	090	792	810	18	2%	42.09	45.00	2.91	7%	-2			1	1	1		3	3	1	1	
35091	Direct repair of aneurysm, ps	090	790	845	55	7%	35.35	38.21	2.86	8%	0							11			1	
35092	Direct repair of aneurysm, ps	090	1172	1179	7	1%	50.97	54.44	3.47	7%	-2			1	1	1		2	3	3	1	
35102	Direct repair of aneurysm, ps	090	732	748	16	2%	36.53	38.80	2.27	6%	-2			1	1	1		2	3		1	
35103	Direct repair of aneurysm, ps	090	740	764	24	3%	43.62	46.28	2.66	6%	0			1	2			4	3		1	
35111	Direct repair of aneurysm, ps	090	483	496	13	3%	26.28	28.15	1.87	7%	0			2	1			2	2		1	
35112	Direct repair of aneurysm, ps	090	690	708	18	3%	32.57	34.55	1.98	6%	0			1	2			2	2		1	
35121	Direct repair of aneurysm, ps	090	563	586	23	4%	31.52	33.87	2.35	7%	0			2	1			4	2		1	
35122	Direct repair of aneurysm, ps	090	770	784	14	2%	37.89	40.07	2.18	6%	0			1	2			2	3		1	
35131	Direct repair of aneurysm, ps	090	528	546	18	3%	26.40	28.51	2.11	8%	0			2	1			3	2		1	
35132	Direct repair of aneurysm, ps	090	655	673	18	3%	32.57	34.55	1.98	6%	0			1	2			2	2		1	
35141	Direct repair of aneurysm, ps	090	427	442	15	4%	20.91	22.36	1.45	7%	0			1	1			2	1		1	
35142	Direct repair of aneurysm, ps	090	555	582	27	5%	25.16	27.18	2.02	8%	0			1	2			3	1		1	
35151	Direct repair of aneurysm, ps	090	473	495	22	5%	23.72	25.63	1.91	8%	0			2	1			3	1		1	
35152	Direct repair of aneurysm, ps	090	590	605	15	3%	27.66	30.04	2.38	9%	0			1	2			2	2	1	1	
35180	Repair, congenital arterioven	090	500	541	41	8%	15.10	17.66	2.56	17%	0			3				7			1	
35182	Repair, congenital arterioven	090	553	572	19	3%	31.71	33.89	2.18	7%	0			1	2			2	1	1	1	
35184	Repair, congenital arterioven	090	413	424	11	3%	18.82	20.14	1.32	7%	0			1.5	1			1	1		1	
35188	Repair, acquired or traumatic	090	380	390	10	3%	18.00	19.21	1.21	7%	0			1	1			1	1		1	
35189	Repair, acquired or traumatic	090	548	560.5	12.5	2%	29.98	32.24	2.26	8%	0			1	2			1.5	2	1	1	
35190	Repair, acquired or traumatic	090	416	444.5	28.5	7%	13.42	15.38	1.96	15%	0			3				4.5			1	
35201	Repair blood vessel, direct; ne	090	382	415.5	33.5	9%	16.93	19.13	2.20	13%	0			3				5.5			1	
35206	Repair blood vessel, direct; up	090	282	301	19	7%	13.84	15.09	1.25	9%	0			1	1			2			1	
35207	Repair blood vessel, direct; ha	090	376	409.5	33.5	9%	10.94	13.14	2.20	20%	0			3				5.5			1	
35211	Repair blood vessel, direct; in	090	806	856	50	6%	24.58	27.51	2.93	12%	0			2.5				9			1	
35216	Repair blood vessel, direct; in	090	658	677	19	3%	36.61	38.90	2.29	6%	-4		1		1	1		3	3		1	
35221	Repair blood vessel, direct; in	090	545	553	8	1%	26.62	28.67	2.05	8%	0			1	1			2	2	1	1	
35226	Repair blood vessel, direct; lo	090	327	337	10	3%	15.30	16.51	1.21	8%	0			1	1			1	1		1	
35231	Repair blood vessel with vein	090	382	384	2	1%	21.16	22.53	1.37	6%	0			1	1				1	1	1	
35236	Repair blood vessel with vein	090	367	382	15	4%	18.02	19.47	1.45	8%	0			1	1			2	1		1	
35241	Repair blood vessel with vein	090	797	847	50	6%	25.58	28.51	2.93	11%	0			2.5				9			1	
35246	Repair blood vessel with vein	090	577	584	7	1%	28.23	29.84	1.61	6%	0			1	1			1	1	1	1	
35251	Repair blood vessel with vein	090	532	540	8	2%	31.91	33.96	2.05	6%	0			1	1			2	2	1	1	
35256	Repair blood vessel with vein	090	347	371	24	7%	19.06	20.55	1.49	8%	0			1	1			3			1	
35261	Repair blood vessel with graft	090	382	384	2	1%	18.96	20.33	1.37	7%	0			1	1				1	1	1	
35266	Repair blood vessel with graft	090	337	352	15	4%	15.83	17.28	1.45	9%	0			1	1			2	1		1	
35271	Repair blood vessel with graft	090	778	828	50	6%	24.58	27.51	2.93	12%	0			2.5				9			1	
35276	Repair blood vessel with graft	090	553.5	572	18.5	3%	25.83	27.45	1.62	6%	0			1	1.5			2	1		1	
35281	Repair blood vessel with graft	090	595	613	18	3%	30.06	32.04	1.98	7%	0			1	2			2	2		1	
35286	Repair blood vessel with graft	090	350	381	31	9%	17.19	19.01	1.82	11%	0			1	2			3			1	
35301	Thromboendarterectomy, inc	090	404	411	7	2%	21.16	22.64	1.48	7%	0				2				1	1	1	
35302	Thromboendarterectomy, inc	090	392	402	10	3%	21.35	22.56	1.21	6%	0			1	1			1	1		1	
35303	Thromboendarterectomy, inc	090	392	402	10	3%	23.60	24.81	1.21	5%	0			1	1			1	1		1	
35304	Thromboendarterectomy, inc	090	422	432	10	2%	24.60	25.81	1.21	5%	0			1	1			1	1		1	
35305	Thromboendarterectomy, inc	090	402	412	10	2%	23.60	24.81	1.21	5%	0			1	1			1	1		1	
35311	Thromboendarterectomy, inc	090	532	535	3	1%	28.60	30.41	1.81	6%	0			1	1			1	2	1	1	
35321	Thromboendarterectomy, inc	090	337	356	19	6%	16.59	17.84	1.25	8%	0			1	1			2			1	
35331	Thromboendarterectomy, inc	090	558	581	23	4%	27.72	30.07	2.35	8%	0			2	1			4	2		1	
35341	Thromboendarterectomy, inc	090	549	596	47	9%	26.21	29.12	2.91	11%	0			3.5				8			1	
35351	Thromboendarterectomy, inc	090	502	505	3	1%	24.61	26.42	1.81	7%	0			1	1			1	2	1	1	
35355	Thromboendarterectomy, inc	090	457	473	16	4%	19.86	21.75	1.89	10%	0			1	1			3	2		1	
35361	Thromboendarterectomy, inc	090	605	620	15	2%	30.24	32.62	2.38	8%	0			1	2			2	2	1	1	
35363	Thromboendarterectomy, inc	090	655	675	20	3%	32.35	34.97	2.62	8%	0			1	2			3	2	1	1	
35371	Thromboendarterectomy, inc	090	325	344	19	6%	15.31	16.56	1.25	8%	0			1	1			2			1	
35372	Thromboendarterectomy, inc	090	347	366	19	5%	18.58	19.83	1.25	7%	0			1	1			2			1	
35501	Bypass graft, with vein; comm	090	449	464	15	3%	29.09	30.41	1.32	5%	0				2			1	1		1	
35506	Bypass graft, with vein; caroti	090	452	464	12	3%	25.33	27.05	1.72	7%	0				2			1	1	1	1	
35508	Bypass graft, with vein; caroti	090	404	419	15	4%	26.09	27.41	1.32	5%	0				2			1	1		1	
35509	Bypass graft, with vein; caroti	090	439	454	15	3%	28.09	29.41	1.32	5%	0				2			1	1		1	
35510	Bypass graft, with vein; caroti	090	497	508	11	2%	24.39	25.91	1.52	6%	0				2			1	2		1	
35511	Bypass graft, with vein; subcl	090	407	408	1	0%	22.20	23.37	1.17	5%	0			1	1				2		1	

35512	Bypass graft, with vein; subcl	090	462	473	11	2%	23.89	25.41	1.52	6%	0				2			1	2		1	
35515	Bypass graft, with vein; subcl	090	414	429	15	4%	26.09	27.41	1.32	5%	0				2			1	1		1	
35516	Bypass graft, with vein; subcl	090	424	444	20	5%	24.21	25.77	1.56	6%	0				2			2	1		1	
35518	Bypass graft, with vein; axilla	090	457	459	2	0%	22.65	24.26	1.61	7%	0			1	1			1	3		1	
35521	Bypass graft, with vein; axilla	090	530	540	10	2%	24.13	26.27	2.14	9%	0			1	2			1	2	1	1	
35522	Bypass graft, with vein; axilla	090	497	508	11	2%	23.15	24.67	1.52	7%	0				2			1	2		1	
35523	Bypass graft, with vein; brach	090	485	498	13	3%	24.13	25.87	1.74	7%	0			1	2			1	2		1	
35525	Bypass graft, with vein; brach	090	415	430	15	4%	21.69	23.01	1.32	6%	0				2			1	1		1	
35526	Bypass graft, with vein; aorto	090	562	565	3	1%	31.55	33.36	1.81	6%	0			1	1			1	2	1	1	
35531	Bypass graft, with vein; aorto	090	740	747	7	1%	39.11	41.65	2.54	6%	0			1	2			1	2	2	1	
35533	Bypass graft, with vein; axilla	090	615	625	10	2%	29.92	32.06	2.14	7%	0			1	2			1	2	1	1	
35535	Bypass graft, with vein; hepat	090	690	705	15	2%	38.13	40.51	2.38	6%	0			1	2			2	2	1	1	
35536	Bypass graft, with vein; splen	090	550	565	15	3%	33.73	36.11	2.38	7%	0			1	2			2	2	1	1	
35537	Bypass graft, with vein; aorto	090	683	696	13	2%	41.88	43.62	1.74	4%	0			1	2			1	2		1	
35538	Bypass graft, with vein; aorto	090	798	820	22	3%	47.03	49.19	2.16	5%	-2			1	2	1		1	2		1	
35539	Bypass graft, with vein; aorto	090	720	738	18	2%	44.11	46.09	1.98	4%	0			1	2			2	2		1	
35540	Bypass graft, with vein; aorto	090	780	798	18	2%	49.33	51.31	1.98	4%	0			1	2			2	2		1	
35556	Bypass graft, with vein; femo	090	586	605	19	3%	26.75	28.93	2.18	8%	0			1	2			2	1	1	1	
35558	Bypass graft, with vein; femo	090	530	540	10	2%	23.13	25.27	2.14	9%	0			1	2			1	2	1	1	
35560	Bypass graft, with vein; aorto	090	590	605	15	3%	34.03	36.41	2.38	7%	0			1	2			2	2	1	1	
35563	Bypass graft, with vein; ilioilia	090	535	545	10	2%	26.12	28.26	2.14	8%	0			1	2			1	2	1	1	
35565	Bypass graft, with vein; iliofer	090	535	545	10	2%	25.13	27.27	2.14	9%	0			1	2			1	2	1	1	
35566	Bypass graft, with vein; femo	090	718	747	29	4%	32.35	35.00	2.65	8%	0			1	2			3	2	1		1
35570	Bypass graft, with vein; tibial-	090	667	683	16	2%	29.15	31.84	2.69	9%	0				3			2	3	1	1	
35571	Bypass graft, with vein; poplit	090	510	542	32	6%	25.52	27.78	2.26	9%	0			1	2			4	1		1	
35583	In-situ vein bypass; femoral-p	090	588	607	19	3%	27.75	29.93	2.18	8%	0			1	2			2	1	1	1	
35585	In-situ vein bypass; femoral-a	090	717	746	29	4%	32.35	35.00	2.65	8%	0			1	2			3	2	1		1
35587	In-situ vein bypass; popliteal-	090	523	555	32	6%	26.21	28.47	2.26	9%	0			1	2			4	1		1	
35601	Bypass graft, with other than	090	484	496	12	2%	27.09	28.81	1.72	6%	0				2			1	1	1	1	
35606	Bypass graft, with other than	090	414	421	7	2%	22.46	23.94	1.48	7%	0				2				1	1	1	
35612	Bypass graft, with other than	090	485	498	13	3%	20.35	22.09	1.74	9%	0			1	2			1	2		1	
35616	Bypass graft, with other than	090	367	377	10	3%	21.82	23.03	1.21	6%	0			1	1			1	1		1	
35621	Bypass graft, with other than	090	412	432	20	5%	21.03	22.72	1.69	8%	0			1	1			3	1		1	
35623	Bypass graft, with other than	090	475	485	10	2%	25.92	28.06	2.14	8%	0			1	2			1	2	1	1	
35626	Bypass graft, with other than	090	520	532	12	2%	29.14	30.99	1.85	6%	0			1	1			2	1	1	1	
35631	Bypass graft, with other than	090	648	663	15	2%	36.03	38.41	2.38	7%	0			1	2			2	2	1	1	
35632	Bypass graft, with other than	090	690	705	15	2%	36.13	38.51	2.38	7%	0			1	2			2	2	1	1	
35633	Bypass graft, with other than	090	705	723	18	3%	39.11	41.09	1.98	5%	0			1	2			2	2		1	
35634	Bypass graft, with other than	090	680	695	15	2%	35.33	37.71	2.38	7%	0			1	2			2	2	1	1	
35636	Bypass graft, with other than	090	603	609	6	1%	31.75	34.09	2.34	7%	0			1	2			1	3	1	1	
35637	Bypass graft, with other than	090	605	623	18	3%	33.05	35.03	1.98	6%	0			1	2			2	2		1	
35638	Bypass graft, with other than	090	635	653	18	3%	33.60	35.58	1.98	6%	0			1	2			2	2		1	
35642	Bypass graft, with other than	090	463	504	41	9%	18.94	21.50	2.56	14%	0			3				7			1	
35645	Bypass graft, with other than	090	463	504	41	9%	18.43	20.99	2.56	14%	0			3				7			1	
35646	Bypass graft, with other than	090	645	662	17	3%	32.98	35.58	2.60	8%	-2			2		1		3	2	1	1	
35647	Bypass graft, with other than	090	573	587	14	2%	29.73	32.04	2.31	8%	0			2	1			3	3		1	
35650	Bypass graft, with other than	090	382	384	2	1%	20.16	21.53	1.37	7%	0			1	1				1	1	1	
35654	Bypass graft, with other than	090	513	526	13	3%	26.28	28.15	1.87	7%	0			2	1			2	2		1	
35656	Bypass graft, with other than	090	447	481	34	8%	20.47	22.44	1.97	10%	0			1	1			5			1	
35661	Bypass graft, with other than	090	440	467	27	6%	20.35	22.37	2.02	10%	0			1	2			3	1		1	
35663	Bypass graft, with other than	090	503	513	10	2%	23.93	26.07	2.14	9%	0			1	2			1	2	1	1	
35665	Bypass graft, with other than	090	480	507	27	6%	22.35	24.37	2.02	9%	0			1	2			3	1		1	
35666	Bypass graft, with other than	090	490	522	32	7%	23.66	25.92	2.26	10%	0			1	2			4	1		1	
35671	Bypass graft, with other than	090	435	448	13	3%	20.77	22.51	1.74	8%	0			1	2			1	2		1	
35691	Transposition and/or reimpla	090	417	433	16	4%	18.41	19.77	1.36	7%	0			3				2			1	
35693	Transposition and/or reimpla	090	372	388	16	4%	15.73	17.09	1.36	9%	0			3				2			1	
35694	Transposition and/or reimpla	090	456	472	16	4%	19.28	20.64	1.36	7%	0			3				2			1	
35695	Transposition and/or reimpla	090	532	535	3	1%	20.06	21.58	1.52	8%	0			3				1	2		1	
35701	Exploration not followed by s	090	229	236	7	3%	7.50	8.18	0.68	9%	0			1				1			1	
35702	Exploration not followed by s	090	219	226	7	3%	7.12	7.80	0.68	10%	0			1				1			1	
35703	Exploration not followed by s	090	229	236	7	3%	7.50	8.18	0.68	9%	0			1				1			1	
35800	Exploration for postoperative	090	336	345	9	3%	12.00	13.83	1.83	15%	0			2	1			1	1	1	1	
35820	Exploration for postoperative	090	799	787	-12	-2%	36.89	40.57	3.68	10%	-2					1		1	2	6	1	
35840	Exploration for postoperative	090	431	433	2	0%	20.75	23.18	2.43	12%	0			2	1			1	2	2	1	
35860	Exploration for postoperative	090	406	411	5	1%	15.25	17.28	2.03	13%	0			2	1			1	2	1	1	
35870	Repair of graft-enteric fistula	090	715	759.5	44.5	6%	24.50	27.29	2.79	11%	0			3.5				7.5			1	

35875	Thrombectomy of arterial or	090	297	316	19	6%	10.72	11.97	1.25	12%	0			1	1			2			1	
35876	Thrombectomy of arterial or	090	402	431	29	7%	17.82	19.55	1.73	10%	0			1	1			4			1	
35879	Revision, lower extremity art	090	421	448	27	6%	17.41	19.30	1.89	11%	-2				1	1		3	1		1	
35881	Revision, lower extremity art	090	450	477	27	6%	19.35	21.37	2.02	10%	0			1	2			3	1		1	
35883	Revision, femoral anastomosi	090	462	468	6	1%	23.15	24.56	1.41	6%	0			1	1			1	2		1	
35884	Revision, femoral anastomosi	090	482	488	6	1%	24.65	26.06	1.41	6%	0			1	1			1	2		1	
35901	Excision of infected graft; ne	090	482	510	28	6%	8.38	10.44	2.06	25%	0			4				4			1	
35903	Excision of infected graft; ext	090	416	437	21	5%	9.53	11.13	1.60	17%	0			3				3			1	
35905	Excision of infected graft; tho	090	720	745	25	3%	33.52	36.38	2.86	9%	0			1	2			4	2	1	1	
35907	Excision of infected graft; abd	090	720	745	25	3%	37.27	40.13	2.86	8%	0			1	2			4	2	1	1	
36260	Insertion of implantable intra	090	287	295.5	8.5	3%	9.91	10.91	1.00	10%	0			3				0.5			1	
36261	Revision of implanted intra-a	090	233	240.5	7.5	3%	5.63	6.52	0.89	16%	0			2.5				0.5			1	
36262	Removal of implanted intra-a	090	181	185	4	2%	4.11	4.77	0.66	16%	0			2							1	
36557	Insertion of tunneled centrall	010	117	119	2	2%	4.89	5.22	0.33	7%	0			1							0.5	
36558	Insertion of tunneled centrall	010	111	113	2	2%	4.59	4.92	0.33	7%	0			1							0.5	
36560	Insertion of tunneled centrall	010	134	136	2	1%	6.04	6.37	0.33	5%	0			1							0.5	
36561	Insertion of tunneled centrall	010	120	122	2	2%	5.79	6.12	0.33	6%	0			1							0.5	
36563	Insertion of tunneled centrall	010	140	142	2	1%	5.99	6.32	0.33	6%	0			1							0.5	
36565	Insertion of tunneled centrall	010	120	122	2	2%	5.79	6.12	0.33	6%	0			1							0.5	
36566	Insertion of tunneled centrall	010	135	137	2	1%	6.29	6.62	0.33	5%	0			1							0.5	
36570	Insertion of peripherally inser	010	135	137	2	1%	5.11	5.44	0.33	6%	0			1							0.5	
36571	Insertion of peripherally inser	010	130	132	2	2%	5.09	5.42	0.33	6%	0			1							0.5	
36576	Repair of central venous acce	010	114	116	2	2%	2.99	3.32	0.33	11%	0			1							0.5	
36578	Replacement, catheter only, c	010	106	108	2	2%	3.29	3.62	0.33	10%	0			1							0.5	
36581	Replacement, complete, of a	010	110	112	2	2%	3.23	3.56	0.33	10%	0			1							0.5	
36582	Replacement, complete, of a	010	146	148	2	1%	4.99	5.32	0.33	7%	0			1							0.5	
36583	Replacement, complete, of a	010	147	149	2	1%	5.04	5.37	0.33	7%	0			1							0.5	
36585	Replacement, complete, of a	010	131	133	2	2%	4.59	4.92	0.33	7%	0			1							0.5	
36589	Removal of tunneled central v	010	79	79	0	0%	2.28	2.39	0.11	5%	-2		1								0.5	
36590	Removal of tunneled central v	010	105	107	2	2%	3.10	3.43	0.33	11%	0			1							0.5	
36818	Arteriovenous anastomosis, d	090	248	257	9	4%	12.39	13.05	0.66	5%	0			1	1						0.5	
36819	Arteriovenous anastomosis, d	090	283	292	9	3%	13.29	13.95	0.66	5%	0			1	1						0.5	
36820	Arteriovenous anastomosis, d	090	258	267	9	3%	13.07	13.73	0.66	5%	0			1	1						0.5	
36821	Arteriovenous anastomosis, d	090	233	242	9	4%	11.90	12.56	0.66	6%	0			1	1						0.5	
36823	Insertion of arterial and veno	090	606	618	12	2%	22.98	25.34	2.36	10%	0			2	2			1	2	1	1	
36825	Creation of arteriovenous fist	090	306	322	16	5%	14.17	15.16	0.99	7%	0			1	2						0.5	
36830	Creation of arteriovenous fist	090	248	257	9	4%	12.03	12.69	0.66	5%	0			1	1						0.5	
36831	Thrombectomy, open, arterio	090	248	257	9	4%	11.00	11.66	0.66	6%	0			1	1						0.5	
36832	Revision, open, arteriovenous	090	276	292	16	6%	13.50	14.49	0.99	7%	0			1	2						0.5	
36833	Revision, open, arteriovenous	090	306	322	16	5%	14.50	15.49	0.99	7%	0			1	2						0.5	
36835	Insertion of Thomas shunt (se	090	242	257	15	6%	7.51	8.76	1.25	17%	0			2.5				2			1	
36838	Distal revascularization and in	090	424	439	15	4%	21.69	23.01	1.32	6%	0				2			1	1		1	
37140	Venous anastomosis, open; p	090	845	866	21	2%	40.00	42.93	2.93	7%	0				3			3	3	1	1	
37145	Venous anastomosis, open; re	090	798	823	25	3%	37.00	39.73	2.73	7%	0				3			3	2	1	1	
37160	Venous anastomosis, open; c	090	785	810	25	3%	38.00	40.73	2.73	7%	0				3			3	2	1	1	
37180	Venous anastomosis, open; s	090	805	830	25	3%	36.50	39.23	2.73	7%	0				3			3	2	1	1	
37181	Venous anastomosis, open; s	090	785	801	16	2%	40.00	42.69	2.69	7%	0				3			2	3	1	1	
37215	Transcatheter placement of in	090	337	347	10	3%	17.75	18.83	1.08	6%	0				2				1		1	
37216	Transcatheter placement of in	090	341	351	10	3%	17.98	19.06	1.08	6%	0				2				1		1	
37217	Transcatheter placement of in	090	403	410	7	2%	20.38	21.86	1.48	7%	0				2				1	1	1	
37218	Transcatheter placement of in	090	255	274	19	7%	14.75	15.87	1.12	8%	0				2			1			1	
37500	Vascular endoscopy, surgical,	090	261	277	16	6%	11.67	12.66	0.99	8%	0			1	2						0.5	
37565	Ligation, internal jugular vein	090	312	314	2	1%	12.05	13.42	1.37	11%	0			1	1				1	1	1	
37600	Ligation; external carotid arte	090	322	324	2	1%	12.42	13.79	1.37	11%	0			1	1				1	1	1	
37605	Ligation; internal or common	090	342	344	2	1%	14.28	15.65	1.37	10%	0			1	1				1	1	1	
37606	Ligation; internal or common	090	606	637	31	5%	8.81	10.89	2.08	24%	0			3				5			1	
37607	Ligation or banding of angioa	090	242	246	4	2%	6.25	6.69	0.44	7%	0			2								
37609	Ligation or biopsy, temporal a	010	130	132	2	2%	3.05	3.38	0.33	11%	0			1							0.5	
37615	Ligation, major artery (eg, po	090	489	511.5	22.5	5%	7.80	9.41	1.61	21%	0			2.5				3.5			1	
37616	Ligation, major artery (eg, po	090	656	696	40	6%	18.97	21.42	2.45	13%	0			2.5				7			1	
37617	Ligation, major artery (eg, po	090	475	483	8	2%	23.79	25.84	2.05	9%	0			1	1			2	2	1	1	
37618	Ligation, major artery (eg, po	090	359	376.5	17.5	5%	6.03	7.40	1.37	23%	0			2.5				2.5			1	
37619	Ligation of inferior vena cava	090	683	698	15	2%	30.00	32.38	2.38	8%	0			1	2			2	2	1	1	
37650	Ligation of femoral vein	090	262	267	5	2%	8.49	9.46	0.97	11%	0			1	1				1		1	
37660	Ligation of common iliac vein	090	397	404	7	2%	22.28	23.89	1.61	7%	0			1	1			1	1	1	1	
37700	Ligation and division of long s	090	152	156	4	3%	3.82	4.37	0.55	14%	0			2							0.5	

37718	Ligation, division, and strippir	090	178	187	9	5%	7.13	7.79	0.66	9%	0			1	1						0.5	
37722	Ligation, division, and strippir	090	198	207	9	5%	8.16	8.82	0.66	8%	0			1	1						0.5	
37735	Ligation and division and com	090	365	381	16	4%	10.90	12.26	1.36	12%	0			3				2			1	
37760	Ligation of perforator veins, s	090	335	348.5	13.5	4%	10.78	12.02	1.24	12%	0			3				1.5			1	
37761	Ligation of perforator vein(s),	090	224	240	16	7%	9.13	10.12	0.99	11%	0			1	2						0.5	
37765	Stab phlebectomy of varicose	010	117	124	7	6%	4.80	5.13	0.33	7%	0				1							
37766	Stab phlebectomy of varicose	010	133	140	7	5%	6.00	6.33	0.33	5%	0				1							
37780	Ligation and division of short	090	179	183	4	2%	3.93	4.59	0.66	17%	0			2							1	
37785	Ligation, division, and/or exci	090	177	181	4	2%	3.93	4.48	0.55	14%	0			2							0.5	
37788	Penile revascularization, arte	090	627	624	-3	0%	23.33	25.23	1.90	8%	0			4					2	1	1	
37790	Penile venous occlusive proce	090	257	261	4	2%	8.43	8.87	0.44	5%	0			2								
38100	Splenectomy; total (separate	090	442	459	17	4%	19.55	21.64	2.09	11%	0			1	1			3	1	1	1	
38101	Splenectomy; partial (separat	090	442	459	17	4%	19.55	21.64	2.09	11%	0			1	1			3	1	1	1	
38115	Repair of ruptured spleen (sp	090	492	505	13	3%	21.88	24.17	2.29	10%	0			1	1			3	2	1	1	
38120	Laparoscopy, surgical, splene	090	434	468	34	8%	17.07	18.91	1.84	11%	0				2			4			1	
38300	Drainage of lymph node absc	010	134	143	9	7%	2.36	2.91	0.55	23%	0			1	1							
38305	Drainage of lymph node absc	090	186	202	16	9%	6.68	7.67	0.99	15%	0			1	2						0.5	
38308	Lymphangiotomy or other op	090	178	187	9	5%	6.81	7.47	0.66	10%	0			1	1						0.5	
38380	Suture and/or ligation of thor	090	350	370.5	20.5	6%	8.46	10.16	1.70	20%	0			4				2.5			1	
38381	Suture and/or ligation of thor	090	348	369.5	21.5	6%	13.38	14.88	1.50	11%	0			2				3.5			1	
38382	Suture and/or ligation of thor	090	335	359	24	7%	10.65	12.58	1.93	18%	0			4.5				3			1	
38500	Biopsy or excision of lymph n	010	115	117	2	2%	3.79	4.12	0.33	9%	0			1							0.5	
38510	Biopsy or excision of lymph n	010	152	159	7	5%	6.74	7.18	0.44	7%	0				1						0.5	
38520	Biopsy or excision of lymph n	090	193	202	9	5%	7.03	7.69	0.66	9%	0			1	1						0.5	
38525	Biopsy or excision of lymph n	090	178	187	9	5%	6.43	7.09	0.66	10%	0			1	1						0.5	
38530	Biopsy or excision of lymph n	090	205.5	214.5	9	4%	8.34	9.00	0.66	8%	0			1	1						0.5	
38531	Biopsy or excision of lymph n	090	223	237	14	6%	6.74	7.51	0.77	11%	0				2						0.5	
38542	Dissection, deep jugular node	090	198	212	14	7%	7.95	8.72	0.77	10%	0				2						0.5	
38550	Excision of cystic hygroma, ax	090	211	219	8	4%	7.11	8.10	0.99	14%	0			4							0.5	
38555	Excision of cystic hygroma, ax	090	536	564.5	28.5	5%	15.59	17.86	2.27	15%	0			5.5				3.5			1	
38562	Limited lymphadenectomy fo	090	326	350	24	7%	11.06	12.99	1.93	17%	0			4.5				3			1	
38564	Limited lymphadenectomy fo	090	349	372.5	23.5	7%	11.38	13.10	1.72	15%	0			3				3.5			1	
38570	Laparoscopy, surgical; with re	010	220	229	9	4%	8.49	9.26	0.77	9%	0			1	1						1	
38571	Laparoscopy, surgical; with bi	010	250	259	9	4%	12.00	12.77	0.77	6%	0			1	1						1	
38572	Laparoscopy, surgical; with bi	010	321	337	16	5%	15.60	16.57	0.97	6%	-2				1	1					1	
38573	Laparoscopy, surgical; with bi	010	360	376	16	4%	20.00	20.86	0.86	4%	-2				1	1					0.5	
38700	Suprahyoid lymphadenectom	090	300	321	21	7%	12.81	14.15	1.34	10%	0			1	2			1			1	
38720	Cervical lymphadenectomy (c	090	482	518	36	7%	21.95	24.26	2.31	11%	-2				3	1		2	1		1	
38724	Cervical lymphadenectomy (r	090	512	548	36	7%	23.95	26.26	2.31	10%	-2				3	1		2	1		1	
38740	Axillary lymphadenectomy; su	090	231	247	16	7%	10.70	11.69	0.99	9%	0			1	2						0.5	
38745	Axillary lymphadenectomy; co	090	270.5	288.5	18	7%	13.87	14.95	1.08	8%	-2			1	1	1					0.5	
38760	Inguinofemoral lymphadenec	090	241	257	16	7%	13.62	14.61	0.99	7%	0			1	2						0.5	
38765	Inguinofemoral lymphadenec	090	465	475	10	2%	21.91	24.05	2.14	10%	0			1	2			1	2	1	1	
38770	Pelvic lymphadenectomy, incl	090	403	438	35	9%	14.06	16.27	2.21	16%	0			2.5				6			1	
38780	Retroperitoneal transabdomi	090	551	597.5	46.5	8%	17.70	20.71	3.01	17%	0			4.5				7.5			1	
38794	Cannulation, thoracic duct	090	207	214	7	3%	4.62	5.61	0.99	21%	0			3.5							1	
39000	Mediastinotomy with explora	090	381.5	412	30.5	8%	7.57	9.25	1.68	22%	0				1.5			4			1	
39010	Mediastinotomy with explora	090	423.5	451.5	28	7%	13.19	14.75	1.56	12%	0				1.5			3.5			1	
39200	Resection of mediastinal cyst	090	459	493.5	34.5	8%	15.09	16.96	1.87	12%	0				1			5.5			1	
39220	Resection of mediastinal tum	090	436	442	6	1%	19.55	20.96	1.41	7%	0			1	1			1	2		1	
39401	Mediastinoscopy; includes bio	000	142	142	0	0%	5.44	5.55	0.11	2%	0										0.5	
39402	Mediastinoscopy; with lymph	000	157	157	0	0%	7.25	7.36	0.11	2%	0										0.5	
39501	Repair, laceration of diaphrag	090	378	411.5	33.5	9%	13.98	16.18	2.20	16%	0			3				5.5			1	
39503	Repair, neonatal diaphragmat	090	2138	2139	1	0%	108.91	113.68	4.77	4%	-2			2	2	1			5	5		1
39540	Repair, diaphragmatic hernia	090	490	521.5	31.5	6%	14.57	16.55	1.98	14%	0			2				5.5			1	
39541	Repair, diaphragmatic hernia	090	522	557	35	7%	15.75	17.96	2.21	14%	0			2.5				6			1	
39545	Imbrication of diaphragm for	090	466	499.5	33.5	7%	14.67	16.87	2.20	15%	0			3				5.5			1	
39560	Resection, diaphragm; with si	090	323	350	27	8%	13.06	15.12	2.06	16%	0			3				5	1			
39561	Resection, diaphragm; with co	090	505	549	44	9%	19.99	22.85	2.86	14%	-6					3		5	2			
40500	Vermilionectomy (lip shave),	090	206	214	8	4%	4.47	5.35	0.88	20%	0			4								
40510	Excision of lip; transverse wed	090	153	158	5	3%	4.82	5.37	0.55	11%	0			2.5								
40520	Excision of lip; V-excision with	090	151	156	5	3%	4.79	5.34	0.55	11%	0			2.5								
40525	Excision of lip; full thickness, i	090	270	277	7	3%	7.72	8.60	0.88	11%	0			3.5							0.5	
40527	Excision of lip; full thickness, i	090	316	324	8	3%	9.32	10.42	1.10	12%	0			4							1	
40530	Resection of lip, more than or	090	191	197	6	3%	5.54	6.31	0.77	14%	0			3							0.5	
40650	Repair lip, full thickness; verm	090	126	132	6	5%	3.78	4.44	0.66	17%	0			3								

40652	Repair lip, full thickness; up to	090	154	161	7	5%	4.43	5.20	0.77	17%	0			3.5								
40654	Repair lip, full thickness; over	090	183	190	7	4%	5.48	6.25	0.77	14%	0			3.5								
40700	Plastic repair of cleft lip/nasal	090	337	370	33	10%	14.17	15.95	1.78	13%	0				4			1			1	
40701	Plastic repair of cleft lip/nasal	090	380	413	33	9%	17.23	19.01	1.78	10%	0				4			1			1	
40702	Plastic repair of cleft lip/nasal	090	348.5	378	29.5	8%	14.27	15.89	1.62	11%	0				3.5			1			1	
40720	Plastic repair of cleft lip/nasal	090	357.5	384.5	27	8%	14.72	16.22	1.50	10%	0				3.5			0.5			1	
40761	Plastic repair of cleft lip/nasal	090	387	415.5	28.5	7%	15.84	17.41	1.57	10%	0				3			1.5			1	
40800	Drainage of abscess, cyst, her	010	63	65	2	3%	1.23	1.45	0.22	18%	-2		1	1								
40801	Drainage of abscess, cyst, her	010	87	91	4	5%	2.63	3.07	0.44	17%	0			2								
40804	Removal of embedded foreig	010	78	80	2	3%	1.30	1.52	0.22	17%	-2		1	1								
40805	Removal of embedded foreig	010	97	101	4	4%	2.79	3.23	0.44	16%	0			2								
40808	Biopsy, vestibule of mouth	010	46	48	2	4%	1.05	1.27	0.22	21%	0			1								
40810	Excision of lesion of mucosa a	010	56	58	2	4%	1.36	1.58	0.22	16%	0			1								
40812	Excision of lesion of mucosa a	010	68	70	2	3%	2.37	2.59	0.22	9%	-2		1	1								
40814	Excision of lesion of mucosa a	090	96	100	4	4%	3.52	3.96	0.44	13%	-2		1	2								
40816	Excision of lesion of mucosa a	090	114	118	4	4%	3.77	4.21	0.44	12%	-2		1	2								
40818	Excision of mucosa of vestibu	090	123	134	11	9%	2.83	3.60	0.77	27%	0			2	1							
40819	Excision of frenum, labial or b	090	77	81	4	5%	2.51	2.95	0.44	18%	0			2								
40820	Destruction of lesion or scar c	010	68	70	2	3%	1.34	1.56	0.22	16%	-2		1	1								
40830	Closure of laceration, vestibu	010	68	70	2	3%	1.82	2.04	0.22	12%	-2		1	1								
40831	Closure of laceration, vestibu	010	99	103	4	4%	2.57	3.01	0.44	17%	-2		1	2								
40840	Vestibuloplasty; anterior	090	272	283	11	4%	9.15	9.92	0.77	8%	-2		1	2	1							
40842	Vestibuloplasty; posterior, un	090	250	261	11	4%	9.15	9.92	0.77	8%	-2		1	2	1							
40843	Vestibuloplasty; posterior, bil	090	370	392	22	6%	12.79	13.81	1.02	8%	-3		1		1		1					
40844	Vestibuloplasty; entire arch	090	417	443	26	6%	16.80	18.26	1.46	9%	-3		1	2	1		1					
40845	Vestibuloplasty; complex (inc	090	397	423	26	7%	19.36	20.82	1.46	8%	-3		1	2	1		1					
41000	Intraoral incision and drainag	010	51	53	2	4%	1.35	1.57	0.22	16%	0			1								
41005	Intraoral incision and drainag	010	53	55	2	4%	1.31	1.53	0.22	17%	0			1								
41006	Intraoral incision and drainag	090	104	108	4	4%	3.34	3.89	0.55	16%	0			2							0.5	
41007	Intraoral incision and drainag	090	106	110	4	4%	3.20	3.75	0.55	17%	0			2							0.5	
41008	Intraoral incision and drainag	090	109	113	4	4%	3.46	4.01	0.55	16%	0			2							0.5	
41009	Intraoral incision and drainag	090	119	124	5	4%	3.71	4.37	0.66	18%	0			2.5							0.5	
41010	Incision of lingual frenum (fre	010	40	42	2	5%	1.11	1.33	0.22	20%	0			1								
41015	Extraoral incision and drainag	090	131	136	5	4%	4.08	4.74	0.66	16%	0			2.5							0.5	
41016	Extraoral incision and drainag	090	169	174	5	3%	4.19	4.96	0.77	18%	0			2.5							1	
41017	Extraoral incision and drainag	090	176	181	5	3%	4.19	4.96	0.77	18%	0			2.5							1	
41018	Extraoral incision and drainag	090	179	184	5	3%	5.22	5.99	0.77	15%	0			2.5							1	
41100	Biopsy of tongue; anterior tw	010	66	68	2	3%	1.42	1.64	0.22	15%	0			1								
41105	Biopsy of tongue; posterior o	010	51	53	2	4%	1.47	1.69	0.22	15%	0			1								
41108	Biopsy of floor of mouth	010	42	44	2	5%	1.10	1.32	0.22	20%	0			1								
41110	Excision of lesion of tongue w	010	56	58	2	4%	1.56	1.78	0.22	14%	0			1								
41112	Excision of lesion of tongue w	090	93	97	4	4%	2.83	3.27	0.44	16%	0			2								
41113	Excision of lesion of tongue w	090	104	108	4	4%	3.29	3.73	0.44	13%	0			2								
41114	Excision of lesion of tongue w	090	275	289.5	14.5	5%	8.82	10.17	1.35	15%	0			3.5				1.5			1	
41115	Excision of lingual frenum (fre	010	48	50	2	4%	1.79	2.01	0.22	12%	0			1								
41116	Excision, lesion of floor of mo	090	74	77	3	4%	2.52	2.85	0.33	13%	0			1.5								
41120	Glossectomy; less than one-h	090	278	308	30	11%	11.14	12.66	1.52	14%	-2				3	1					0.5	
41130	Glossectomy; hemiglossecton	090	407	452	45	11%	15.74	18.09	2.35	15%	-2				3	1		3			1	
41135	Glossectomy; partial, with un	090	696	734	38	5%	30.14	33.60	3.46	11%	-2			1	4	1		2	2	1	1	
41140	Glossectomy; complete or tot	090	728	769	41	6%	29.15	33.14	3.99	14%	-4			1	3	2		3	3	1	1	
41145	Glossectomy; complete or tot	090	913	964	51	6%	37.93	42.40	4.47	12%	-4			1	3	2		5	3	1	1	
41150	Glossectomy; composite proc	090	713	758	45	6%	29.86	33.65	3.79	13%	-4			1	3	2		3	2	1	1	
41153	Glossectomy; composite proc	090	826	865	39	5%	33.59	37.49	3.90	12%	-2			1	4	1		3	3	1	1	
41155	Glossectomy; composite proc	090	968	1011	43	4%	44.30	48.93	4.63	10%	-4			1	3	2		4	3	2	1	
41250	Repair of laceration 2.5 cm or	010	69	71	2	3%	1.96	2.18	0.22	11%	0			1								
41251	Repair of laceration 2.5 cm or	010	80	82	2	2%	2.32	2.54	0.22	9%	0			1								
41252	Repair of laceration of tongue	010	91	93	2	2%	3.02	3.24	0.22	7%	0			1								
41510	Suture of tongue to lip for mi	090	97	101	4	4%	3.51	3.95	0.44	13%	0			2								
41512	Tongue base suspension, per	090	209	220	11	5%	6.86	7.74	0.88	13%	0			2	1						0.5	
41520	Frenoplasty (surgical revision	090	90	94	4	4%	2.83	3.27	0.44	16%	0			2								
41800	Drainage of abscess, cyst, her	010	59	63	4	7%	1.27	1.71	0.44	35%	0			2								
41805	Removal of embedded foreig	010	55	59	4	7%	1.34	1.78	0.44	33%	0			2								
41806	Removal of embedded foreig	010	80	84	4	5%	2.79	3.23	0.44	16%	0			2								
41822	Excision of fibrous tuberositie	010	107	111	4	4%	2.41	2.85	0.44	18%	0			2								
41823	Excision of osseous tuberositi	090	138	151	13	9%	3.77	4.76	0.99	26%	0			3	1							
41825	Excision of lesion or tumor (e	010	57	61	4	7%	1.41	1.85	0.44	31%	0			2								

41826	Excision of lesion or tumor (e	010	73	77	4	5%	2.41	2.85	0.44	18%	0			2									
41827	Excision of lesion or tumor (e	090	141	152	11	8%	3.83	4.60	0.77	20%	0			2	1								
41828	Excision of hyperplastic alveo	010	129	131	2	2%	3.14	3.36	0.22	7%	0			1									
41830	Alveolectomy, including curet	010	154	158	4	3%	3.45	3.89	0.44	13%	-2		1	2									
41872	Gingivoplasty, each quadrant	090	122	133	11	9%	3.01	3.78	0.77	26%	0			2	1								
41874	Alveoloplasty, each quadrant	090	152	156	4	3%	3.19	3.63	0.44	14%	0			2									
42000	Drainage of abscess of palate	010	49	51	2	4%	1.28	1.50	0.22	17%	0			1									
42100	Biopsy of palate, uvula	010	42	44	2	5%	1.36	1.58	0.22	16%	0			1									
42104	Excision, lesion of palate, uvu	010	52	54	2	4%	1.69	1.91	0.22	13%	0			1									
42106	Excision, lesion of palate, uvu	010	68	70	2	3%	2.15	2.37	0.22	10%	0			1									
42107	Excision, lesion of palate, uvu	090	160	165	5	3%	4.56	5.22	0.66	14%	0			2.5								0.5	
42120	Resection of palate or extens	090	306	329	23	8%	11.86	13.42	1.56	13%	0			2	2			1				1	
42140	Uvulectomy, excision of uvula	090	84	87	3	4%	1.70	2.03	0.33	19%	0			1.5									
42145	Palatopharyngoplasty (eg, uv	090	262	283	21	8%	9.78	10.99	1.21	12%	0				3							1	
42160	Destruction of lesion, palate (	010	54	56	2	4%	1.85	2.07	0.22	12%	0			1									
42180	Repair, laceration of palate; u	010	65	67	2	3%	2.55	2.77	0.22	9%	0			1									
42182	Repair, laceration of palate; c	010	90	92	2	2%	3.87	4.09	0.22	6%	0			1									
42200	Palatoplasty for cleft palate, s	090	330	346	16	5%	12.53	13.76	1.23	10%	-2		1	2	1			1				1	
42205	Palatoplasty for cleft palate, v	090	288	304	16	6%	13.66	15.02	1.36	10%	0			3				2				1	
42210	Palatoplasty for cleft palate, v	090	390	406	16	4%	15.03	16.26	1.23	8%	-2		1	2	1			1				1	
42215	Palatoplasty for cleft palate; r	090	265	272	7	3%	8.99	9.98	0.99	11%	0			3.5								1	
42220	Palatoplasty for cleft palate; s	090	260	266	6	2%	7.16	8.04	0.88	12%	0			3								1	
42225	Palatoplasty for cleft palate; a	090	287	296.5	9.5	3%	9.77	10.88	1.11	11%	0			3.5				0.5				1	
42226	Lengthening of palate, and ph	090	316	330.5	14.5	5%	10.35	11.70	1.35	13%	0			3.5				1.5				1	
42227	Lengthening of palate, with is	090	291	307	16	5%	9.90	11.26	1.36	14%	0			3				2				1	
42235	Repair of anterior palate, incl	090	248	254	6	2%	8.01	8.89	0.88	11%	0			3								1	
42260	Repair of nasolabial fistula	090	280	291	11	4%	10.22	11.21	0.99	10%	-2		1	2	1							1	
42280	Maxillary impression for palat	010	53	55	2	4%	1.59	1.81	0.22	14%	0			1									
42281	Insertion of pin-retained pala	010	83	85	2	2%	1.98	2.31	0.33	17%	0			1								0.5	
42300	Drainage of abscess; parotid,	010	66	68	2	3%	1.98	2.20	0.22	11%	0			1									
42305	Drainage of abscess; parotid,	090	203	213	10	5%	6.31	7.32	1.01	16%	0			2.5				1				1	
42310	Drainage of abscess; submaxi	010	57	59	2	4%	1.61	1.83	0.22	14%	0			1									
42320	Drainage of abscess; submaxi	010	77	79	2	3%	2.40	2.62	0.22	9%	0			1									
42330	Sialolithotomy; submandibula	010	63	65	2	3%	2.26	2.48	0.22	10%	0			1									
42335	Sialolithotomy; submandibula	090	98	102	4	4%	3.41	3.85	0.44	13%	0			2									
42340	Sialolithotomy; parotid, extra	090	136	141	5	4%	4.72	5.27	0.55	12%	0			2.5									
42405	Biopsy of salivary gland; incis	010	95	97	2	2%	3.34	3.56	0.22	7%	0			1									
42408	Excision of sublingual salivary	090	134	139	5	4%	4.66	5.21	0.55	12%	0			2.5									
42409	Marsupialization of sublingua	090	87	91	4	5%	2.91	3.35	0.44	15%	0			2									
42410	Excision of parotid tumor or p	090	285	294.5	9.5	3%	9.57	10.68	1.11	12%	0			3.5				0.5				1	
42415	Excision of parotid tumor or p	090	333	349	16	5%	17.16	18.15	0.99	6%	0			1	2							0.5	
42420	Excision of parotid tumor or p	090	383	399	16	4%	19.53	20.52	0.99	5%	0			1	2							0.5	
42425	Excision of parotid tumor or p	090	348	365	17	5%	13.42	14.89	1.47	11%	0			3.5				2				1	
42426	Excision of parotid tumor or p	090	654	692	38	6%	22.66	25.20	2.54	11%	0			4				6				1	
42440	Excision of submandibular (su	090	198	207	9	5%	6.14	6.80	0.66	11%	0			1	1							0.5	
42450	Excision of sublingual gland	090	155	160	5	3%	4.74	5.40	0.66	14%	0			2.5								0.5	
42500	Plastic repair of salivary duct,	090	148	153	5	3%	4.42	5.08	0.66	15%	0			2.5								0.5	
42505	Plastic repair of salivary duct,	090	207	213	6	3%	6.32	7.09	0.77	12%	0			3								0.5	
42507	Parotid duct diversion, bilater	090	191	197	6	3%	6.25	6.91	0.66	11%	0			3									
42509	Parotid duct diversion, bilater	090	349	358.5	9.5	3%	11.76	12.87	1.11	9%	0			3.5				0.5				1	
42510	Parotid duct diversion, bilater	090	270	278.5	8.5	3%	8.35	9.35	1.00	12%	0			3				0.5				1	
42600	Closure salivary fistula	090	163	168	5	3%	4.94	5.60	0.66	13%	0			2.5								0.5	
42665	Ligation salivary duct, intraor	090	92	96	4	4%	2.63	3.07	0.44	17%	0			2									
42700	Incision and drainage abscess	010	53	55	2	4%	1.67	1.89	0.22	13%	0			1									
42720	Incision and drainage abscess	010	278	280	2	1%	6.31	7.41	1.10	17%	0							2	2			1	
42725	Incision and drainage abscess	090	390	413	23	6%	12.41	14.63	2.22	18%	0			1	2			3	2			1	
42800	Biopsy; oropharynx	010	45	47	2	4%	1.44	1.66	0.22	15%	0			1									
42804	Biopsy; nasopharynx, visible l	010	49	51	2	4%	1.29	1.51	0.22	17%	0			1									
42806	Biopsy; nasopharynx, survey t	010	74	76	2	3%	1.63	1.85	0.22	13%	0			1									
42808	Excision or destruction of lesi	010	87	89	2	2%	2.35	2.57	0.22	9%	0			1									
42809	Removal of foreign body fron	010	72	74	2	3%	1.86	2.08	0.22	12%	0			1									
42810	Excision branchial cleft cyst o	090	126	131	5	4%	3.38	3.93	0.55	16%	0			2.5									
42815	Excision branchial cleft cyst, v	090	240	250	10	4%	7.31	8.32	1.01	14%	0			2.5				1				1	
42820	Tonsillectomy and adenoidec	090	151	158	7	5%	4.22	4.77	0.55	13%	0				1							1	
42821	Tonsillectomy and adenoidec	090	141	144	3	2%	4.36	4.80	0.44	10%	0			1.5								0.5	
42825	Tonsillectomy, primary or sec	090	130	134	4	3%	3.51	4.06	0.55	16%	0			2								0.5	

42826	Tonsillectomy, primary or sec	090	124	127	3	2%	3.45	3.89	0.44	13%	0			1.5							0.5	
42830	Adenoidectomy, primary; you	090	103	106	3	3%	2.65	2.98	0.33	12%	0			1.5								
42831	Adenoidectomy, primary; age	090	93	97	4	4%	2.81	3.25	0.44	16%	0			2								
42835	Adenoidectomy, secondary; y	090	81	84	3	4%	2.38	2.71	0.33	14%	0			1.5								
42836	Adenoidectomy, secondary; a	090	84	87	3	4%	3.26	3.59	0.33	10%	0			1.5								
42842	Radical resection of tonsil, to	090	330	360	30	9%	12.23	13.99	1.76	14%	-2			1	2	1		1			1	
42844	Radical resection of tonsil, to	090	445	476	31	7%	17.78	19.98	2.20	12%	-2			1	2	1		2	1		1	
42845	Radical resection of tonsil, to	090	825	852	27	3%	32.56	36.44	3.88	12%	-2			1	2	1		4	3	2	1	
42860	Excision of tonsil tags	090	76	79	3	4%	2.30	2.63	0.33	14%	0			1.5								
42870	Excision or destruction lingua	090	167	172	5	3%	5.52	6.18	0.66	12%	0			2.5							0.5	
42890	Limited pharyngectomy	090	510	542	32	6%	19.13	21.77	2.64	14%	-2			1	2	1		3	2		1	
42892	Resection of lateral pharynge	090	643	679	36	6%	26.03	29.40	3.37	13%	-2			1	3	1		3	2	1	1	
42894	Resection of pharyngeal wall	090	836	871	35	4%	33.92	38.02	4.10	12%	-2			1	4	1		3	4	1	1	
42900	Suture pharynx for wound or	010	163	165	2	1%	5.29	5.73	0.44	8%	0			1							1	
42950	Pharyngoplasty (plastic or rec	090	293	300	7	2%	8.27	9.26	0.99	12%	0			3.5							1	
42953	Pharyngoesophageal repair	090	409	429.5	20.5	5%	9.45	11.15	1.70	18%	0			4				2.5			1	
42955	Pharyngostomy (fistulization	090	282	308	26	9%	8.01	9.85	1.84	23%	0			3				4			1	
42960	Control oropharyngeal hemor	010	70	72	2	3%	2.38	2.60	0.22	9%	0			1								
42961	Control oropharyngeal hemor	090	193	200.5	7.5	4%	5.77	6.66	0.89	15%	0			2.5				0.5			1	
42962	Control oropharyngeal hemor	090	234	245	11	5%	7.40	8.52	1.12	15%	0			3				1			1	
42970	Control of nasopharyngeal he	090	193	209.5	16.5	9%	5.82	7.08	1.26	22%	0			2				2.5			1	
42971	Control of nasopharyngeal he	090	227	243.5	16.5	7%	6.60	7.86	1.26	19%	0			2				2.5			1	
42972	Control of nasopharyngeal he	090	243	259.5	16.5	7%	7.59	8.85	1.26	17%	0			2				2.5			1	
43020	Esophagotomy, cervical appro	090	221	227	6	3%	8.23	9.11	0.88	11%	0			3							1	
43030	Cricopharyngeal myotomy	090	244	256.5	12.5	5%	7.99	9.12	1.13	14%	0			2.5				1.5			1	
43045	Esophagotomy, thoracic appr	090	536.5	588.5	52	10%	21.88	24.58	2.70	12%	0				3.5			5.5			1	
43100	Excision of lesion, esophagus,	090	334	353.5	19.5	6%	9.66	11.25	1.59	16%	0			3.5				2.5			1	
43101	Excision of lesion, esophagus,	090	459	494	35	8%	17.07	19.28	2.21	13%	0			2.5				6			1	
43107	Total or near total esophagec	090	977	1003	26	3%	52.05	55.48	3.43	7%	-2			1	2	1		2	3	2		1
43108	Total or near total esophagec	090	1358	1358	0	0%	82.87	87.86	4.99	6%	-2			1	2	1		1	6	5		1
43112	Total or near total esophagec	090	1097	1128	31	3%	62.00	65.67	3.67	6%	-2			1	2	1		3	3	2		1
43113	Total or near total esophagec	090	1358	1358	0	0%	80.06	85.05	4.99	6%	-2			1	2	1		1	6	5		1
43116	Partial esophagectomy, cervic	090	1403	1406	3	0%	92.99	97.58	4.59	5%	-2			1	2	1		1	6	4		1
43117	Partial esophagectomy, distal	090	1067	1098	31	3%	57.50	61.17	3.67	6%	-2			1	2	1		3	3	2		1
43118	Partial esophagectomy, distal	090	1184	1188	4	0%	67.07	71.86	4.79	7%	-2			1	2	1		1	5	5		1
43121	Partial esophagectomy, distal	090	962	977	15	2%	51.43	55.42	3.99	8%	-2			1	2	1		1	3	4		1
43122	Partial esophagectomy, thora	090	1015	1054	39	4%	44.18	47.69	3.51	8%	-2			1	2	1		4	3	1		1
43123	Partial esophagectomy, thora	090	1419	1411	-8	-1%	83.12	88.51	5.39	6%	-2			1	2	1		1	8	5		1
43124	Total or partial esophagecton	090	1398	1398	0	0%	69.09	75.01	5.92	9%	-2			1	3	1		1	7	6		1
43130	Diverticulectomy of hypophar	090	362	395	33	9%	12.53	14.83	2.30	18%	0			4				5			1	
43135	Diverticulectomy of hypophar	090	571	570	-1	0%	26.17	28.18	2.01	8%	0			1	1			1	3	1	1	
43180	Esophagoscopy, rigid, transor	090	201	208	7	3%	9.03	9.58	0.55	6%	0				1						1	
43279	Laparoscopy, surgical, esopha	090	404	419	15	4%	22.10	23.42	1.32	6%	0				2			1	1		1	
43280	Laparoscopy, surgical, esopha	090	404	428	24	6%	18.10	19.46	1.36	8%	0				2			2			1	
43281	Laparoscopy, surgical, repair	090	424	439	15	4%	26.60	27.92	1.32	5%	0				2			1	1		1	
43282	Laparoscopy, surgical, repair	090	454	469	15	3%	30.10	31.42	1.32	4%	0				2			1	1		1	
43284	Laparoscopy, surgical, esopha	090	218	232	14	6%	10.13	10.90	0.77	8%	0				2						0.5	
43285	Removal of esophageal sphin	090	233	247	14	6%	10.47	11.24	0.77	7%	0				2						0.5	
43286	Esophagectomy, total or near	090	957	983	26	3%	55.00	58.43	3.43	6%	-2			1	2	1		2	3	2		1
43287	Esophagectomy, distal two-th	090	1097	1123	26	2%	63.00	66.43	3.43	5%	-2			1	2	1		2	3	2		1
43288	Esophagectomy, total or near	090	1157	1183	26	2%	66.42	69.85	3.43	5%	-2			1	2	1		2	3	2		1
43300	Esophagoplasty (plastic repai	090	312	320	8	3%	9.33	10.43	1.10	12%	0			4							1	
43305	Esophagoplasty (plastic repai	090	403	433.5	30.5	8%	18.10	20.28	2.18	12%	0			4				4.5			1	
43310	Esophagoplasty (plastic repai	090	528	565.5	37.5	7%	26.26	28.59	2.33	9%	0			2.5				6.5			1	
43312	Esophagoplasty (plastic repai	090	563	599	36	6%	29.25	31.26	2.01	7%	0			0.5				7			1	
43313	Esophagoplasty for congenita	090	713	758	45	6%	48.45	51.72	3.27	7%	-2				4	1		2	2	1		1
43314	Esophagoplasty for congenita	090	713	758	45	6%	53.43	56.70	3.27	6%	-2				4	1		2	2	1		1
43320	Esophagogastrostomy (cardio	090	740	748	8	1%	23.31	26.29	2.98	13%	0			1	2			2	3	2	1	
43325	Esophagogastric fundoplasty,	090	600	612	12	2%	22.60	25.38	2.78	12%	0			1	2			2	2	2	1	
43327	Esophagogastric fundoplasty	090	412	424	12	3%	13.35	15.07	1.72	13%	0				2			1	1	1	1	
43328	Esophagogastric fundoplasty	090	514	523	9	2%	19.91	22.03	2.12	11%	0				2			1	1	2	1	
43330	Esophagomyotomy (Heller ty	090	550	557	7	1%	22.19	24.73	2.54	11%	0			1	2			1	2	2	1	
43331	Esophagomyotomy (Heller ty	090	620	627	7	1%	23.06	25.60	2.54	11%	0			1	2			1	2	2	1	
43332	Repair, paraesophageal hiata	090	482	490	8	2%	19.62	21.54	1.92	10%	0				2			1	2	1	1	
43333	Repair, paraesophageal hiata	090	512	520	8	2%	21.46	23.38	1.92	9%	0				2			1	2	1	1	
43334	Repair, paraesophageal hiata	090	549	562	13	2%	22.12	24.28	2.16	10%	0				2			2	2	1	1	

43335	Repair, paraesophageal hiata	090	569	582	13	2%	23.97	26.13	2.16	9%	0				2			2	2	1	1	
43336	Repair, paraesophageal hiata	090	695	710	15	2%	25.81	28.19	2.38	9%	0			1	2			2	2	1	1	
43337	Repair, paraesophageal hiata	090	715	730	15	2%	27.65	30.03	2.38	9%	0			1	2			2	2	1	1	
43340	Esophagojejunostomy (witho	090	770	778	8	1%	22.99	25.97	2.98	13%	0			1	2			2	3	2	1	
43341	Esophagojejunostomy (witho	090	770	778	8	1%	24.23	27.21	2.98	12%	0			1	2			2	3	2	1	
43351	Esophagostomy, fistulization	090	778	793	15	2%	22.05	25.36	3.31	15%	0			1	3			2	3	2	1	
43352	Esophagostomy, fistulization	090	570	582	12	2%	17.81	20.59	2.78	16%	0			1	2			2	2	2	1	
43360	Gastrointestinal reconstructio	090	830	852	22	3%	40.11	43.75	3.64	9%	-2			1	2	1		3	3	2	1	
43361	Gastrointestinal reconstructio	090	1108	1120	12	1%	45.68	49.39	3.71	8%	0			1	3			2	3	3	1	
43400	Ligation, direct, esophageal v	090	835	843	8	1%	25.60	28.58	2.98	12%	0			1	2			2	3	2	1	
43405	Ligation or stapling at gastroe	090	873	888	15	2%	24.73	28.04	3.31	13%	0			1	3			2	3	2	1	
43410	Suture of esophageal wound	090	590	597	7	1%	16.41	18.95	2.54	15%	0			1	2			1	2	2	1	
43415	Suture of esophageal wound	090	842	863	21	2%	44.88	47.53	2.65	6%	-4			1	1	2		1	2	1	1	
43420	Closure of esophagostomy or	090	520	527	7	1%	16.78	19.32	2.54	15%	0			1	2			1	2	2	1	
43425	Closure of esophagostomy or	090	845	858	13	2%	25.04	28.26	3.22	13%	0			1	2			3	3	2	1	
43496	Free jejunum transfer with m	090	902	979	77	9%	0.00	N/A	N/A	N/A	0			2	4			9			1	
43497	Lower esophageal myotomy,	090	281	295	14	5%	13.29	14.06	0.77	6%	0				2						0.5	
43500	Gastrotomy; with exploration	090	402	410	8	2%	12.79	14.84	2.05	16%	0			1	1			2	2	1	1	
43501	Gastrotomy; with suture repa	090	555	570	15	3%	22.60	24.98	2.38	11%	0			1	2			2	2	1	1	
43502	Gastrotomy; with suture repa	090	555	570	15	3%	25.69	28.07	2.38	9%	0			1	2			2	2	1	1	
43510	Gastrotomy; with esophageal	090	485	500	15	3%	15.14	17.52	2.38	16%	0			1	2			2	2	1	1	
43520	Pyloromyotomy, cutting of py	090	342	349	7	2%	11.29	12.90	1.61	14%	0			1	1			1	1	1	1	
43605	Biopsy of stomach, by laparot	090	402	410	8	2%	13.72	15.77	2.05	15%	0			1	1			2	2	1	1	
43610	Excision, local; ulcer or benign	090	432	440	8	2%	16.34	18.39	2.05	13%	0			1	1			2	2	1	1	
43611	Excision, local; malignant tum	090	520	532	12	2%	20.38	23.16	2.78	14%	0			1	2			2	2	2	1	
43620	Gastrectomy, total; with esop	090	695	711	16	2%	34.04	36.86	2.82	8%	0			1	2			3	3	1	1	
43621	Gastrectomy, total; with Roux	090	790	803	13	2%	39.53	42.75	3.22	8%	0			1	2			3	3	2	1	
43622	Gastrectomy, total; with form	090	790	803	13	2%	40.03	43.25	3.22	8%	0			1	2			3	3	2	1	
43631	Gastrectomy, partial, distal; w	090	535	568	33	6%	24.51	27.21	2.70	11%	0			1	2			5	2		1	
43632	Gastrectomy, partial, distal; w	090	725	743	18	2%	35.14	38.60	3.46	10%	0			1	2			4	3	2	1	
43633	Gastrectomy, partial, distal; w	090	740	758	18	2%	33.14	36.60	3.46	10%	0			1	2			4	3	2	1	
43634	Gastrectomy, partial, distal; w	090	740	758	18	2%	36.64	40.10	3.46	9%	0			1	2			4	3	2	1	
43640	Vagotomy including pyloropla	090	540	552	12	2%	19.56	22.34	2.78	14%	0			1	2			2	2	2	1	
43641	Vagotomy including pyloropla	090	570	582	12	2%	19.81	22.59	2.78	14%	0			1	2			2	2	2	1	
43644	Laparoscopy, surgical, gastric	090	502	517	15	3%	29.40	31.23	1.83	6%	-2			1	1	1		1	2		1	
43645	Laparoscopy, surgical, gastric	090	537	552	15	3%	31.53	33.36	1.83	6%	-2			1	1	1		1	2		1	
43653	Laparoscopy, surgical; gastros	090	264	283	19	7%	8.48	9.60	1.12	13%	0				2			1			1	
43770	Laparoscopy, surgical, gastric	090	367	384	17	5%	18.00	19.41	1.41	8%	0				3				1		1	
43771	Laparoscopy, surgical, gastric	090	377	394	17	5%	20.79	22.20	1.41	7%	0				3				1		1	
43772	Laparoscopy, surgical, gastric	090	317	322	5	2%	15.70	16.67	0.97	6%	0			1	1				1		1	
43773	Laparoscopy, surgical, gastric	090	377	394	17	5%	20.79	22.20	1.41	7%	0				3				1		1	
43774	Laparoscopy, surgical, gastric	090	304	323	19	6%	15.76	16.88	1.12	7%	0				2			1			1	
43775	Laparoscopy, surgical, gastric	090	412	431	19	5%	20.38	22.01	1.63	8%	-2			1	1	1		1	1		1	
43800	Pyloroplasty	090	432	440	8	2%	15.43	17.48	2.05	13%	0			1	1			2	2	1	1	
43810	Gastroduodenostomy	090	502	507	5	1%	16.88	19.33	2.45	15%	0			1	1			2	2	2	1	
43820	Gastrojejunostomy; without v	090	545	561	16	3%	22.53	25.35	2.82	13%	0			1	2			3	3	1	1	
43825	Gastrojejunostomy; with vago	090	540	552	12	2%	21.76	24.54	2.78	13%	0			1	2			2	2	2	1	
43830	Gastrostomy, open; without c	090	319	344	25	8%	10.85	12.65	1.80	17%	0				2			3	1		1	
43831	Gastrostomy, open; neonatal	090	293	320	27	9%	8.49	10.44	1.95	23%	0			3.5				4			1	
43832	Gastrostomy, open; with cons	090	417	425	8	2%	17.34	19.39	2.05	12%	0			1	1			2	2	1	1	
43840	Gastrorrhaphy, suture of perf	090	565	590	25	4%	22.83	25.69	2.86	13%	0			1	2			4	2	1	1	
43842	Gastric restrictive procedure,	090	585	600	15	3%	21.03	23.41	2.38	11%	0			1	2			2	2	1	1	
43843	Gastric restrictive procedure,	090	585	600	15	3%	21.21	23.59	2.38	11%	0			1	2			2	2	1	1	
43845	Gastric restrictive procedure	090	628	648	20	3%	33.30	35.37	2.07	6%	0			1	3			1	2		1	
43846	Gastric restrictive procedure,	090	693	712	19	3%	27.41	30.52	3.11	11%	0			1	3			2	2	2	1	
43847	Gastric restrictive procedure,	090	733	752	19	3%	30.28	33.39	3.11	10%	0			1	3			2	2	2	1	
43848	Revision, open, of gastric rest	090	708	727	19	3%	32.75	35.86	3.11	9%	0			1	3			2	2	2	1	
43860	Revision of gastrojejunal anas	090	675	702	27	4%	27.89	31.39	3.50	13%	0			1	2			5	2	2	1	
43865	Revision of gastrojejunal anas	090	615	627	12	2%	29.05	31.83	2.78	10%	0			1	2			2	2	2	1	
43870	Closure of gastrostomy, surgi	090	402	410	8	2%	11.44	13.49	2.05	18%	0			1	1			2	2	1	1	
43880	Closure of gastrocolic fistula	090	540	552	12	2%	27.18	29.96	2.78	10%	0			1	2			2	2	2	1	
43886	Gastric restrictive procedure,	090	155	169	14	9%	4.64	5.41	0.77	17%	0				2						0.5	
43887	Gastric restrictive procedure,	090	148	157	9	6%	4.32	4.98	0.66	15%	0			1	1						0.5	
43888	Gastric restrictive procedure,	090	180	194	14	8%	6.44	7.21	0.77	12%	0				2						0.5	
44005	Enterolysis (freeing of intestir	090	517	522	5	1%	18.46	20.91	2.45	13%	0			1	1			2	2	2	1	
44010	Duodenotomy, for exploratio	090	432	440	8	2%	14.26	16.31	2.05	14%	0			1	1			2	2	1	1	

44020	Enterotomy, small intestine, c	090	487	492	5	1%	16.22	18.67	2.45	15%	0			1	1			2	2	2	1	
44021	Enterotomy, small intestine, c	090	487	492	5	1%	16.31	18.76	2.45	15%	0			1	1			2	2	2	1	
44025	Colotomy, for exploration, bi	090	487	492	5	1%	16.51	18.96	2.45	15%	0			1	1			2	2	2	1	
44050	Reduction of volvulus, intussu	090	409.5	430.5	21	5%	15.52	17.65	2.13	14%	0			1	1			4	2		1	
44055	Correction of malrotation by	090	663	659	-4	-1%	25.63	28.15	2.52	10%	0				2			1	5	1	1	
44110	Excision of 1 or more lesions	090	487	492	5	1%	14.04	16.49	2.45	17%	0			1	1			2	2	2	1	
44111	Excision of 1 or more lesions	090	517	522	5	1%	16.52	18.97	2.45	15%	0			1	1			2	2	2	1	
44120	Enterectomy, resection of sm	090	611	622	11	2%	20.82	23.95	3.13	15%	0			1	1			4	3	2	1	
44125	Enterectomy, resection of sm	090	524	534	10	2%	20.03	22.59	2.56	13%	0				2			2	2	2	1	
44126	Enterectomy, resection of sm	090	1125	1167	42	4%	42.23	48.55	6.32	15%	-2			1	2	1		10	6	3	1	
44127	Enterectomy, resection of sm	090	1357	1416	59	4%	49.30	56.97	7.67	16%	-2			1	2	1		13	7	4		1
44130	Enteroenterostomy, anastom	090	516	550	34	7%	22.11	25.01	2.90	13%	0			1	2			5	1	1	1	
44140	Colectomy, partial; with anas	090	480	517	37	8%	22.59	25.09	2.50	11%	0			1	2			5	1		1	
44141	Colectomy, partial; with skin	090	672	696	24	4%	29.91	33.26	3.35	11%	-2			1	1	1		4	2	2	1	
44143	Colectomy, partial; with end	090	607	626	19	3%	27.79	30.90	3.11	11%	-2			1	1	1		3	2	2	1	
44144	Colectomy, partial; with resec	090	677	701	24	4%	29.91	33.26	3.35	11%	-2			1	1	1		4	2	2	1	
44145	Colectomy, partial; with colo	090	615	635	20	3%	28.58	31.20	2.62	9%	0			1	2			3	2	1	1	
44146	Colectomy, partial; with colo	090	692	714	22	3%	35.30	38.01	2.71	8%	-2			1	1	1		3	2	1	1	
44147	Colectomy, partial; abdomina	090	710	727	17	2%	33.69	36.71	3.02	9%	0			1	2			3	2	2	1	
44150	Colectomy, total, abdominal,	090	638	658	20	3%	30.18	33.31	3.13	10%	-2			2	1	1		3	3	1	1	
44151	Colectomy, total, abdominal,	090	738	768	30	4%	34.92	38.53	3.61	10%	-2			2	1	1		5	3	1	1	
44155	Colectomy, total, abdominal,	090	738	768	30	4%	34.42	38.03	3.61	10%	-2			2	1	1		5	3	1	1	
44156	Colectomy, total, abdominal,	090	798	828	30	4%	37.42	41.03	3.61	10%	-2			2	1	1		5	3	1	1	
44157	Colectomy, total, abdominal,	090	705	743	38	5%	35.70	39.02	3.32	9%	-2			1	2	1		5	3		1	
44158	Colectomy, total, abdominal,	090	725	763	38	5%	36.70	40.02	3.32	9%	-2			1	2	1		5	3		1	
44160	Colectomy, partial, with remo	090	551	558	7	1%	20.89	23.56	2.67	13%	0			2	1			2	2	2	1	
44180	Laparoscopy, surgical, entero	090	407	436	29	7%	15.27	17.00	1.73	11%	0			1	1			4			1	
44186	Laparoscopy, surgical; jejunos	090	267	286	19	7%	10.38	11.63	1.25	12%	0			1	1			2			1	
44187	Laparoscopy, surgical; ileosto	090	385	398	13	3%	17.40	19.14	1.74	10%	0			1	2			1	2		1	
44188	Laparoscopy, surgical, colosto	090	407	425	18	4%	19.35	21.20	1.85	10%	0				3			1	2		1	
44202	Laparoscopy, surgical; entere	090	505	532	27	5%	23.39	25.41	2.02	9%	0			1	2			3	1		1	
44204	Laparoscopy, surgical; colecto	090	455	482	27	6%	26.42	28.44	2.02	8%	0			1	2			3	1		1	
44205	Laparoscopy, surgical; colecto	090	428.5	459.5	31	7%	22.95	25.03	2.08	9%	0			3				5			1	
44206	Laparoscopy, surgical; colecto	090	647	662	15	2%	29.79	32.86	3.07	10%	-2			1	1	1		2	1	3	1	
44207	Laparoscopy, surgical; colecto	090	560	570	10	2%	31.92	34.06	2.14	7%	0			1	2			1	2	1	1	
44208	Laparoscopy, surgical; colecto	090	595	614	19	3%	33.99	36.41	2.42	7%	0			1	2			3	3		1	
44210	Laparoscopy, surgical; colecto	090	630	662	32	5%	30.09	32.73	2.64	9%	-2			1	2	1		3	2		1	
44211	Laparoscopy, surgical; colecto	090	695	727	32	5%	37.08	39.72	2.64	7%	-2			1	2	1		3	2		1	
44212	Laparoscopy, surgical; colecto	090	660	692	32	5%	34.58	37.22	2.64	8%	-2			1	2	1		3	2		1	
44227	Laparoscopy, surgical, closure	090	530	541	11	2%	28.62	30.96	2.34	8%	0			1	2			1	1	2	1	
44300	Placement, enterostomy or c	090	389	410	21	5%	13.75	15.75	2.00	15%	0				2			3	2		1	
44310	Ileostomy or jejunostomy, no	090	391.5	412.5	21	5%	17.59	19.59	2.00	11%	0				2			3	2		1	
44312	Revision of ileostomy; simple	090	349	360	11	3%	9.43	10.95	1.52	16%	0				2			1	2		1	
44314	Revision of ileostomy; compli	090	465	488	23	5%	16.74	18.96	2.22	13%	0			1	2			3	2		1	
44316	Continent ileostomy (Kock pr	090	590	606	16	3%	23.59	26.41	2.82	12%	0			1	2			3	3	1	1	
44320	Colostomy or skin level cecos	090	507	529	22	4%	19.91	22.62	2.71	14%	-2			1	1	1		3	2	1	1	
44322	Colostomy or skin level cecos	090	483	539	56	12%	13.32	16.91	3.59	27%	0			5.5				9			1	
44340	Revision of colostomy; simple	090	382	397	15	4%	9.28	11.11	1.83	20%	-2			1	1	1		1	2		1	
44345	Revision of colostomy; compl	090	482	507	25	5%	17.22	19.53	2.31	13%	-2			1	1	1		3	2		1	
44346	Revision of colostomy; with r	090	572	586	14	2%	19.63	22.50	2.87	15%	-2			1	1	1		2	2	2	1	
44602	Suture of small intestine (ent	090	562	571	9	2%	24.72	27.21	2.49	10%	0			1	1			3	3	1	1	
44603	Suture of small intestine (ent	090	635	656	21	3%	28.16	31.22	3.06	11%	0			1	2			4	3	1	1	
44604	Suture of large intestine (colo	090	459	477	18	4%	18.16	20.56	2.40	13%	0				2			3	2	1	1	
44605	Suture of large intestine (colo	090	562	563	1	0%	22.08	24.73	2.65	12%	0			1	1			2	3	2	1	
44615	Intestinal stricturoplasty (ent	090	502	507	5	1%	18.16	20.61	2.45	13%	0			1	1			2	2	2	1	
44620	Closure of enterostomy, large	090	487	492	5	1%	14.43	16.88	2.45	17%	0			1	1			2	2	2	1	
44625	Closure of enterostomy, large	090	517	522	5	1%	17.28	19.73	2.45	14%	0			1	1			2	2	2	1	
44626	Closure of enterostomy, large	090	587	588	1	0%	27.90	30.55	2.65	9%	0			1	1			2	3	2	1	
44640	Closure of intestinal cutaneou	090	587	588	1	0%	24.20	26.85	2.65	11%	0			1	1			2	3	2	1	
44650	Closure of enteroenteric or e	090	587	588	1	0%	25.12	27.77	2.65	11%	0			1	1			2	3	2	1	
44660	Closure of enterovesical fistu	090	587	588	1	0%	23.91	26.56	2.65	11%	0			1	1			2	3	2	1	
44661	Closure of enterovesical fistu	090	617	618	1	0%	27.35	30.00	2.65	10%	0			1	1			2	3	2	1	
44680	Intestinal plication (separate	090	602	603	1	0%	17.96	20.61	2.65	15%	0			1	1			2	3	2	1	
44700	Exclusion of small intestine fr	090	402	418	16	4%	17.48	19.37	1.89	11%	0			1	1			3	2		1	
44800	Excision of Meckel's diverticu	090	366	400.5	34.5	9%	12.05	14.36	2.31	19%	0			3.5				5.5			1	
44820	Excision of lesion of mesente	090	404	425	21	5%	13.73	15.73	2.00	15%	0				2			3	2		1	

44850	Suture of mesentery (separat	090	367	383	16	4%	12.11	14.00	1.89	16%	0			1	1			3	2		1	
44900	Incision and drainage of appe	090	450	457	7	2%	12.57	15.11	2.54	20%	0			1	2			1	2	2	1	
44950	Appendectomy;	090	252	271	19	8%	10.60	11.85	1.25	12%	0			1	1			2			1	
44960	Appendectomy; for ruptured	090	458	460	2	0%	14.50	16.93	2.43	17%	0			2	1			1	2	2	1	
44970	Laparoscopy, surgical, appen	090	242	261	19	8%	9.45	10.57	1.12	12%	0				2			1			1	
45000	Transrectal drainage of pelvi	090	384	387	3	1%	6.30	7.98	1.68	27%	0				2				2	1	1	
45005	Incision and drainage of subn	010	54	55	1	2%	2.02	2.13	0.11	5%	0			0.5								
45020	Incision and drainage of deep	090	255	276	21	8%	8.56	9.90	1.34	16%	0			1	2			1			1	
45100	Biopsy of anorectal wall, anal	090	178	187	9	5%	4.04	4.70	0.66	16%	0			1	1						0.5	
45108	Anorectal myomectomy	090	193	202	9	5%	5.12	5.78	0.66	13%	0			1	1						0.5	
45110	Proctectomy; complete, comb	090	678	703	25	4%	30.76	34.13	3.37	11%	-2			2	1	1		4	3	1	1	
45111	Proctectomy; partial resectio	090	496	539	43	9%	18.01	20.79	2.78	15%	0			4				7			1	
45112	Proctectomy, combined abdo	090	675	692	17	3%	33.18	36.20	3.02	9%	0			1	2			3	2	2	1	
45113	Proctectomy, partial, with re	090	675	692	17	3%	33.22	36.24	3.02	9%	0			1	2			3	2	2	1	
45114	Proctectomy, partial, with an	090	792	802	10	1%	30.79	33.86	3.07	10%	-2			1	1	1		2	3	2	1	
45116	Proctectomy, partial, with an	090	702	716	14	2%	27.72	30.59	2.87	10%	-2			1	1	1		2	2	2	1	
45119	Proctectomy, combined abdo	090	685	702	17	2%	33.48	36.50	3.02	9%	0			1	2			3	2	2	1	
45120	Proctectomy, complete (for c	090	689	744	55	8%	26.40	29.88	3.48	13%	0			5				9			1	
45121	Proctectomy, complete (for c	090	741	806	65	9%	29.08	33.04	3.96	14%	0			5				11			1	
45123	Proctectomy, partial, without	090	687	704	17	2%	18.86	21.33	2.47	13%	-2			1	1	1		2	2	1	1	
45126	Pelvic exenteration for colore	090	755	776	21	3%	49.10	52.30	3.20	7%	-2			1	2	1		2	2	2	1	
45130	Excision of rectal procidentia,	090	520	535	15	3%	18.50	20.88	2.38	13%	0			1	2			2	2	1	1	
45135	Excision of rectal procidentia,	090	735	761	26	4%	22.36	25.80	3.44	15%	-2			1	2	1		3	2	2	1	
45136	Excision of ileoanal reservoir	090	783	795	12	2%	30.82	34.11	3.29	11%	-2			2	1	1		2	3	2	1	
45150	Division of stricture of rectum	090	184	191.5	7.5	4%	5.85	6.74	0.89	15%	0			2.5				0.5			1	
45160	Excision of rectal tumor by pr	090	342	370	28	8%	16.33	18.00	1.67	10%	-2			1	1	1		2			1	
45171	Excision of rectal tumor, trans	090	209	225	16	8%	8.13	9.12	0.99	12%	0			1	2						0.5	
45172	Excision of rectal tumor, trans	090	290	311	21	7%	12.13	13.47	1.34	11%	0			1	2			1			1	
45190	Destruction of rectal tumor (e	090	266	282	16	6%	10.42	11.41	0.99	10%	0			1	2						0.5	
45395	Laparoscopy, surgical; procte	090	645	669	24	4%	33.00	35.80	2.80	8%	-2			1	2	1		2	2	1	1	
45397	Laparoscopy, surgical; procte	090	675	699	24	4%	36.50	39.30	2.80	8%	-2			1	2	1		2	2	1	1	
45400	Laparoscopy, surgical; procto	090	410	437	27	7%	19.44	21.46	2.02	10%	0			1	2			3	1		1	
45402	Laparoscopy, surgical; procto	090	470	483	13	3%	26.51	28.25	1.74	7%	0			1	2			1	2		1	
45500	Proctoplasty; for stenosis	090	266	284.5	18.5	7%	7.73	9.21	1.48	19%	0			3				2.5			1	
45505	Proctoplasty; for prolapse of	090	300.5	318.5	18	6%	8.36	9.44	1.08	13%	-2			1	1	1					0.5	
45540	Proctopexy (eg, for prolapse)	090	481.5	493.5	12	2%	18.12	20.08	1.96	11%	0				2			2	3		1	
45541	Proctopexy (eg, for prolapse)	090	420	433	13	3%	14.85	16.59	1.74	12%	0			1	2			1	2		1	
45550	Proctopexy (eg, for prolapse)	090	540	568	28	5%	24.80	27.26	2.46	10%	0			1	2			4	2		1	
45560	Repair of rectocele (separate	090	367	382	15	4%	11.50	12.95	1.45	13%	0			1	1			2	1		1	
45562	Exploration, repair, and presa	090	561	575	14	2%	17.98	20.98	3.00	17%	0			2	2			2	2	2	1	
45563	Exploration, repair, and presa	090	636	646	10	2%	26.38	29.58	3.20	12%	0			2	2			2	3	2	1	
45800	Closure of rectovesical fistula	090	570	582	12	2%	20.31	23.09	2.78	14%	0			1	2			2	2	2	1	
45805	Closure of rectovesical fistula	090	595	607	12	2%	23.32	26.10	2.78	12%	0			1	2			2	2	2	1	
45820	Closure of rectourethral fistu	090	480	494	14	3%	20.37	22.55	2.18	11%	0			1	2			2	3		1	
45825	Closure of rectourethral fistu	090	646	656	10	2%	24.17	27.37	3.20	13%	0			2	2			2	3	2	1	
45900	Reduction of procidentia (sep	010	219	217	-2	-1%	2.99	3.63	0.64	21%	0			1					1		1	
45905	Dilation of anal sphincter (sep	010	130	132	2	2%	2.35	2.68	0.33	14%	0			1							0.5	
45910	Dilation of rectal stricture (se	010	130	132	2	2%	2.85	3.18	0.33	12%	0			1							0.5	
45915	Removal of fecal impaction o	010	145	147	2	1%	3.19	3.52	0.33	10%	0			1							0.5	
46040	Incision and drainage of ischi	090	184	195	11	6%	5.37	6.25	0.88	16%	0			2	1						0.5	
46045	Incision and drainage of intra	090	197	206	9	5%	5.87	6.64	0.77	13%	0			1	1						1	
46050	Incision and drainage, perian	010	59	61	2	3%	1.24	1.46	0.22	18%	0			1								
46060	Incision and drainage of ischi	090	201	217	16	8%	6.37	7.36	0.99	16%	0			1	2						0.5	
46070	Incision, anal septum (infant)	090	74	77	3	4%	2.79	3.12	0.33	12%	0			1.5								
46080	Sphincterotomy, anal, divisio	010	99	100	1	1%	2.52	2.74	0.22	9%	0			0.5							0.5	
46083	Incision of thrombosed hemo	010	51	53	2	4%	1.45	1.67	0.22	15%	0			1								
46200	Fissurectomy, including sphin	090	171	178	7	4%	3.59	4.47	0.88	25%	0			3.5							0.5	
46220	Excision of single external pa	010	67	69	2	3%	1.61	1.83	0.22	14%	0			1								
46221	Hemorrhoidectomy, internal,	010	68	75	7	10%	2.36	2.69	0.33	14%	0				1							
46230	Excision of multiple external	010	74	76	2	3%	2.62	2.84	0.22	8%	0			1								
46250	Hemorrhoidectomy, external,	090	188	197	9	5%	4.25	4.91	0.66	16%	0			1	1						0.5	
46255	Hemorrhoidectomy, internal,	090	193	202	9	5%	4.96	5.62	0.66	13%	0			1	1						0.5	
46257	Hemorrhoidectomy, internal,	090	203	212	9	4%	5.76	6.42	0.66	11%	0			1	1						0.5	
46258	Hemorrhoidectomy, internal,	090	241	257	16	7%	6.41	7.40	0.99	15%	0			1	2						0.5	
46260	Hemorrhoidectomy, internal,	090	208	217	9	4%	6.73	7.39	0.66	10%	0			1	1						0.5	
46261	Hemorrhoidectomy, internal,	090	241	257	16	7%	7.76	8.75	0.99	13%	0			1	2						0.5	

46262	Hemorrhoidectomy, internal	090	179	190	11	6%	7.91	8.79	0.88	11%	0			2	1						0.5	
46270	Surgical treatment of anal fist	090	169	180	11	7%	4.92	5.80	0.88	18%	0			2	1						0.5	
46275	Surgical treatment of anal fist	090	184	195	11	6%	5.42	6.30	0.88	16%	0			2	1						0.5	
46280	Surgical treatment of anal fist	090	199	210	11	6%	6.39	7.27	0.88	14%	0			2	1						0.5	
46285	Surgical treatment of anal fist	090	184	195	11	6%	5.42	6.30	0.88	16%	0			2	1						0.5	
46288	Closure of anal fistula with re	090	236	252	16	7%	7.81	8.80	0.99	13%	0			1	2						0.5	
46320	Excision of thrombosed hemo	010	55	56	1	2%	1.64	1.75	0.11	7%	0			0.5								
46500	Injection of sclerosing solutio	010	61	68	7	11%	1.74	2.07	0.33	19%	0				1							
46505	Chemodenervation of interna	010	102	109	7	7%	3.18	3.62	0.44	14%	0				1						0.5	
46700	Anoplasty, plastic operation f	090	283.5	299.5	16	6%	9.81	10.80	0.99	10%	0			1	2						0.5	
46705	Anoplasty, plastic operation f	090	277	299	22	8%	7.43	9.14	1.71	23%	0			3.5				3			1	
46706	Repair of anal fistula with fibr	010	100	102	2	2%	2.44	2.77	0.33	14%	0			1							0.5	
46707	Repair of anorectal fistula wit	090	187	198	11	6%	6.39	7.27	0.88	14%	0			2	1						0.5	
46710	Repair of ileoanal pouch fistu	090	370	387	17	5%	17.14	18.68	1.54	9%	0			1	2			1	1		1	
46712	Repair of ileoanal pouch fistu	090	670	677	7	1%	36.45	38.99	2.54	7%	0			1	2			1	2	2	1	
46715	Repair of low imperforate ant	090	265	282.5	17.5	7%	7.62	8.99	1.37	18%	0			2.5				2.5			1	
46716	Repair of low imperforate ant	090	530	594	64	12%	17.54	20.37	2.83	16%	-10					5		2				1
46730	Repair of high imperforate an	090	775	832	57	7%	30.65	34.46	3.81	12%	-12					6		1	2	1		1
46735	Repair of high imperforate an	090	850	916	66	8%	36.14	40.23	4.09	11%	-12					6		3	3			1
46740	Repair of high imperforate an	090	775	832	57	7%	33.90	37.71	3.81	11%	-12					6		1	2	1		1
46742	Repair of high imperforate an	090	895	953	58	6%	40.14	44.39	4.25	11%	-12					6		2	3	1		1
46744	Repair of cloacal anomaly by	090	1303	1355	52	4%	58.94	63.99	5.05	9%	-12					6		2	3	3		1
46746	Repair of cloacal anomaly by	090	1566	1625	59	4%	65.44	71.20	5.76	9%	-11					5	1	3	4	3		1
46748	Repair of cloacal anomaly by	090	1686	1745	59	3%	71.42	77.18	5.76	8%	-11					5	1	3	4	3		1
46750	Sphincteroplasty, anal, for inc	090	475	489	14	3%	12.15	14.33	2.18	18%	0			1	2			2	3		1	
46751	Sphincteroplasty, anal, for inc	090	299	321	22	7%	9.30	11.01	1.71	18%	0			3.5				3			1	
46753	Graft (Thiersch operation) for	090	297	316	19	6%	8.89	10.14	1.25	14%	0			1	1			2			1	
46754	Removal of Thiersch wire or s	010	175	196	21	12%	3.01	4.35	1.34	45%	0			1	2			1			1	
46760	Sphincteroplasty, anal, for inc	090	676	699	23	3%	17.45	20.87	3.42	20%	-2			2	2	1		2	2	2	1	
46761	Sphincteroplasty, anal, for inc	090	410	423	13	3%	15.29	17.03	1.74	11%	0			1	2			1	2		1	
46900	Destruction of lesion(s), anus	010	63	70	7	11%	1.91	2.24	0.33	17%	0				1							
46910	Destruction of lesion(s), anus	010	73	75	2	3%	1.91	2.13	0.22	12%	0			1								
46916	Destruction of lesion(s), anus	010	67	69	2	3%	1.91	2.13	0.22	12%	0			1								
46917	Destruction of lesion(s), anus	010	73	75	2	3%	1.91	2.13	0.22	12%	0			1								
46922	Destruction of lesion(s), anus	010	83	85	2	2%	1.91	2.13	0.22	12%	0			1								
46924	Destruction of lesion(s), anus	010	93	95	2	2%	2.81	3.03	0.22	8%	0			1								
46930	Destruction of internal hemo	090	46	53	7	15%	1.61	1.94	0.33	20%	0				1							
46940	Curettage or cautery of anal f	010	63	64	1	2%	2.35	2.46	0.11	5%	0			0.5								
46942	Curettage or cautery of anal f	010	67	68	1	1%	2.07	2.18	0.11	5%	0			0.5								
46945	Hemorrhoidectomy, internal,	090	133	142	9	7%	3.69	4.35	0.66	18%	0			1	1						0.5	
46946	Hemorrhoidectomy, internal,	090	148	157	9	6%	4.50	5.16	0.66	15%	0			1	1						0.5	
46947	Hemorrhoidopexy (eg, for pro	090	170	179	9	5%	5.57	6.23	0.66	12%	0			1	1						0.5	
46948	Hemorrhoidectomy, internal,	090	163	172	9	6%	5.57	6.23	0.66	12%	0			1	1						0.5	
47010	Hepatotomy, for open draina	090	645	653	8	1%	19.40	22.38	2.98	15%	0			1	2			2	3	2	1	
47015	Laparotomy, with aspiration a	090	665	673	8	1%	18.50	21.48	2.98	16%	0			1	2			2	3	2	1	
47100	Biopsy of liver, wedge	090	345	367	22	6%	12.91	14.69	1.78	14%	0			1	2			2	1		1	
47120	Hepatectomy, resection of liv	090	803	815	12	1%	39.01	42.30	3.29	8%	-2			2	1	1		2	3	2	1	
47122	Hepatectomy, resection of liv	090	1000	1008	8	1%	59.48	62.46	2.98	5%	0			1	2			2	3	2	1	
47125	Hepatectomy, resection of liv	090	855	863	8	1%	53.04	56.02	2.98	6%	0			1	2			2	3	2	1	
47130	Hepatectomy, resection of liv	090	870	878	8	1%	57.19	60.17	2.98	5%	0			1	2			2	3	2	1	
47135	Liver allotransplantation, orth	090	1648	1708	60	4%	90.00	97.03	7.03	8%	-13				1	6	1	1	3	6		1
47140	Donor hepatectomy (includin	090	1073	1088	15	1%	59.40	63.95	4.55	8%	0			1	3			3	2	5	1	
47141	Donor hepatectomy (includin	090	1101	1135	34	3%	71.50	76.02	4.52	6%	0			1	4			4	1	4	1	
47142	Donor hepatectomy (includin	090	1221	1256	35	3%	79.44	84.40	4.96	6%	0			1	4			5	2	4	1	
47300	Marsupialization of cyst or ab	090	605	617	12	2%	18.14	20.92	2.78	15%	0			1	2			2	2	2	1	
47350	Management of liver hemorr	090	575	582	7	1%	22.49	25.03	2.54	11%	0			1	2			1	2	2	1	
47360	Management of liver hemorr	090	857.5	865.5	8	1%	31.31	34.29	2.98	10%	0			1	2			2	3	2	1	
47361	Management of liver hemorr	090	1035	1045	10	1%	52.60	56.22	3.62	7%	0			1	2			3	3	3	1	
47362	Management of liver hemorr	090	880	893	13	1%	23.54	26.76	3.22	14%	0			1	2			3	3	2	1	
47370	Laparoscopy, surgical, ablatio	090	450	467	17	4%	20.80	22.34	1.54	7%	0			1	2			1	1		1	
47371	Laparoscopy, surgical, ablatio	090	455	472	17	4%	20.80	22.34	1.54	7%	0			1	2			1	1		1	
47380	Ablation, open, of 1 or more l	090	550	568	18	3%	24.56	26.54	1.98	8%	0			1	2			2	2		1	
47381	Ablation, open, of 1 or more l	090	576	596	20	3%	24.88	27.08	2.20	9%	0			2	2			2	2		1	
47382	Ablation, 1 or more liver tum	010	265	267	2	1%	14.97	15.30	0.33	2%	0			1							0.5	
47383	Ablation, 1 or more liver tum	010	196	198	2	1%	8.88	9.21	0.33	4%	0			1							0.5	
47400	Hepaticotomy or hepaticosto	090	810	818	8	1%	36.36	39.34	2.98	8%	0			1	2			2	3	2	1	

47420	Choledochotomy or choledoc	090	588	590	2	0%	22.03	24.46	2.43	11%	0			2	1			1	2	2	1	
47425	Choledochotomy or choledoc	090	628	626	-2	0%	22.31	24.94	2.63	12%	0			2	1			1	3	2	1	
47460	Transduodenal sphincteroton	090	578	576	-2	0%	20.52	23.15	2.63	13%	0			2	1			1	3	2	1	
47480	Cholecystotomy or cholecyst	090	495	502	7	1%	13.25	15.79	2.54	19%	0			1	2			1	2	2	1	
47490	Cholecystostomy, percutaned	010	133	143	10	8%	4.76	5.24	0.48	10%	0							2				
47562	Laparoscopy, surgical; cholec	090	251	267	16	6%	10.47	11.46	0.99	9%	0			1	2						0.5	
47563	Laparoscopy, surgical; cholec	090	238	247	9	4%	11.47	12.13	0.66	6%	0			1	1						0.5	
47564	Laparoscopy, surgical; cholec	090	415	428	13	3%	18.00	19.74	1.74	10%	0			1	2			1	2		1	
47600	Cholecystectomy;	090	475	485	10	2%	17.48	19.62	2.14	12%	0			1	2			1	2	1	1	
47605	Cholecystectomy; with cholar	090	490	500	10	2%	18.48	20.62	2.14	12%	0			1	2			1	2	1	1	
47610	Cholecystectomy with explora	090	512	512	0	0%	20.92	23.13	2.21	11%	0			1	1			1	2	2	1	
47612	Cholecystectomy with explora	090	597	593	-4	-1%	21.21	23.62	2.41	11%	0			1	1			1	3	2	1	
47620	Cholecystectomy with explora	090	627	623	-4	-1%	23.07	25.48	2.41	10%	0			1	1			1	3	2	1	
47700	Exploration for congenital atr	090	456	493	37	8%	16.50	18.93	2.43	15%	0			3.5				6			1	
47701	Portoenterostomy (eg, Kasai	090	498	537.5	39.5	8%	28.73	31.28	2.55	9%	0			3.5				6.5			1	
47711	Excision of bile duct tumor, w	090	670	678	8	1%	25.90	28.88	2.98	12%	0			1	2			2	3	2	1	
47712	Excision of bile duct tumor, w	090	790	803	13	2%	33.72	36.94	3.22	10%	0			1	2			3	3	2	1	
47715	Excision of choledochal cyst	090	650	653	3	0%	21.55	24.29	2.74	13%	0			1	2			1	3	2	1	
47720	Cholecystoenterostomy; dire	090	520	527	7	1%	18.34	20.88	2.54	14%	0			1	2			1	2	2	1	
47721	Cholecystoenterostomy; with	090	610	618	8	1%	21.99	24.97	2.98	14%	0			1	2			2	3	2	1	
47740	Cholecystoenterostomy; Rou	090	590	593	3	1%	21.23	23.97	2.74	13%	0			1	2			1	3	2	1	
47741	Cholecystoenterostomy; Rou	090	640	648	8	1%	24.21	27.19	2.98	12%	0			1	2			2	3	2	1	
47760	Anastomosis, of extrahepatic	090	759	783	24	3%	38.32	41.54	3.22	8%	-2				2	1		3	2	2	1	
47765	Anastomosis, of intrahepatic	090	882	911	29	3%	52.19	55.65	3.46	7%	-2				2	1		4	2	2	1	
47780	Anastomosis, Roux-en-Y, of e	090	799	823	24	3%	42.32	45.54	3.22	8%	-2				2	1		3	2	2	1	
47785	Anastomosis, Roux-en-Y, of in	090	939	968	29	3%	56.19	59.65	3.46	6%	-2				2	1		4	2	2	1	
47800	Reconstruction, plastic, of ext	090	652.5	660.5	8	1%	26.17	29.15	2.98	11%	0			1	2			2	3	2	1	
47801	Placement of choledochal ste	090	525	532	7	1%	17.60	20.14	2.54	14%	0			1	2			1	2	2	1	
47802	U-tube hepaticoenterostomy	090	705	713	8	1%	24.93	27.91	2.98	12%	0			1	2			2	3	2	1	
47900	Suture of extrahepatic biliary	090	570	582	12	2%	22.44	25.22	2.78	12%	0			1	2			2	2	2	1	
48000	Placement of drains, peripan	090	743	751	8	1%	31.95	34.93	2.98	9%	0			1	2			2	3	2	1	
48001	Placement of drains, peripan	090	815.5	815.5	0	0%	39.69	42.83	3.14	8%	0			1	2			1	3	3	1	
48020	Removal of pancreatic calculu	090	678	686	8	1%	19.09	22.07	2.98	16%	0			1	2			2	3	2	1	
48100	Biopsy of pancreas, open (eg,	090	497.5	502.5	5	1%	14.46	16.91	2.45	17%	0			1	1			2	2	2	1	
48102	Biopsy of pancreas, percutan	010	120	121	1	1%	4.70	4.92	0.22	5%	0			0.5							0.5	
48105	Resection or debridement of	090	1220	1250.5	30.5	2%	49.26	55.18	5.92	12%	-2			1	2	1		7.5	5	4	1	
48120	Excision of lesion of pancreas	090	595	596	1	0%	18.41	21.06	2.65	14%	0			1	1			2	3	2	1	
48140	Pancreatectomy, distal subto	090	725	733	8	1%	26.32	29.30	2.98	11%	0			1	2			2	3	2	1	
48145	Pancreatectomy, distal subto	090	762.5	770.5	8	1%	27.39	30.37	2.98	11%	0			1	2			2	3	2	1	
48146	Pancreatectomy, distal, near-	090	893	908	15	2%	30.60	33.91	3.31	11%	0			1	3			2	3	2	1	
48148	Excision of ampulla of Vater	090	700	712	12	2%	20.39	23.17	2.78	14%	0			1	2			2	2	2	1	
48150	Pancreatectomy, proximal su	090	1110	1133	23	2%	52.84	56.92	4.08	8%	-2			1	2	1		4	4	2	1	
48152	Pancreatectomy, proximal su	090	1063	1085	22	2%	48.65	52.84	4.19	9%	0			1	3			4	3	3	1	
48153	Pancreatectomy, proximal su	090	1078	1100	22	2%	52.79	56.98	4.19	8%	0			1	3			4	3	3	1	
48154	Pancreatectomy, proximal su	090	1033	1050	17	2%	48.88	52.83	3.95	8%	0			1	3			3	3	3	1	
48155	Pancreatectomy, total	090	1043	1060	17	2%	29.45	33.40	3.95	13%	0			1	3			3	3	3	1	
48500	Marsupialization of pancreati	090	603	611	8	1%	18.16	21.14	2.98	16%	0			1	2			2	3	2	1	
48510	External drainage, pseudocys	090	580.5	588.5	8	1%	17.19	20.17	2.98	17%	0			1	2			2	3	2	1	
48520	Internal anastomosis of panc	090	580	581	1	0%	18.15	20.80	2.65	15%	0			1	1			2	3	2	1	
48540	Internal anastomosis of panc	090	560	565	5	1%	21.94	24.39	2.45	11%	0			1	1			2	2	2	1	
48545	Pancreatorrhaphy for injury	090	773	782	9	1%	22.23	25.41	3.18	14%	0			1	2			2	2	3	1	
48547	Duodenal exclusion with gast	090	903	912	9	1%	30.38	33.56	3.18	10%	0			1	2			2	2	3	1	
48548	Pancreaticojejunostomy, side	090	765	773	8	1%	28.09	31.07	2.98	11%	0			1	2			2	3	2	1	
48554	Transplantation of pancreatic	090	1237	1337	100	8%	37.80	42.45	4.65	12%	-9				4	3	3					
48556	Removal of transplanted panc	090	952	1011	59	6%	19.47	24.06	4.59	24%	-2				3	1		9	4		1	
49000	Exploratory laparotomy, explo	090	304	328	24	8%	12.54	13.90	1.36	11%	0				2			2			1	
49002	Reopening of recent laparoto	090	437	450	13	3%	17.63	19.92	2.29	13%	0			1	1			3	2	1	1	
49010	Exploration, retroperitoneal a	090	357	377	20	6%	16.06	17.75	1.69	11%	0			1	1			3	1		1	
49020	Drainage of peritoneal absces	090	710	746	36	5%	26.67	30.59	3.92	15%	-2			1	2	1		5	2	2	1	
49040	Drainage of subdiaphragmati	090	603	601	-2	0%	16.52	19.15	2.63	16%	0			2	1			1	3	2	1	
49060	Drainage of retroperitoneal a	090	563	565	2	0%	18.53	20.96	2.43	13%	0			2	1			1	2	2	1	
49062	Drainage of extraperitoneal l	090	334	358	24	7%	12.22	13.58	1.36	11%	0				2			2			1	
49203	Excision or destruction, open,	090	420	447	27	6%	20.13	22.15	2.02	10%	0			1	2			3	1		1	
49204	Excision or destruction, open,	090	511	548	37	7%	26.13	28.63	2.50	10%	0			1	2			5	1		1	
49205	Excision or destruction, open,	090	645	670	25	4%	30.13	32.99	2.86	9%	0			1	2			4	2	1	1	
49215	Excision of presacral or sacro	090	855	859	4	0%	37.81	40.62	2.81	7%	0				3				2	3	1	

49250	Umbilectomy, omphalectomy	090	292	319.5	27.5	9%	9.01	10.86	1.85	21%	0			2.5				4.5			1	
49255	Omentectomy, epiploectomy	090	345	386	41	12%	12.56	14.73	2.17	17%	0				3			4			1	
49320	Laparoscopy, abdomen, perit	010	157	164	7	4%	5.14	5.58	0.44	9%	0				1						0.5	
49321	Laparoscopy, surgical; with bi	010	201	213	12	6%	5.44	6.23	0.79	15%	0				1			1			1	
49322	Laparoscopy, surgical; with as	010	133	140	7	5%	6.01	6.34	0.33	5%	0				1							
49323	Laparoscopy, surgical; with dr	090	299	318	19	6%	10.23	11.35	1.12	11%	0				2			1			1	
49324	Laparoscopy, surgical; with in	010	162	169	7	4%	6.32	6.76	0.44	7%	0				1						0.5	
49325	Laparoscopy, surgical; with re	010	162	169	7	4%	6.82	7.26	0.44	6%	0				1						0.5	
49402	Removal of peritoneal foreign	090	422	421	-1	0%	14.09	16.10	2.01	14%	0			1	1			1	3	1	1	
49419	Insertion of tunneled intraper	090	231	243	12	5%	7.08	7.87	0.79	11%	0				1			1			1	
49425	Insertion of peritoneal-venou	090	367	403	36	10%	12.22	14.54	2.32	19%	0			3				6			1	
49426	Revision of peritoneal-venous	090	330	362.5	32.5	10%	10.41	12.50	2.09	20%	0			2.5				5.5			1	
49428	Ligation of peritoneal-venous	010	239.5	249.5	10	4%	6.87	8.08	1.21	18%	0			1	1			1	1		1	
49429	Removal of peritoneal-venou	010	317	349	32	10%	7.44	9.32	1.88	25%	0			1				6			1	
49436	Delayed creation of exit site f	010	93	95	2	2%	2.72	3.05	0.33	12%	0			1							0.5	
49440	Insertion of gastrostomy tube	010	116	121	5	4%	3.93	4.17	0.24	6%	0							1				
49441	Insertion of duodenostomy o	010	123	128	5	4%	4.52	4.76	0.24	5%	0							1				
49442	Insertion of cecostomy or oth	010	108	113	5	5%	3.75	3.99	0.24	6%	0							1				
49491	Repair, initial inguinal hernia,	090	398	406	8	2%	12.53	13.92	1.39	11%	0			2	1					1	1	
49492	Repair, initial inguinal hernia,	090	398	406	8	2%	15.43	16.82	1.39	9%	0			2	1					1	1	
49495	Repair, initial inguinal hernia,	090	148	155	7	5%	6.20	6.53	0.33	5%	0				1							
49496	Repair, initial inguinal hernia,	090	246	260	14	6%	9.42	10.08	0.66	7%	0				2							
49500	Repair initial inguinal hernia,	090	178	187	9	5%	5.84	6.50	0.66	11%	0			1	1						0.5	
49501	Repair initial inguinal hernia,	090	232	246	14	6%	9.36	10.37	1.01	11%	0			1	1			1			1	
49505	Repair initial inguinal hernia,	090	198	207	9	5%	7.96	8.62	0.66	8%	0			1	1						0.5	
49507	Repair initial inguinal hernia,	090	231	240	9	4%	9.09	9.75	0.66	7%	0			1	1						0.5	
49520	Repair recurrent inguinal hern	090	185.5	194.5	9	5%	9.99	10.65	0.66	7%	0			1	1						0.5	
49521	Repair recurrent inguinal hern	090	251	260	9	4%	11.48	12.14	0.66	6%	0			1	1						0.5	
49525	Repair inguinal hernia, sliding	090	193	202	9	5%	8.93	9.59	0.66	7%	0			1	1						0.5	
49540	Repair lumbar hernia	090	218	227	9	4%	10.74	11.40	0.66	6%	0			1	1						0.5	
49550	Repair initial femoral hernia,	090	193	202	9	5%	8.99	9.65	0.66	7%	0			1	1						0.5	
49553	Repair initial femoral hernia,	090	247	261	14	6%	9.92	10.93	1.01	10%	0			1	1			1			1	
49555	Repair recurrent femoral hern	090	218	227	9	4%	9.39	10.05	0.66	7%	0			1	1						0.5	
49557	Repair recurrent femoral hern	090	262	276	14	5%	11.62	12.63	1.01	9%	0			1	1			1			1	
49600	Repair of small omphalocele,	090	286	311	25	9%	11.55	13.28	1.73	15%	0			2.5				4			1	
49605	Repair of large omphalocele c	090	1720	1746	26	2%	87.09	92.80	5.71	7%	-6					3		5	5	5		1
49606	Repair of large omphalocele c	090	297	314.5	17.5	6%	19.00	20.37	1.37	7%	0			2.5				2.5			1	
49610	Repair of omphalocele (Gross	090	282	299.5	17.5	6%	10.91	12.28	1.37	13%	0			2.5				2.5			1	
49611	Repair of omphalocele (Gross	090	270	287.5	17.5	6%	9.34	10.71	1.37	15%	0			2.5				2.5			1	
49650	Laparoscopy, surgical; repair	090	147	151	4	3%	6.36	6.80	0.44	7%	0			2								
49651	Laparoscopy, surgical; repair	090	193	199	6	3%	8.38	9.04	0.66	8%	0			3								
49900	Suture, secondary, of abdomi	090	567	658	91	16%	12.41	16.98	4.57	37%	0				3			14			1	
49904	Omental flap, extra-abdomina	090	670	703	33	5%	22.35	25.69	3.34	15%	0			3	2			5	3		1	
49906	Free omental flap with microv	090	892	964	72	8%	0.00	N/A	N/A	N/A	0			2	4			8			1	
50010	Renal exploration, not necess	090	341	377	36	11%	12.28	14.21	1.93	16%	0				3			3			1	
50020	Drainage of perirenal or rena	090	650	697	47	7%	18.08	22.10	4.02	22%	0				4			7	4		1	
50040	Nephrostomy, nephrotomy w	090	405	453	48	12%	16.68	19.18	2.50	15%	0				4			4			1	
50045	Nephrotomy, with exploratio	090	382	420.5	38.5	10%	16.82	18.87	2.05	12%	0				3			3.5			1	
50060	Nephrolithotomy; removal of	090	440	491	51	12%	20.95	23.60	2.65	13%	0				3			6			1	
50065	Nephrolithotomy; secondary	090	471	517	46	10%	22.32	24.73	2.41	11%	0				3			5			1	
50070	Nephrolithotomy; complicate	090	482	528	46	10%	21.85	24.26	2.41	11%	0				3			5			1	
50075	Nephrolithotomy; removal of	090	569.5	621.5	52	9%	27.09	29.79	2.70	10%	0				3.5			5.5			1	
50080	Percutaneous nephrolithoton	090	244	258	14	6%	13.50	14.27	0.77	6%	0				2						0.5	
50081	Percutaneous nephrolithoton	090	302	316	14	5%	22.00	22.77	0.77	3%	0				2						0.5	
50100	Transection or repositioning c	090	400	438.5	38.5	10%	17.45	19.50	2.05	12%	0				3			3.5			1	
50120	Pyelotomy; with exploration	090	362	398	36	10%	17.21	19.14	1.93	11%	0				3			3			1	
50125	Pyelotomy; with drainage, py	090	364	400	36	10%	17.82	19.75	1.93	11%	0				3			3			1	
50130	Pyelotomy; with removal of c	090	427	473	46	11%	18.82	21.23	2.41	13%	0				3			5			1	
50135	Pyelotomy; complicated (eg, s	090	443	484	41	9%	20.59	22.76	2.17	11%	0				3			4			1	
50205	Renal biopsy; by surgical expo	090	324	353	29	9%	12.29	13.89	1.60	13%	0				2			3			1	
50220	Nephrectomy, including parti	090	432	478	46	11%	18.68	21.09	2.41	13%	0				3			5			1	
50225	Nephrectomy, including parti	090	512	563	51	10%	21.88	24.53	2.65	12%	0				3			6			1	
50230	Nephrectomy, including parti	090	573.5	631	57.5	10%	23.81	26.78	2.97	12%	0				2.5			8			1	
50234	Nephrectomy with total urete	090	512	563	51	10%	24.05	26.70	2.65	11%	0				3			6			1	
50236	Nephrectomy with total urete	090	570	633	63	11%	26.94	30.16	3.22	12%	0				4			7			1	
50240	Nephrectomy, partial	090	605	673	68	11%	24.21	27.67	3.46	14%	0				4			8			1	

50250	Ablation, open, 1 or more ren	090	541	563	22	4%	22.22	25.06	2.84	13%	0			2	2			3	2	1	1	
50280	Excision or unroofing of cyst(s	090	379	420	41	11%	17.09	19.26	2.17	13%	0				3			4			1	
50290	Excision of perinephric cyst	090	386	427	41	11%	16.15	18.32	2.17	13%	0				3			4			1	
50320	Donor nephrectomy (includin	090	524	554	30	6%	22.43	24.71	2.28	10%	0			5				4			1	
50340	Recipient nephrectomy (sepa	090	436.5	493.5	57	13%	14.04	16.98	2.94	21%	0				3.5			6.5			1	
50360	Renal allotransplantation, im	090	774	805	31	4%	39.88	43.40	3.52	9%	-5				1	2	1	1	2	2	1	
50365	Renal allotransplantation, im	090	1446	1455	9	1%	46.13	52.02	5.89	13%	0				9				13.5		1	
50370	Removal of transplanted rena	090	898	961	63	7%	18.88	22.10	3.22	17%	0				4			7			1	
50380	Renal autotransplantation, re	090	1469	1478	9	1%	30.11	36.00	5.89	20%	0				9				13.5		1	
50400	Pyeloplasty (Foley Y-pyeopla	090	483	539	56	12%	21.27	24.16	2.89	14%	0				3			7			1	
50405	Pyeloplasty (Foley Y-pyeopla	090	550.5	610	59.5	11%	25.86	28.92	3.06	12%	0				3.5			7			1	
50500	Nephrorrhaphy, suture of kid	090	463	514	51	11%	21.22	23.87	2.65	12%	0				3			6			1	
50520	Closure of nephrocutaneous c	090	465	516	51	11%	18.88	21.53	2.65	14%	0				3			6			1	
50525	Closure of nephrovisceral fist	090	569.5	636.5	67	12%	24.39	27.81	3.42	14%	0				3.5			8.5			1	
50526	Closure of nephrovisceral fist	090	624.5	699	74.5	12%	26.31	30.09	3.78	14%	0				3.5			10			1	
50540	Symphysiotomy for horsesho	090	421	452	31	7%	21.10	22.79	1.69	8%	0				3			2			1	
50541	Laparoscopy, surgical; ablatio	090	319	343	24	8%	16.86	18.22	1.36	8%	0				2			2			1	
50542	Laparoscopy, surgical; ablatio	090	449	468	19	4%	21.36	22.86	1.50	7%	-2				2	1			1		1	
50543	Laparoscopy, surgical; partial	090	557	593	36	6%	27.41	29.72	2.31	8%	-2				3	1		2	1		1	
50544	Laparoscopy, surgical; pyelop	090	459	488	29	6%	23.37	24.97	1.60	7%	0				2			3			1	
50545	Laparoscopy, surgical; radical	090	491	522	31	6%	25.06	26.75	1.69	7%	-2				1	1		3			1	
50546	Laparoscopy, surgical; nephre	090	466.5	504.5	38	8%	21.87	23.89	2.02	9%	-2				2	1		3			1	
50547	Laparoscopy, surgical; donor	090	501.5	525.5	24	5%	26.34	27.70	1.36	5%	0				2			2			1	
50548	Laparoscopy, surgical; nephre	090	494	523	29	6%	25.36	26.96	1.60	6%	0				2			3			1	
50562	Renal endoscopy through est	090	187.5	187.5	0	0%	10.90	11.01	0.11	1%	0										0.5	
50590	Lithotripsy, extracorporeal sh	090	207	223	16	8%	9.77	10.76	0.99	10%	0			1	2						0.5	
50592	Ablation, 1 or more renal tum	010	145	147	2	1%	6.55	6.88	0.33	5%	0			1							0.5	
50593	Ablation, renal tumor(s), unila	010	207	214	7	3%	8.88	9.32	0.44	5%	0				1						0.5	
50600	Ureterotomy with exploration	090	361.5	401.5	40	11%	17.17	19.30	2.13	12%	0				2.5			4.5			1	
50605	Ureterotomy for insertion of	090	361.5	401.5	40	11%	16.79	18.92	2.13	13%	0				2.5			4.5			1	
50610	Ureterolithotomy; upper one	090	354.5	394.5	40	11%	17.25	19.38	2.13	12%	0				2.5			4.5			1	
50620	Ureterolithotomy; middle one	090	330.5	368	37.5	11%	16.43	18.44	2.01	12%	0				2.5			4			1	
50630	Ureterolithotomy; lower one-	090	339.5	377	37.5	11%	16.21	18.22	2.01	12%	0				2.5			4			1	
50650	Ureterectomy, with bladder c	090	387	428	41	11%	18.82	20.99	2.17	12%	0				3			4			1	
50660	Ureterectomy, total, ectopic u	090	434	477.5	43.5	10%	21.02	23.31	2.29	11%	0				3			4.5			1	
50688	Change of ureterostomy tube	010	52	53	1	2%	1.20	1.31	0.11	9%	0			0.5								
50700	Ureteroplasty, plastic operati	090	415	458.5	43.5	10%	16.69	18.98	2.29	14%	0				3			4.5			1	
50715	Ureterolysis, with or without	090	467	504	37	8%	20.64	23.01	2.37	11%	0				3			4	1		1	
50722	Ureterolysis for ovarian vein s	090	423	471.5	48.5	11%	17.95	20.48	2.53	14%	0				3			5.5			1	
50725	Ureterolysis for retrocaval ur	090	486	539.5	53.5	11%	20.20	22.97	2.77	14%	0				3			6.5			1	
50727	Revision of urinary-cutaneous	090	225	241	16	7%	8.28	9.51	1.23	15%	0			2	1			1			1	
50728	Revision of urinary-cutaneous	090	286	314	28	10%	12.18	13.85	1.67	14%	0			1	3			1			1	
50740	Ureteropyelostomy, anastom	090	465	516	51	11%	20.07	22.72	2.65	13%	0				3			6			1	
50750	Ureterocalycostomy, anastom	090	507	560.5	53.5	11%	21.22	23.99	2.77	13%	0				3			6.5			1	
50760	Ureteroureterostomy	090	451	502	51	11%	20.07	22.72	2.65	13%	0				3			6			1	
50770	Transureteroureterostomy, a	090	489	542.5	53.5	11%	21.22	23.99	2.77	13%	0				3			6.5			1	
50780	Ureteroneocystostomy; anast	090	413	461.5	48.5	12%	19.95	22.48	2.53	13%	0				3			5.5			1	
50782	Ureteroneocystostomy; anast	090	384	415	31	8%	19.66	21.35	1.69	9%	0				3			2			1	
50783	Ureteroneocystostomy; with	090	427	460	33	8%	20.70	22.61	1.91	9%	0			1	3			2			1	
50785	Ureteroneocystostomy; with	090	485	538.5	53.5	11%	22.23	25.00	2.77	12%	0				3			6.5			1	
50800	Ureteroenterostomy, direct a	090	470.5	527.5	57	12%	16.41	19.35	2.94	18%	0				3.5			6.5			1	
50810	Ureterosigmoidostomy, with	090	731.5	810.5	79	11%	22.61	26.60	3.99	18%	0				4.5			9.5			1	
50815	Ureterocolon conduit, includi	090	630	703	73	12%	22.26	25.96	3.70	17%	0				4			9			1	
50820	Ureteroileal conduit (ileal bla	090	606.5	676	69.5	11%	24.07	27.61	3.54	15%	0				3.5			9			1	
50825	Continent diversion, including	090	761	841.5	80.5	11%	30.68	34.74	4.06	13%	0				4			10.5			1	
50830	Urinary undiversion (eg, takin	090	761	841.5	80.5	11%	33.77	37.83	4.06	12%	0				4			10.5			1	
50840	Replacement of all or part of	090	678	753.5	75.5	11%	22.39	26.21	3.82	17%	0				4			9.5			1	
50845	Cutaneous appendico-vesicos	090	613	673	60	10%	22.46	25.53	3.07	14%	0				5			5			1	
50860	Ureterostomy, transplantatio	090	434	487.5	53.5	12%	17.08	19.85	2.77	16%	0				3			6.5			1	
50900	Ureterorrhaphy, suture of ure	090	363	404	41	11%	15.04	17.21	2.17	14%	0				3			4			1	
50920	Closure of ureterocutaneous	090	409	452.5	43.5	11%	15.81	18.10	2.29	14%	0				3			4.5			1	
50930	Closure of ureterovisceral fist	090	438	481.5	43.5	10%	20.19	22.48	2.29	11%	0				3			4.5			1	
50940	Deligation of ureter	090	383	424	41	11%	15.93	18.10	2.17	14%	0				3			4			1	
50945	Laparoscopy, surgical; ureter	090	341.5	370.5	29	8%	17.97	19.57	1.60	9%	0				2			3			1	
50947	Laparoscopy, surgical; ureter	090	512	548	36	7%	25.78	27.71	1.93	7%	0				3			3			1	
50948	Laparoscopy, surgical; ureter	090	506	524	18	4%	23.82	25.43	1.61	7%	-2				1	1		1		1	1	

51020	Cystotomy or cystostomy; wi	090	266.5	291.5	25	9%	7.69	9.10	1.41	18%	0				2.5			1.5			1	
51030	Cystotomy or cystostomy; wi	090	284.5	312	27.5	10%	7.81	9.34	1.53	20%	0				2.5			2			1	
51040	Cystostomy, cystotomy with c	090	139	143	4	3%	4.49	5.04	0.55	12%	0			2							0.5	
51045	Cystotomy, with insertion of	090	271.5	299	27.5	10%	7.81	9.34	1.53	20%	0				2.5			2			1	
51050	Cystolithotomy, cystotomy w	090	276	307.5	31.5	11%	7.97	9.69	1.72	22%	0				2			3.5			1	
51060	Transvesical ureterolithotom	090	319.5	349.5	30	9%	9.95	11.60	1.65	17%	0				2.5			2.5			1	
51065	Cystotomy, with calculus bas	090	318.5	348.5	30	9%	9.95	11.60	1.65	17%	0				2.5			2.5			1	
51080	Drainage of perivesical or pe	090	238	257	19	8%	6.71	7.83	1.12	17%	0				2			1			1	
51500	Excision of urachal cyst or sin	090	290.5	313	22.5	8%	11.05	12.34	1.29	12%	0				2.5			1			1	
51520	Cystotomy; for simple excisio	090	271.5	294	22.5	8%	10.21	11.50	1.29	13%	0				2.5			1			1	
51525	Cystotomy; for excision of bla	090	386.5	431.5	45	12%	15.42	17.79	2.37	15%	0				2.5			5.5			1	
51530	Cystotomy; for excision of bla	090	357.5	397.5	40	11%	13.71	15.84	2.13	15%	0				2.5			4.5			1	
51535	Cystotomy for excision, incisi	090	374.5	414.5	40	11%	13.90	16.03	2.13	15%	0				2.5			4.5			1	
51550	Cystectomy, partial; simple	090	419.5	469.5	50	12%	17.23	19.84	2.61	15%	0				2.5			6.5			1	
51555	Cystectomy, partial; complica	090	534	597.5	63.5	12%	23.18	26.43	3.25	14%	0				3			8.5			1	
51565	Cystectomy, partial, with rein	090	571.5	636	64.5	11%	23.68	26.98	3.30	14%	0				3.5			8			1	
51570	Cystectomy, complete; (separ	090	710	773.5	63.5	9%	27.46	30.71	3.25	12%	0				3			8.5			1	
51575	Cystectomy, complete; with b	090	863.5	945.5	82	9%	34.18	38.32	4.14	12%	0				3.5			11.5			1	
51580	Cystectomy, complete, with u	090	987.5	1086.5	99	10%	35.37	40.32	4.95	14%	0				4.5			13.5			1	
51585	Cystectomy, complete, with u	090	1073.5	1177.5	104	10%	39.64	44.83	5.19	13%	0				4.5			14.5			1	
51590	Cystectomy, complete, with u	090	990.5	1070	79.5	8%	36.33	40.35	4.02	11%	0				3.5			11			1	
51595	Cystectomy, complete, with u	090	1039	1137	98	9%	41.32	46.22	4.90	12%	0				4			14			1	
51596	Cystectomy, complete, with c	090	1231	1346	115	9%	44.26	49.97	5.71	13%	0				5			16			1	
51597	Pelvic exenteration, complete	090	1023	1093	70	7%	42.86	48.37	5.51	13%	0				5			11	5		1	
51800	Cystoplasty or cystourethropl	090	434	477.5	43.5	10%	18.89	21.18	2.29	12%	0				3			4.5			1	
51820	Cystourethroplasty with unila	090	511.5	561	49.5	10%	19.59	22.17	2.58	13%	0				3.5			5			1	
51840	Anterior vesicourethropexy, c	090	319	346.5	27.5	9%	11.36	13.21	1.85	16%	0			2.5				4.5			1	
51841	Anterior vesicourethropexy, c	090	354	381.5	27.5	8%	13.68	15.53	1.85	14%	0			2.5				4.5			1	
51845	Abdomino-vaginal vesical nec	090	265	282.5	17.5	7%	10.15	11.52	1.37	13%	0			2.5				2.5			1	
51860	Cystorrhaphy, suture of bladd	090	308	332.5	24.5	8%	12.60	14.43	1.83	15%	0			3.5				3.5			1	
51865	Cystorrhaphy, suture of bladd	090	398	430	32	8%	15.80	17.99	2.19	14%	0			3.5				5			1	
51880	Closure of cystostomy (separ	090	216	225	9	4%	7.87	8.77	0.90	11%	0			2				1			1	
51900	Closure of vesicovaginal fistul	090	487	538	51	10%	14.63	17.28	2.65	18%	0				3			6			1	
51920	Closure of vesicouterine fistu	090	458	506.5	48.5	11%	13.41	15.94	2.53	19%	0				3			5.5			1	
51925	Closure of vesicouterine fistu	090	536.5	596	59.5	11%	17.53	20.59	3.06	17%	0				3.5			7			1	
51940	Closure, exstrophy of bladder	090	671.5	743.5	72	11%	30.66	34.32	3.66	12%	0				3.5			9.5			1	
51960	Enterocystoplasty, including i	090	663	738.5	75.5	11%	25.40	29.22	3.82	15%	0				4			9.5			1	
51980	Cutaneous vesicostomy	090	320.5	355.5	35	11%	12.57	14.46	1.89	15%	0				2.5			3.5			1	
51990	Laparoscopy, surgical; urethra	090	324	348	24	7%	13.36	14.72	1.36	10%	0				2			2			1	
51992	Laparoscopy, surgical; sling o	090	324	348	24	7%	14.87	16.23	1.36	9%	0				2			2			1	
52301	Cystourethroscopy; with rese	000	183	183	0	0%	5.50	5.72	0.22	4%	0										1	
52400	Cystourethroscopy with incisi	090	197.5	199.5	2	1%	8.69	9.02	0.33	4%	0			1							0.5	
52450	Transurethral incision of pros	090	209	230	21	10%	7.78	8.88	1.10	14%	0				3						0.5	
52500	Transurethral resection of bla	090	230.5	251.5	21	9%	8.14	9.24	1.10	14%	0				3						0.5	
52601	Transurethral electrosurgical	090	236	250	14	6%	13.16	13.93	0.77	6%	0				2						0.5	
52630	Transurethral resection; resid	090	222	233	11	5%	6.55	7.43	0.88	13%	0			2	1						0.5	
52640	Transurethral resection; of po	090	184	200	16	9%	4.79	5.78	0.99	21%	0			1	2						0.5	
52647	Laser coagulation of prostate	090	219	240	21	10%	11.30	12.29	0.99	9%	0				3							
52648	Laser vaporization of prostate	090	249	270	21	8%	12.15	13.14	0.99	8%	0				3							
52649	Laser enucleation of the pros	090	279	295	16	6%	14.56	15.55	0.99	7%	0			1	2						0.5	
52700	Transurethral drainage of pro	090	201	217.5	16.5	8%	7.49	8.49	1.00	13%	0				2			0.5			1	
53000	Urethrotomy or urethrostom	010	138	140	2	1%	2.33	2.77	0.44	19%	0			1							1	
53010	Urethrotomy or urethrostom	090	228	249.5	21.5	9%	4.45	5.69	1.24	28%	0				2			1.5			1	
53040	Drainage of deep periurethra	090	179	185.5	6.5	4%	6.55	7.33	0.78	12%	0			2				0.5			1	
53060	Drainage of Skene's gland abs	010	68	70	2	3%	2.68	2.90	0.22	8%	0			1								
53080	Drainage of perineal urinary e	090	193	207	14	7%	6.92	7.80	0.88	13%	0				2						1	
53085	Drainage of perineal urinary e	090	254.5	277	22.5	9%	11.18	12.47	1.29	11%	0				2.5			1			1	
53210	Urethrectomy, total, including	090	325.5	358	32.5	10%	13.72	15.49	1.77	13%	0				2.5			3			1	
53215	Urethrectomy, total, including	090	371.5	409	37.5	10%	16.85	18.86	2.01	12%	0				2.5			4			1	
53220	Excision or fulguration of carc	090	201	215	14	7%	7.63	8.51	0.88	12%	0				2						1	
53230	Excision of urethral diverticul	090	267.5	287.5	20	7%	10.44	11.61	1.17	11%	0				2.5			0.5			1	
53235	Excision of urethral diverticul	090	281.5	301.5	20	7%	10.99	12.16	1.17	11%	0				2.5			0.5			1	
53240	Marsupialization of urethral d	090	199	213	14	7%	7.08	7.96	0.88	12%	0				2						1	
53250	Excision of bulbourethral glan	090	153	167	14	9%	6.52	7.18	0.66	10%	0				2							
53260	Excision or fulguration; urethr	010	74	76	2	3%	3.03	3.25	0.22	7%	0			1								
53265	Excision or fulguration; urethr	010	76	78	2	3%	3.17	3.39	0.22	7%	0			1								

53270	Excision or fulguration; Skene	010	93	95	2	2%	3.14	3.47	0.33	11%	0			1							0.5	
53275	Excision or fulguration; urethr	010	121	123	2	2%	4.57	4.90	0.33	7%	0			1							0.5	
53400	Urethroplasty; first stage, for	090	343	381.5	38.5	11%	14.13	16.18	2.05	15%	0				3			3.5			1	
53405	Urethroplasty; second stage (	090	330	361	31	9%	15.66	17.35	1.69	11%	0				3			2			1	
53410	Urethroplasty, 1-stage recons	090	364	397.5	33.5	9%	17.68	19.49	1.81	10%	0				3			2.5			1	
53415	Urethroplasty, transpubic or r	090	424	460	36	8%	20.70	22.63	1.93	9%	0				3			3			1	
53420	Urethroplasty, 2-stage recons	090	340.5	370.5	30	9%	15.17	16.82	1.65	11%	0				2.5			2.5			1	
53425	Urethroplasty, 2-stage recons	090	349.5	379.5	30	9%	17.07	18.72	1.65	10%	0				2.5			2.5			1	
53430	Urethroplasty, reconstruction	090	344.5	374.5	30	9%	17.43	19.08	1.65	9%	0				2.5			2.5			1	
53431	Urethroplasty with tubulariza	090	426	462	36	8%	21.18	23.11	1.93	9%	0				3			3			1	
53440	Sling operation for correction	090	248	264	16	6%	13.36	14.35	0.99	7%	0			1	2						0.5	
53442	Removal or revision of sling fo	090	395	415	20	5%	13.49	15.43	1.94	14%	0				4				2		1	
53444	Insertion of tandem cuff (dua	090	320	341	21	7%	14.19	15.53	1.34	9%	0			1	2			1			1	
53445	Insertion of inflatable urethra	090	314	337	23	7%	13.00	14.32	1.32	10%	0			1	3						0.5	
53446	Removal of inflatable urethra	090	300	321	21	7%	11.02	12.36	1.34	12%	0			1	2			1			1	
53447	Removal and replacement of	090	340	361	21	6%	14.28	15.62	1.34	9%	0			1	2			1			1	
53448	Removal and replacement of	090	564	604	40	7%	23.44	26.34	2.90	12%	-2				2	1		5	2		1	
53449	Repair of inflatable urethral/b	090	280.5	300.5	20	7%	10.56	11.73	1.17	11%	0				2.5			0.5			1	
53450	Urethromeatoplasty, with mu	090	202	216	14	7%	6.77	7.65	0.88	13%	0				2						1	
53460	Urethromeatoplasty, with pa	090	205	219	14	7%	7.75	8.63	0.88	11%	0				2						1	
53500	Urethrolysis, transvaginal, se	090	289	310	21	7%	13.00	14.34	1.34	10%	0			1	2			1			1	
53502	Urethrorrhaphy, suture of ure	090	212	226	14	7%	8.26	9.14	0.88	11%	0				2						1	
53505	Urethrorrhaphy, suture of ure	090	218	232	14	6%	8.26	9.14	0.88	11%	0				2						1	
53510	Urethrorrhaphy, suture of ure	090	270.5	290.5	20	7%	10.96	12.13	1.17	11%	0				2.5			0.5			1	
53515	Urethrorrhaphy, suture of ure	090	322.5	345	22.5	7%	14.22	15.51	1.29	9%	0				2.5			1			1	
53520	Closure of urethrostomy or u	090	250.5	268	17.5	7%	9.48	10.53	1.05	11%	0				2.5						1	
53850	Transurethral destruction of p	090	151	172	21	14%	5.42	6.41	0.99	18%	0				3							
53852	Transurethral destruction of p	090	142	163	21	15%	5.93	6.92	0.99	17%	0				3							
53854	Transurethral destruction of p	090	137	158	21	15%	5.93	6.92	0.99	17%	0				3							
53860	Transurethral radiofrequency	090	98	112	14	14%	3.97	4.63	0.66	17%	0				2							
54000	Slitting of prepuce, dorsal or l	010	54	56	2	4%	1.59	1.81	0.22	14%	0			1								
54001	Slitting of prepuce, dorsal or l	010	69	71	2	3%	2.24	2.46	0.22	10%	0			1								
54015	Incision and drainage of penis	010	119	121	2	2%	5.36	5.69	0.33	6%	0			1							0.5	
54050	Destruction of lesion(s), penis	010	54	56	2	4%	1.29	1.51	0.22	17%	0			1								
54055	Destruction of lesion(s), penis	010	44	45	1	2%	1.25	1.36	0.11	9%	0			0.5								
54056	Destruction of lesion(s), penis	010	56	58	2	4%	1.29	1.51	0.22	17%	0			1								
54057	Destruction of lesion(s), penis	010	73	75	2	3%	1.29	1.51	0.22	17%	0			1								
54060	Destruction of lesion(s), penis	010	66	68	2	3%	1.98	2.20	0.22	11%	0			1								
54065	Destruction of lesion(s), penis	010	68	70	2	3%	2.47	2.69	0.22	9%	0			1								
54105	Biopsy of penis; deep structur	010	102	104	2	2%	3.54	3.76	0.22	6%	0			1								
54110	Excision of penile plaque (Pey	090	256.5	274	17.5	7%	10.92	11.97	1.05	10%	0				2.5						1	
54111	Excision of penile plaque (Pey	090	318.5	338.5	20	6%	14.42	15.59	1.17	8%	0				2.5			0.5			1	
54112	Excision of penile plaque (Pey	090	368	396.5	28.5	8%	16.98	18.55	1.57	9%	0				3			1.5			1	
54115	Removal foreign body from d	090	207.5	225	17.5	8%	6.95	8.00	1.05	15%	0				2.5						1	
54120	Amputation of penis; partial	090	272.5	300	27.5	10%	11.01	12.54	1.53	14%	0				2.5			2			1	
54125	Amputation of penis; complet	090	298.5	326	27.5	9%	14.56	16.09	1.53	10%	0				2.5			2			1	
54130	Amputation of penis, radical;	090	502.5	552	49.5	10%	21.84	24.42	2.58	12%	0				3.5			5			1	
54135	Amputation of penis, radical;	090	599.5	654	54.5	9%	28.17	30.99	2.82	10%	0				3.5			6			1	
54160	Circumcision, surgical excision	010	83	85	2	2%	2.53	2.75	0.22	9%	0			1								
54161	Circumcision, surgical excision	010	88	90	2	2%	3.32	3.54	0.22	7%	0			1								
54162	Lysis or excision of penile pos	010	107	114	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
54163	Repair incomplete circumcisio	010	107	114	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
54164	Frenulotomy of penis	010	97	104	7	7%	2.82	3.26	0.44	16%	0				1						0.5	
54200	Injection procedure for Peyro	010	71	73	2	3%	1.11	1.33	0.22	20%	0			1								
54205	Injection procedure for Peyro	090	262.5	290	27.5	10%	8.97	10.50	1.53	17%	0				2.5			2			1	
54300	Plastic operation of penis for	090	268.5	286	17.5	7%	11.20	12.14	0.94	8%	0				2.5						0.5	
54304	Plastic operation on penis for	090	273.5	291	17.5	6%	13.28	14.22	0.94	7%	0				2.5						0.5	
54308	Urethroplasty for second stag	090	234.5	252	17.5	7%	12.62	13.45	0.83	7%	0				2.5							
54312	Urethroplasty for second stag	090	317	338	21	7%	14.51	15.61	1.10	8%	0				3						0.5	
54316	Urethroplasty for second stag	090	401	434.5	33.5	8%	18.05	19.86	1.81	10%	0				3			2.5			1	
54318	Urethroplasty for third stage	090	309	340	31	10%	12.43	14.12	1.69	14%	0				3			2			1	
54322	1-stage distal hypospadias re	090	307.5	332.5	25	8%	13.98	15.39	1.41	10%	0				2.5			1.5			1	
54324	1-stage distal hypospadias re	090	374	407.5	33.5	9%	17.55	19.36	1.81	10%	0				3			2.5			1	
54326	1-stage distal hypospadias re	090	437	473	36	8%	17.02	18.95	1.93	11%	0				3			3			1	
54328	1-stage distal hypospadias re	090	395	428.5	33.5	8%	16.89	18.70	1.81	11%	0				3			2.5			1	
54332	1-stage proximal penile or pe	090	421	457	36	9%	18.37	20.30	1.93	11%	0				3			3			1	

54336	1-stage perineal hypospadias	090	450.5	495	44.5	10%	21.62	23.96	2.34	11%	0				3.5			4			1	
54340	Repair of hypospadias compli	090	234.5	252	17.5	7%	9.71	10.65	0.94	10%	0				2.5						0.5	
54344	Repair of hypospadias compli	090	371	399.5	28.5	8%	17.06	18.63	1.57	9%	0				3			1.5			1	
54348	Repair of hypospadias compli	090	408	439	31	8%	18.32	20.01	1.69	9%	0				3			2			1	
54352	Revision of prior hypospadias	090	497.5	534.5	37	7%	26.13	28.11	1.98	8%	0				3.5			2.5			1	
54360	Plastic operation on penis to (	090	280.5	300.5	20	7%	12.78	13.95	1.17	9%	0				2.5			0.5			1	
54380	Plastic operation on penis for	090	337	360.5	23.5	7%	14.18	15.51	1.33	9%	0				3			0.5			1	
54385	Plastic operation on penis for	090	424.5	451.5	27	6%	16.56	18.06	1.50	9%	0				3.5			0.5			1	
54390	Plastic operation on penis for	090	464.5	491.5	27	6%	22.77	24.27	1.50	7%	0				3.5			0.5			1	
54400	Insertion of penile prosthesis	090	237	244.5	7.5	3%	9.17	10.06	0.89	10%	0			2.5				0.5			1	
54401	Insertion of penile prosthesis,	090	248	271	23	9%	10.44	11.63	1.19	11%	-2				2	1					0.5	
54405	Insertion of multi-component	090	272.5	290	17.5	6%	14.52	15.46	0.94	6%	0				2.5						0.5	
54406	Removal of all components of	090	295	316	21	7%	12.89	14.23	1.34	10%	0			1	2			1			1	
54408	Repair of component(s) of a r	090	334	362	28	8%	13.91	15.45	1.54	11%	-2				2	1		1			1	
54410	Removal and replacement of	090	329	352	23	7%	15.18	16.50	1.32	9%	0			1	3						0.5	
54411	Removal and replacement of	090	580	622	42	7%	18.35	21.47	3.12	17%	-2			1	2	1		5	2		1	
54415	Removal of non-inflatable (se	090	221	237	16	7%	8.88	9.87	0.99	11%	0			1	2						0.5	
54416	Removal and replacement of	090	315	345	30	10%	12.08	13.84	1.76	15%	-2			1	2	1		1			1	
54417	Removal and replacement of	090	465	495	30	6%	16.10	18.65	2.55	16%	-2			1	1	1		4	2		1	
54420	Corpora cavernosa-saphenou	090	324.5	349.5	25	8%	12.39	13.80	1.41	11%	0				2.5			1.5			1	
54430	Corpora cavernosa-corpus sp	090	273.5	296	22.5	8%	11.06	12.35	1.29	12%	0				2.5			1			1	
54435	Corpora cavernosa-glans pen	090	193	209.5	16.5	9%	6.81	7.81	1.00	15%	0				2			0.5			1	
54437	Repair of traumatic corporeal	090	264	287	23	9%	11.50	12.93	1.43	12%	0			1	3						1	
54438	Replantation, penis, complete	090	531	548	17	3%	24.50	26.84	2.34	10%	0				4				2	1	1	
54440	Plastic operation of penis for	090	386	407	21	5%	0.00	N/A	N/A	N/A	0			3				3			1	
54505	Biopsy of testis, incisional (se	010	97	99	2	2%	3.50	3.72	0.22	6%	0			1								
54512	Excision of extraparenchymal	090	216	235	19	9%	9.33	10.23	0.90	10%	0				2			1				
54520	Orchiectomy, simple (includir	090	144	147	3	2%	5.30	5.74	0.44	8%	0			1.5							0.5	
54522	Orchiectomy, partial	090	211	230	19	9%	10.25	11.15	0.90	9%	0				2			1				
54530	Orchiectomy, radical, for tum	090	246.5	257.5	11	4%	8.46	9.34	0.88	10%	0			2	1						0.5	
54535	Orchiectomy, radical, for tum	090	298.5	326	27.5	9%	13.19	14.72	1.53	12%	0				2.5			2			1	
54550	Exploration for undescended	090	228	242	14	6%	8.41	9.29	0.88	10%	0				2						1	
54560	Exploration for undescended	090	303.5	328.5	25	8%	12.10	13.51	1.41	12%	0				2.5			1.5			1	
54600	Reduction of torsion of testis,	090	202	216	14	7%	7.64	8.52	0.88	12%	0				2						1	
54620	Fixation of contralateral testis	010	127	134	7	6%	5.21	5.65	0.44	8%	0				1						0.5	
54640	Orchiopexy, inguinal or scrota	090	162	169	7	4%	7.73	8.17	0.44	6%	0				1						0.5	
54650	Orchiopexy, abdominal appro	090	301	322	21	7%	12.39	13.38	0.99	8%	0				3							
54660	Insertion of testicular prosthe	090	163	177	14	9%	5.74	6.51	0.77	13%	0				2						0.5	
54670	Suture or repair of testicular i	090	230	240	10	4%	6.65	7.66	1.01	15%	0			2.5				1			1	
54680	Transplantation of testis(es) t	090	364.5	407	42.5	12%	14.04	16.29	2.25	16%	0				2.5			5			1	
54690	Laparoscopy, surgical; orchiec	090	329	348	19	6%	11.70	12.82	1.12	10%	0				2			1			1	
54692	Laparoscopy, surgical; orchiop	090	319	343	24	8%	13.74	15.10	1.36	10%	0				2			2			1	
54700	Incision and drainage of epidi	010	97	99	2	2%	3.47	3.69	0.22	6%	0			1								
54830	Excision of local lesion of epic	090	170	184	14	8%	6.01	6.78	0.77	13%	0				2						0.5	
54840	Excision of spermatocele, wit	090	146	149	3	2%	5.27	5.71	0.44	8%	0			1.5							0.5	
54860	Epididymectomy; unilateral	090	194	208	14	7%	6.95	7.72	0.77	11%	0				2						0.5	
54861	Epididymectomy; bilateral	090	245.5	263	17.5	7%	9.70	10.64	0.94	10%	0				2.5						0.5	
54865	Exploration of epididymis, wit	090	182	196	14	8%	5.77	6.65	0.88	15%	0				2						1	
54900	Epididymovasostomy, anasto	090	345	368.5	23.5	7%	14.20	15.53	1.33	9%	0				3			0.5			1	
54901	Epididymovasostomy, anasto	090	445.5	472.5	27	6%	19.10	20.60	1.50	8%	0				3.5			0.5			1	
55040	Excision of hydrocele; unilate	090	162	166	4	2%	5.45	6.00	0.55	10%	0			2							0.5	
55041	Excision of hydrocele; bilatera	090	232.5	250	17.5	8%	8.54	9.48	0.94	11%	0				2.5						0.5	
55060	Repair of tunica vaginalis hyd	090	185	199	14	8%	6.15	6.92	0.77	13%	0				2						0.5	
55100	Drainage of scrotal wall absce	010	90	97	7	8%	2.45	2.78	0.33	13%	0				1							
55110	Scrotal exploration	090	194	208	14	7%	6.33	7.21	0.88	14%	0				2						1	
55120	Removal of foreign body in sc	090	165	179	14	8%	5.72	6.49	0.77	13%	0				2						0.5	
55150	Resection of scrotum	090	279.5	302	22.5	8%	8.14	9.43	1.29	16%	0				2.5			1			1	
55175	Scrotoplasty; simple	090	186	200	14	8%	5.87	6.64	0.77	13%	0				2						0.5	
55180	Scrotoplasty; complicated	090	297	323	26	9%	11.78	13.23	1.45	12%	0				3			1			1	
55200	Vasotomy, cannulization with	090	98	105	7	7%	4.55	4.88	0.33	7%	0				1							
55250	Vasectomy, unilateral or bilat	090	105	108	3	3%	3.37	3.70	0.33	10%	0			1.5								
55400	Vasovasostomy, vasovasorrha	090	186	191	5	3%	8.61	9.27	0.66	8%	0			2.5							0.5	
55500	Excision of hydrocele of sperr	090	184	198	14	8%	6.22	6.99	0.77	12%	0				2						0.5	
55520	Excision of lesion of spermati	090	188	202	14	7%	6.66	7.43	0.77	12%	0				2						0.5	
55530	Excision of varicocele or ligati	090	152	156	4	3%	5.75	6.30	0.55	10%	0			2							0.5	
55535	Excision of varicocele or ligati	090	187	201	14	7%	7.19	7.96	0.77	11%	0				2						0.5	

55540	Excision of varicocele or ligati	090	224	238	14	6%	8.30	9.18	0.88	11%	0				2						1	
55550	Laparoscopy, surgical, with lig	090	196	210	14	7%	7.20	7.86	0.66	9%	0				2							
55600	Vesiculotomy;	090	204	218	14	7%	7.01	7.78	0.77	11%	0				2						0.5	
55605	Vesiculotomy; complicated	090	198.5	216	17.5	9%	8.76	9.70	0.94	11%	0				2.5						0.5	
55650	Vesiculectomy, any approach	090	304.5	324.5	20	7%	12.65	13.82	1.17	9%	0				2.5			0.5			1	
55680	Excision of Mullerian duct cys	090	206.5	217	10.5	5%	5.67	6.39	0.72	13%	0				1.5						1	
55705	Biopsy, prostate; incisional, a	010	122	124	2	2%	4.61	4.94	0.33	7%	0			1							0.5	
55706	Biopsies, prostate, needle, tra	010	195	211	16	8%	6.28	7.14	0.86	14%	-2				1	1					0.5	
55720	Prostatotomy, external draina	090	150	154	4	3%	7.73	8.17	0.44	6%	0			2								
55725	Prostatotomy, external draina	090	305	343.5	38.5	13%	10.05	12.10	2.05	20%	0				3			3.5			1	
55801	Prostatectomy, perineal, subt	090	497.5	559.5	62	12%	19.80	22.98	3.18	16%	0				3.5			7.5			1	
55810	Prostatectomy, perineal radic	090	515	568.5	53.5	10%	24.29	27.06	2.77	11%	0				3			6.5			1	
55812	Prostatectomy, perineal radic	090	684	759.5	75.5	11%	29.89	33.71	3.82	13%	0				4			9.5			1	
55815	Prostatectomy, perineal radic	090	771	851.5	80.5	10%	32.95	37.01	4.06	12%	0				4			10.5			1	
55821	Prostatectomy (including con	090	315	325	10	3%	15.18	16.26	1.08	7%	0				2				1		1	
55831	Prostatectomy (including con	090	322	332	10	3%	15.60	16.68	1.08	7%	0				2				1		1	
55840	Prostatectomy, retropubic ra	090	448	472	24	5%	21.36	23.10	1.74	8%	-2				2	1		1	1		1	
55842	Prostatectomy, retropubic ra	090	448	472	24	5%	21.36	23.10	1.74	8%	-2				2	1		1	1		1	
55845	Prostatectomy, retropubic ra	090	466	490	24	5%	25.18	26.92	1.74	7%	-2				2	1		1	1		1	
55860	Exposure of prostate, any app	090	371.5	414	42.5	11%	15.84	18.09	2.25	14%	0				2.5			5			1	
55862	Exposure of prostate, any app	090	450	501	51	11%	20.04	22.69	2.65	13%	0				3			6			1	
55865	Exposure of prostate, any app	090	492.5	542	49.5	10%	24.57	27.15	2.58	10%	0				3.5			5			1	
55866	Laparoscopy, surgical prostat	090	362	376	14	4%	22.46	23.23	0.77	3%	0				2						0.5	
55873	Cryosurgical ablation of the p	090	274	295	21	8%	13.60	14.70	1.10	8%	0				3						0.5	
55875	Transperineal placement of n	090	249	270	21	8%	13.46	14.45	0.99	7%	0				3							
55880	Ablation of malignant prostat	090	373	396	23	6%	17.73	18.92	1.19	7%	-2				2	1					0.5	
56405	Incision and drainage of vulva	010	56	58	2	4%	1.49	1.71	0.22	15%	0			1								
56420	Incision and drainage of Barth	010	56	58	2	4%	1.44	1.66	0.22	15%	0			1								
56440	Marsupialization of Bartholin'	010	93	95	2	2%	2.89	3.11	0.22	8%	0			1								
56441	Lysis of labial adhesions	010	67	69	2	3%	2.02	2.24	0.22	11%	0			1								
56501	Destruction of lesion(s), vulva	010	55	57	2	4%	1.58	1.80	0.22	14%	0			1								
56515	Destruction of lesion(s), vulva	010	157	164	7	4%	3.08	3.52	0.44	14%	0				1						0.5	
56620	Vulvectomy simple; partial	090	239	262	23	10%	7.53	8.85	1.32	18%	0			1	3						0.5	
56625	Vulvectomy simple; complete	090	341.5	379	37.5	11%	9.68	11.69	2.01	21%	0				2.5			4			1	
56630	Vulvectomy, radical, partial;	090	562.5	627.5	65	12%	14.80	18.13	3.33	22%	0				2.5			9.5			1	
56631	Vulvectomy, radical, partial; v	090	658.5	680.5	22	3%	18.99	21.56	2.57	14%	-2				2	1		1	3	1		1
56632	Vulvectomy, radical, partial; v	090	683	753	70	10%	21.86	25.41	3.55	16%	0				5			7			1	
56633	Vulvectomy, radical, complet	090	602	615	13	2%	19.62	22.71	3.09	16%	0				3			2	3	2	1	
56634	Vulvectomy, radical, complet	090	686	708	22	3%	20.66	23.23	2.57	12%	-2				2	1		1	3	1		1
56637	Vulvectomy, radical, complet	090	726	748	22	3%	24.75	27.32	2.57	10%	-2				2	1		1	3	1		1
56640	Vulvectomy, radical, complet	090	640.5	713	72.5	11%	24.78	28.47	3.69	15%	0				2.5			11			1	
56700	Partial hymenectomy or revis	010	94	101	7	7%	2.84	3.17	0.33	12%	0				1							
56740	Excision of Bartholin's gland c	010	176	183	7	4%	4.88	5.43	0.55	11%	0				1						1	
56800	Plastic repair of introitus	010	116	118	2	2%	3.93	4.26	0.33	8%	0			1							0.5	
56805	Clitoroplasty for intersex stat	090	460	491	31	7%	19.88	21.70	1.82	9%	0			1	2			3			1	
56810	Perineoplasty, repair of perin	010	119	126	7	6%	4.29	4.86	0.57	13%	0			1				1			0.5	
57000	Colpotomy; with exploration	010	79	81	2	3%	3.02	3.24	0.22	7%	0			1								
57010	Colpotomy; with drainage of	090	229	250.5	21.5	9%	6.84	8.08	1.24	18%	0				2			1.5			1	
57022	Incision and drainage of vagir	010	116	123	7	6%	2.73	3.19	0.46	17%	0			1				1				
57023	Incision and drainage of vagir	010	201	213	12	6%	5.18	5.97	0.79	15%	0				1			1			1	
57061	Destruction of vaginal lesion(	010	55	57	2	4%	1.30	1.52	0.22	17%	0			1								
57065	Destruction of vaginal lesion(	010	78	80	2	3%	2.66	2.88	0.22	8%	0			1								
57105	Biopsy of vaginal mucosa; ext	010	79	81	2	3%	1.74	1.96	0.22	13%	0			1								
57106	Vaginectomy, partial removal	090	239	265	26	11%	7.50	8.95	1.45	19%	0				3			1			1	
57107	Vaginectomy, partial removal	090	515	533	18	3%	24.56	26.54	1.98	8%	0			1	2			2	2		1	
57109	Vaginectomy, partial removal	090	539.5	580.5	41	8%	28.40	30.57	2.17	8%	0				3			4			1	
57110	Vaginectomy, complete remo	090	386	406	20	5%	15.48	17.04	1.56	10%	0				2			2	1		1	
57111	Vaginectomy, complete remo	090	554.5	595.5	41	7%	28.40	30.57	2.17	8%	0				3			4			1	
57120	Colpocleisis (Le Fort type)	090	253	277	24	9%	8.28	9.64	1.36	16%	0				2			2			1	
57130	Excision of vaginal septum	010	54	55	1	2%	2.46	2.57	0.11	4%	0			0.5								
57135	Excision of vaginal cyst or tun	010	56	57	1	2%	2.70	2.81	0.11	4%	0			0.5								
57180	Introduction of any hemostat	010	59	61	2	3%	1.63	1.85	0.22	13%	0			1								
57200	Colporrhaphy, suture of injur	090	138.5	149	10.5	8%	4.42	5.03	0.61	14%	0				1.5						0.5	
57210	Colpoperineorrhaphy, suture	090	190.5	203.5	13	7%	5.71	6.55	0.84	15%	0				1.5			0.5			1	
57220	Plastic operation on urethral	090	194.5	207.5	13	7%	4.85	5.69	0.84	17%	0				1.5			0.5			1	
57230	Plastic repair of urethrocele	090	209.5	227.5	18	9%	6.30	7.38	1.08	17%	0				1.5			1.5			1	

57240	Anterior colporrhaphy, repair	090	211	225	14	7%	10.08	10.85	0.77	8%	0				2						0.5	
57250	Posterior colporrhaphy, repai	090	211	225	14	7%	10.08	10.85	0.77	8%	0				2						0.5	
57260	Combined anteroposterior co	090	241	255	14	6%	13.25	14.02	0.77	6%	0				2						0.5	
57265	Combined anteroposterior co	090	271	285	14	5%	15.00	15.77	0.77	5%	0				2						0.5	
57268	Repair of enterocele, vaginal	090	234	255.5	21.5	9%	7.57	8.81	1.24	16%	0				2			1.5			1	
57270	Repair of enterocele, abdomi	090	381	393	12	3%	13.67	15.39	1.72	13%	0				2			1	1	1	1	
57280	Colpopexy, abdominal approa	090	439	456	17	4%	16.72	18.68	1.96	12%	0				2			2	1	1	1	
57282	Colpopexy, vaginal; extra-per	090	229	243	14	6%	11.63	12.40	0.77	7%	0				2						0.5	
57283	Colpopexy, vaginal; intra-peri	090	231	245	14	6%	11.66	12.43	0.77	7%	0				2						0.5	
57284	Paravaginal defect repair (inc	090	327	337	10	3%	14.33	15.54	1.21	8%	0			1	1			1	1		1	
57285	Paravaginal defect repair (inc	090	267	272	5	2%	11.60	12.57	0.97	8%	0			1	1				1		1	
57287	Removal or revision of sling f	090	239	262	23	10%	11.15	12.47	1.32	12%	0			1	3						0.5	
57288	Sling operation for stress inc	090	246	269	23	9%	12.13	13.45	1.32	11%	0			1	3						0.5	
57289	Pereyra procedure, including	090	373	377	4	1%	12.80	14.39	1.59	12%	0			2	1				1	1	1	
57291	Construction of artificial vagi	090	248	264.5	16.5	7%	8.64	9.64	1.00	12%	0				2			0.5			1	
57292	Construction of artificial vagi	090	322	348.5	26.5	8%	14.01	15.49	1.48	11%	0				2			2.5			1	
57295	Revision (including removal) c	090	202	211	9	4%	7.82	8.59	0.77	10%	0			1	1						1	
57296	Revision (including removal) c	090	429	445	16	4%	16.56	18.32	1.76	11%	0				2			2	2		1	
57300	Closure of rectovaginal fistula	090	271.5	301.5	30	11%	8.71	10.36	1.65	19%	0				2.5			2.5			1	
57305	Closure of rectovaginal fistula	090	468	487	19	4%	15.35	17.66	2.31	15%	0			2	1			3	1	1	1	
57307	Closure of rectovaginal fistula	090	363	396.5	33.5	9%	17.17	18.98	1.81	11%	0				3			2.5			1	
57308	Closure of rectovaginal fistula	090	313	334	21	7%	10.59	12.06	1.47	14%	0			2	1			2			1	
57310	Closure of urethrovaginal fist	090	259	283	24	9%	7.65	9.01	1.36	18%	0				2			2			1	
57311	Closure of urethrovaginal fist	090	319	345.5	26.5	8%	8.91	10.39	1.48	17%	0				2			2.5			1	
57320	Closure of vesicovaginal fistul	090	277	301	24	9%	8.88	10.24	1.36	15%	0				2			2			1	
57330	Closure of vesicovaginal fistul	090	288	312	24	8%	13.21	14.57	1.36	10%	0				2			2			1	
57335	Vaginoplasty for intersex stat	090	459	495	36	8%	20.02	21.73	1.71	9%	0				3			3				
57415	Removal of impacted vaginal	010	113	120	7	6%	2.49	2.82	0.33	13%	0				1							
57423	Paravaginal defect repair (inc	090	357	362	5	1%	16.08	17.05	0.97	6%	0			1	1				1		1	
57425	Laparoscopy, surgical, colpop	090	351	365	14	4%	17.03	17.80	0.77	5%	0				2						0.5	
57426	Revision (including removal) c	090	360	377	17	5%	14.30	15.71	1.41	10%	0				3				1		1	
57505	Endocervical curettage (not d	010	36	38	2	6%	1.19	1.41	0.22	18%	0			1								
57511	Cautery of cervix; cryocauter	010	55	57	2	4%	1.95	2.17	0.22	11%	0			1								
57513	Cautery of cervix; laser ablati	010	88	90	2	2%	1.95	2.17	0.22	11%	0			1								
57520	Conization of cervix, with or v	090	110	113	3	3%	4.11	4.44	0.33	8%	0			1.5								
57522	Conization of cervix, with or v	090	178	185	7	4%	3.67	4.00	0.33	9%	0				1							
57530	Trachelectomy (cervicectomy	090	180.5	191	10.5	6%	5.27	5.99	0.72	14%	0				1.5						1	
57531	Radical trachelectomy, with b	090	604	648	44	7%	29.95	32.65	2.70	9%	-2				2	1		5	1		1	
57540	Excision of cervical stump, ab	090	309	324	15	5%	13.29	14.61	1.32	10%	0				2			1	1		1	
57545	Excision of cervical stump, ab	090	364	379	15	4%	14.10	15.42	1.32	9%	0				2			1	1		1	
57550	Excision of cervical stump, va	090	228	249.5	21.5	9%	6.34	7.58	1.24	20%	0				2			1.5			1	
57555	Excision of cervical stump, va	090	311	340	29	9%	9.94	11.54	1.60	16%	0				2			3			1	
57556	Excision of cervical stump, va	090	292	321	29	10%	9.36	10.96	1.60	17%	0				2			3			1	
57558	Dilation and curettage of cerv	010	55	57	2	4%	1.72	1.94	0.22	13%	0			1								
57700	Cerclage of uterine cervix, no	090	129.5	147	17.5	14%	4.35	5.18	0.83	19%	0				2.5							
57720	Trachelorrhaphy, plastic repa	090	136.5	147	10.5	8%	4.61	5.22	0.61	13%	0				1.5						0.5	
58120	Dilation and curettage, diagn	010	129	136	7	5%	3.59	4.03	0.44	12%	0				1						0.5	
58140	Myomectomy, excision of fibr	090	374	394	20	5%	15.79	17.35	1.56	10%	0				2			2	1		1	
58145	Myomectomy, excision of fibr	090	267	291	24	9%	8.91	10.27	1.36	15%	0				2			2			1	
58146	Myomectomy, excision of fibr	090	429	450	21	5%	20.34	22.10	1.76	9%	0				2			2		1	1	
58150	Total abdominal hysterectom	090	394	419	25	6%	17.31	19.11	1.80	10%	0				2			3	1		1	
58152	Total abdominal hysterectom	090	373.5	411	37.5	10%	21.86	23.87	2.01	9%	0				2.5			4			1	
58180	Supracervical abdominal hyst	090	414	439	25	6%	16.60	18.40	1.80	11%	0				2			3	1		1	
58200	Total abdominal hysterectom	090	459	475	16	3%	23.10	24.86	1.76	8%	0				2			2	2		1	
58210	Radical abdominal hysterecto	090	627	660	33	5%	30.91	33.48	2.57	8%	0				3			4	2		1	
58240	Pelvic exenteration for gynec	090	1118	1157	39	3%	49.33	53.46	4.13	8%	-2			1	4	1		3	6			1
58260	Vaginal hysterectomy, for ute	090	311	328	17	5%	14.15	15.56	1.41	10%	-2				1	1		1	1		1	
58262	Vaginal hysterectomy, for ute	090	342	359	17	5%	15.94	17.35	1.41	9%	-2				1	1		1	1		1	
58263	Vaginal hysterectomy, for ute	090	363	380	17	5%	17.23	18.64	1.41	8%	-2				1	1		1	1		1	
58267	Vaginal hysterectomy, for ute	090	392.5	432.5	40	10%	18.36	20.49	2.13	12%	0				2.5			4.5			1	
58270	Vaginal hysterectomy, for ute	090	304	335.5	31.5	10%	15.30	17.02	1.72	11%	0				2			3.5			1	
58275	Vaginal hysterectomy, with to	090	365.5	403	37.5	10%	17.03	19.04	2.01	12%	0				2.5			4			1	
58280	Vaginal hysterectomy, with to	090	387.5	427.5	40	10%	18.33	20.46	2.13	12%	0				2.5			4.5			1	
58285	Vaginal hysterectomy, radical	090	499.5	505.5	6	1%	23.38	24.79	1.41	6%	0			1	1			1	2		1	
58290	Vaginal hysterectomy, for ute	090	389	395	6	2%	20.27	21.55	1.28	6%	0				2				2		1	
58291	Vaginal hysterectomy, for ute	090	410	416	6	1%	22.06	23.34	1.28	6%	0				2				2		1	

58292	Vaginal hysterectomy, for ute	090	423	429	6	1%	23.35	24.63	1.28	5%	0				2				2		1	
58294	Vaginal hysterectomy, for ute	090	405	411	6	1%	21.55	22.83	1.28	6%	0				2				2		1	
58345	Transcervical introduction of	010	116	118	2	2%	4.70	5.03	0.33	7%	0			1							0.5	
58346	Insertion of Heyman capsules	090	267	277	10	4%	7.56	8.77	1.21	16%	0			1	1				1	1	1	
58350	Chromotubation of oviduct, in	010	53	55	2	4%	1.06	1.28	0.22	21%	0			1								
58353	Endometrial ablation, therma	010	151.5	153.5	2	1%	3.60	4.04	0.44	12%	0			1							1	
58356	Endometrial cryoablation with	010	167	174	7	4%	6.41	6.85	0.44	7%	0				1						0.5	
58400	Uterine suspension, with or w	090	241.5	264.5	23	10%	7.14	8.46	1.32	18%	0				1.5			2.5			1	
58410	Uterine suspension, with or w	090	354	369	15	4%	13.80	15.12	1.32	10%	0				2			1	1		1	
58520	Hysterorrhaphy, repair of rup	090	379	391	12	3%	13.48	15.20	1.72	13%	0				2			1	1	1	1	
58540	Hysteroplasty, repair of uteri	090	364	379	15	4%	15.71	17.03	1.32	8%	0				2			1	1		1	
58541	Laparoscopy, surgical, suprac	090	226	240	14	6%	12.29	13.06	0.77	6%	0				2						0.5	
58542	Laparoscopy, surgical, suprac	090	239	253	14	6%	14.16	14.93	0.77	5%	0				2						0.5	
58543	Laparoscopy, surgical, suprac	090	261	275	14	5%	14.39	15.16	0.77	5%	0				2						0.5	
58544	Laparoscopy, surgical, suprac	090	271	285	14	5%	15.60	16.37	0.77	5%	0				2						0.5	
58545	Laparoscopy, surgical, myome	090	334	344	10	3%	15.55	16.63	1.08	7%	0				2				1		1	
58546	Laparoscopy, surgical, myome	090	394	404	10	3%	19.94	21.02	1.08	5%	0				2				1		1	
58548	Laparoscopy, surgical, with ra	090	564	593	29	5%	31.63	33.61	1.98	6%	-2				2	1		2	1		1	
58550	Laparoscopy, surgical, with va	090	330	356	26	8%	15.10	16.68	1.58	10%	0			1	2			2			1	
58552	Laparoscopy, surgical, with va	090	350	376	26	7%	16.91	18.49	1.58	9%	0			1	2			2			1	
58553	Laparoscopy, surgical, with va	090	391.5	406.5	15	4%	20.06	21.38	1.32	7%	0				2			1	1		1	
58554	Laparoscopy, surgical, with va	090	425	442	17	4%	23.11	24.65	1.54	7%	0			1	2			1	1		1	
58565	Hysteroscopy, surgical; with b	090	191	195	4	2%	7.12	7.67	0.55	8%	0			2							0.5	
58570	Laparoscopy, surgical, with to	090	241	255	14	6%	13.36	14.13	0.77	6%	0				2						0.5	
58571	Laparoscopy, surgical, with to	090	241	255	14	6%	15.00	15.77	0.77	5%	0				2						0.5	
58572	Laparoscopy, surgical, with to	090	271	285	14	5%	17.71	18.48	0.77	4%	0				2						0.5	
58573	Laparoscopy, surgical, with to	090	281	295	14	5%	20.79	21.56	0.77	4%	0				2						0.5	
58575	Laparoscopy, surgical, total h	090	510	529	19	4%	32.60	34.10	1.50	5%	-2				2	1			1		1	
58600	Ligation or transection of fall	090	166	173	7	4%	5.91	6.46	0.55	9%	0				1						1	
58605	Ligation or transection of fall	090	141	153	12	9%	5.28	5.98	0.70	13%	0			1				2				
58615	Occlusion of fallopian tube(s)	010	99	101	2	2%	3.94	4.16	0.22	6%	0			1								
58660	Laparoscopy, surgical; with ly	090	209.5	216.5	7	3%	11.59	12.03	0.44	4%	0				1						0.5	
58661	Laparoscopy, surgical; with re	010	217	224	7	3%	11.35	11.79	0.44	4%	0				1						0.5	
58662	Laparoscopy, surgical; with fu	090	186.5	194.5	8	4%	12.15	12.53	0.38	3%	-1				0.5	0.5						
58670	Laparoscopy, surgical; with fu	090	118	125	7	6%	5.91	6.24	0.33	6%	0				1							
58671	Laparoscopy, surgical; with oc	090	118	125	7	6%	5.91	6.24	0.33	6%	0				1							
58672	Laparoscopy, surgical; with fi	090	96	98	2	2%	12.91	13.13	0.22	2%	0			1								
58673	Laparoscopy, surgical; with sa	090	185	192	7	4%	14.04	14.37	0.33	2%	0				1							
58674	Laparoscopy, surgical, ablatio	090	266	280	14	5%	14.08	14.85	0.77	5%	0				2						0.5	
58700	Salpingectomy, complete or p	090	321.5	333.5	12	4%	12.95	14.25	1.30	10%	-2			1		1		1	1		1	
58720	Salpingo-oophorectomy, com	090	309	319	10	3%	12.16	13.37	1.21	10%	0			1	1			1	1		1	
58740	Lysis of adhesions (salpingoly	090	374	386	12	3%	14.90	16.20	1.30	9%	-2			1		1		1	1		1	
58750	Tubotubal anastomosis	090	357	367	10	3%	15.64	16.85	1.21	8%	0			1	1			1	1		1	
58752	Tubouterine implantation	090	377	387	10	3%	15.64	16.85	1.21	8%	0			1	1			1	1		1	
58760	Fimbrioplasty	090	357	367	10	3%	13.93	15.14	1.21	9%	0			1	1			1	1		1	
58770	Salpingostomy (salpingoneost	090	347	357	10	3%	14.77	15.98	1.21	8%	0			1	1			1	1		1	
58800	Drainage of ovarian cyst(s), u	090	159.5	170	10.5	7%	4.62	5.34	0.72	15%	0				1.5						1	
58805	Drainage of ovarian cyst(s), u	090	198.5	211.5	13	7%	6.42	7.26	0.84	13%	0				1.5			0.5			1	
58820	Drainage of ovarian abscess;	090	131.5	142	10.5	8%	4.70	5.31	0.61	13%	0				1.5						0.5	
58822	Drainage of ovarian abscess;	090	399	416	17	4%	11.81	13.77	1.96	17%	0				2			2	1	1	1	
58825	Transposition, ovary(s)	090	282	292	10	4%	11.78	12.99	1.21	10%	0			1	1			1	1		1	
58900	Biopsy of ovary, unilateral or	090	205.5	221	15.5	8%	6.59	7.55	0.96	14%	0				1.5			1			1	
58920	Wedge resection or bisection	090	214.5	230	15.5	7%	11.95	12.91	0.96	8%	0				1.5			1			1	
58925	Ovarian cystectomy, unilatera	090	329	344	15	5%	12.43	13.75	1.32	11%	0				2			1	1		1	
58940	Oophorectomy, partial or tota	090	257	283.5	26.5	10%	8.22	9.70	1.48	18%	0				2			2.5			1	
58943	Oophorectomy, partial or tota	090	385	419	34	9%	19.52	21.36	1.84	9%	0				2			4			1	
58950	Resection (initial) of ovarian,	090	420	433	13	3%	18.37	20.11	1.74	9%	0			1	2			1	2		1	
58951	Resection (initial) of ovarian,	090	581.5	581.5	0	0%	24.26	26.16	1.90	8%	-2			1		1		1	4		1	
58952	Resection (initial) of ovarian,	090	710	727	17	2%	27.29	30.13	2.84	10%	-2			2		1		4	4		1	
58953	Bilateral salpingo-oophorecto	090	712	729	17	2%	34.13	36.60	2.47	7%	-2			1	1	1		2	2	1	1	
58954	Bilateral salpingo-oophorecto	090	757	774	17	2%	37.13	39.60	2.47	7%	-2			1	1	1		2	2	1	1	
58956	Bilateral salpingo-oophorecto	090	534.5	558.5	24	4%	22.80	25.09	2.29	10%	0				3			2	1	1	1	
58957	Resection (tumor debulking) (	090	552	572	20	4%	26.22	28.29	2.07	8%	-2			1	1	1		2	2		1	
58958	Resection (tumor debulking) (	090	582	602	20	3%	29.22	31.29	2.07	7%	-2			1	1	1		2	2		1	
58960	Laparotomy, for staging or re	090	449	471	22	5%	15.79	17.57	1.78	11%	-2			1		1		3	1		1	
59100	Hysterotomy, abdominal (eg,	090	329	346	17	5%	13.37	14.91	1.54	12%	-2			1		1		2	1		1	

59120	Surgical treatment of ectopic	090	384	402	18	5%	12.67	14.41	1.74	14%	-2			1		1		2		1	1	
59121	Surgical treatment of ectopic	090	324	339	15	5%	12.74	14.06	1.32	10%	0				2			1	1		1	
59130	Surgical treatment of ectopic	090	349	373	24	7%	15.08	16.44	1.36	9%	0				2			2			1	
59136	Surgical treatment of ectopic	090	334	349	15	4%	14.25	15.57	1.32	9%	0				2			1	1		1	
59140	Surgical treatment of ectopic	090	186.5	197	10.5	6%	5.94	6.66	0.72	12%	0				1.5						1	
59150	Laparoscopic treatment of ec	090	225	239	14	6%	12.29	13.06	0.77	6%	0				2						0.5	
59151	Laparoscopic treatment of ec	090	235	249	14	6%	12.11	12.88	0.77	6%	0				2						0.5	
59160	Curettage, postpartum	010	79	81	2	3%	2.76	2.98	0.22	8%	0			1								
59410	Vaginal delivery only (with or	MMM	327.5	327.5	0	0%	18.34	18.34	-	0%	0											
59515	Cesarean delivery only; inclu	MMM	392.5	392.5	0	0%	22.13	22.13	-	0%	0											
59614	Vaginal delivery only, after pr	MMM	327.5	327.5	0	0%	20.06	20.06	-	0%	0											
59622	Cesarean delivery only, follow	MMM	367.5	367.5	0	0%	22.66	22.66	-	0%	0											
59812	Treatment of incomplete abo	090	135.5	147.5	12	9%	4.44	5.01	0.57	13%	0				1			1				
59820	Treatment of missed abortion	090	162	180	18	11%	4.84	5.68	0.84	17%	-4					2						
59821	Treatment of missed abortion	090	148	161.5	13.5	9%	5.09	5.72	0.63	12%	-3					1.5						
59830	Treatment of septic abortion,	090	115.5	126	10.5	9%	6.59	7.09	0.50	8%	0				1.5							
59841	Induced abortion, by dilation	010	203	212	9	4%	5.65	6.29	0.64	11%	-2					1					1	
59855	Induced abortion, by 1 or mo	090	158	165	7	4%	6.43	6.76	0.33	5%	0				1							
59856	Induced abortion, by 1 or mo	090	183	190	7	4%	7.79	8.12	0.33	4%	0				1							
59857	Induced abortion, by 1 or mo	090	301	303	2	1%	9.33	9.55	0.22	2%	0			1								
59870	Uterine evacuation and curet	090	256	271	15	6%	6.57	7.87	1.30	20%	-2			3		1					1	
60000	Incision and drainage of thyro	010	59	61	2	3%	1.81	2.03	0.22	12%	0			1								
60200	Excision of cyst or adenoma o	090	297	316.5	19.5	7%	10.02	11.61	1.59	16%	0			3.5				2.5			1	
60210	Partial thyroid lobectomy, un	090	264	273	9	3%	11.23	11.78	0.55	5%	0			1	1							
60212	Partial thyroid lobectomy, un	090	358	369	11	3%	16.43	17.20	0.77	5%	0			2	1							
60220	Total thyroid lobectomy, unila	090	267	281	14	5%	11.19	11.96	0.77	7%	0				2						0.5	
60225	Total thyroid lobectomy, unila	090	374	399.5	25.5	7%	14.79	16.73	1.94	13%	0			4				3.5			1	
60240	Thyroidectomy, total or comp	090	327	341	14	4%	15.04	15.81	0.77	5%	0				2						0.5	
60252	Thyroidectomy, total or subto	090	470	483	13	3%	22.01	23.75	1.74	8%	0			1	2			1	2		1	
60254	Thyroidectomy, total or subto	090	500	513	13	3%	28.42	30.16	1.74	6%	0			1	2			1	2		1	
60260	Thyroidectomy, removal of al	090	372	382	10	3%	18.26	19.47	1.21	7%	0			1	1			1	1		1	
60270	Thyroidectomy, including sub	090	650	657	7	1%	23.20	25.74	2.54	11%	0			1	2			1	2	2	1	
60271	Thyroidectomy, including sub	090	377	387	10	3%	17.62	18.83	1.21	7%	0			1	1			1	1		1	
60280	Excision of thyroglossal duct c	090	262	274	12	5%	6.16	7.39	1.23	20%	0			3.5				1			1	
60281	Excision of thyroglossal duct c	090	262	274	12	5%	8.82	10.05	1.23	14%	0			3.5				1			1	
60500	Parathyroidectomy or explora	090	313	329	16	5%	15.60	16.59	0.99	6%	0			1	2						0.5	
60502	Parathyroidectomy or explora	090	465	499	34	7%	21.15	23.56	2.41	11%	0			4.5				5			1	
60505	Parathyroidectomy or explora	090	636	681	45	7%	23.06	26.06	3.00	13%	0			5				7			1	
60520	Thymectomy, partial or total;	090	474	493	19	4%	17.16	18.41	1.25	7%	-2		1	1	1			2			1	
60521	Thymectomy, partial or total;	090	445	477	32	7%	19.18	20.93	1.75	9%	-4		2		1			5			1	
60522	Thymectomy, partial or total;	090	533	579	46	9%	23.48	26.15	2.67	11%	0			2	1			7			1	
60540	Adrenalectomy, partial or cor	090	485	527	42	9%	18.02	20.69	2.67	15%	0			3.5				7			1	
60545	Adrenalectomy, partial or cor	090	538	582.5	44.5	8%	20.93	23.72	2.79	13%	0			3.5				7.5			1	
60600	Excision of carotid body tumo	090	429	444	15	3%	25.09	26.41	1.32	5%	0				2			1	1		1	
60605	Excision of carotid body tumo	090	530	537	7	1%	31.96	33.44	1.48	5%	0				2				1	1	1	
60650	Laparoscopy, surgical, with ad	090	384	403	19	5%	20.73	21.85	1.12	5%	0				2			1			1	
61105	Twist drill hole for subdural o	090	152	159	7	5%	5.45	6.00	0.55	10%	0				1						1	
61108	Twist drill hole(s) for subdura	090	326.5	371.5	45	14%	11.64	14.01	2.37	20%	0				2.5			5.5			1	
61120	Burr hole(s) for ventricular pu	090	238.5	264	25.5	11%	9.60	11.04	1.44	15%	0				1.5			3			1	
61140	Burr hole(s) or trephine; with	090	367.5	407.5	40	11%	17.23	19.36	2.13	12%	0				2.5			4.5			1	
61150	Burr hole(s) or trephine; with	090	378	422	44	12%	18.90	21.22	2.32	12%	0				2			6			1	
61151	Burr hole(s) or trephine; with	090	312.5	348	35.5	11%	13.49	15.41	1.92	14%	0				1.5			5			1	
61154	Burr hole(s) with evacuation a	090	447	480	33	7%	17.07	19.64	2.57	15%	0				3			4	2		1	
61156	Burr hole(s); with aspiration c	090	339.5	377.5	38	11%	17.45	19.49	2.04	12%	0				1.5			5.5			1	
61215	Insertion of subcutaneous res	090	275.5	306	30.5	11%	5.85	7.53	1.68	29%	0				1.5			4			1	
61250	Burr hole(s) or trephine, supr	090	304.5	340	35.5	12%	11.49	13.41	1.92	17%	0				1.5			5			1	
61253	Burr hole(s) or trephine, infra	090	333.5	371.5	38	11%	13.49	15.53	2.04	15%	0				1.5			5.5			1	
61304	Craniectomy or craniotomy, e	090	493	542	49	10%	23.41	25.97	2.56	11%	0				2			7			1	
61305	Craniectomy or craniotomy, e	090	617.5	687.5	70	11%	28.64	32.21	3.57	12%	0				2.5			10.5			1	
61312	Craniectomy or craniotomy fo	090	689	714	25	4%	30.17	33.69	3.52	12%	0				2			6	4	1	1	
61313	Craniectomy or craniotomy fo	090	687	719	32	5%	28.09	31.70	3.61	13%	0				3			5	2	2	1	
61314	Craniectomy or craniotomy fo	090	540.5	595.5	55	10%	25.90	28.75	2.85	11%	0				2.5			7.5			1	
61315	Craniectomy or craniotomy fo	090	625.5	693	67.5	11%	29.65	33.10	3.45	12%	0				2.5			10			1	
61320	Craniectomy or craniotomy, d	090	570	634	64	11%	27.42	30.70	3.28	12%	0				2			10			1	
61321	Craniectomy or craniotomy, d	090	636.5	706.5	70	11%	30.53	34.10	3.57	12%	0				2.5			10.5			1	
61322	Craniectomy or craniotomy, d	090	893	927	34	4%	34.26	39.57	5.31	15%	0			1	3			7	3	4	1	

61323	Craniectomy or craniotomy, c	090	865	900	35	4%	35.06	39.88	4.82	14%	0			1	2			8	3	3	1	
61330	Decompression of orbit only,	090	597.5	665	67.5	11%	25.30	28.75	3.45	14%	0				2.5			10			1	
61333	Exploration of orbit (transcra	090	573	617	44	8%	29.27	31.59	2.32	8%	0				2			6			1	
61340	Subtemporal cranial decompr	090	445	494	49	11%	20.11	22.67	2.56	13%	0				2			7			1	
61343	Craniectomy, suboccipital wit	090	669.5	742	72.5	11%	31.86	35.55	3.69	12%	0				2.5			11			1	
61345	Other cranial decompression,	090	622.5	692.5	70	11%	29.23	32.80	3.57	12%	0				2.5			10.5			1	
61450	Craniectomy, subtemporal, fo	090	541	602.5	61.5	11%	27.69	30.85	3.16	11%	0				2			9.5			1	
61458	Craniectomy, suboccipital; fo	090	551.5	601.5	50	9%	28.84	31.45	2.61	9%	0				2.5			6.5			1	
61460	Craniectomy, suboccipital; fo	090	609.5	672	62.5	10%	30.24	33.45	3.21	11%	0				2.5			9			1	
61500	Craniectomy; with excision of	090	412.5	450	37.5	9%	19.18	21.19	2.01	10%	0				2.5			4			1	
61501	Craniectomy; for osteomyelit	090	438.5	486	47.5	11%	16.35	18.84	2.49	15%	0				2.5			6			1	
61510	Craniectomy, trephination, bo	090	635	675	40	6%	30.83	33.73	2.90	9%	0				4			4	2		1	
61512	Craniectomy, trephination, bo	090	652	685	33	5%	37.14	39.71	2.57	7%	0				3			4	2		1	
61514	Craniectomy, trephination, bo	090	599.5	667	67.5	11%	27.23	30.68	3.45	13%	0				2.5			10			1	
61516	Craniectomy, trephination, bo	090	598.5	666	67.5	11%	26.58	30.03	3.45	13%	0				2.5			10			1	
61518	Craniectomy for excision of b	090	755	783	28	4%	39.89	43.15	3.26	8%	0				4			3	3	1	1	
61519	Craniectomy for excision of b	090	732	765	33	5%	43.43	46.00	2.57	6%	0				3			4	2		1	
61520	Craniectomy for excision of b	090	815	869	54	7%	57.09	60.27	3.18	6%	0				4			6	1		1	
61521	Craniectomy for excision of b	090	928	1016.5	88.5	10%	46.99	51.44	4.45	9%	0				3			13.5			1	
61522	Craniectomy, infratentorial or	090	654.5	727	72.5	11%	31.54	35.23	3.69	12%	0				2.5			11			1	
61524	Craniectomy, infratentorial or	090	625.5	695.5	70	11%	29.89	33.46	3.57	12%	0				2.5			10.5			1	
61526	Craniectomy, bone flap craniu	090	789	833	44	6%	54.08	56.78	2.70	5%	-2				2	1		5	1		1	
61530	Craniectomy, bone flap craniu	090	869.5	927	57.5	7%	45.56	48.53	2.97	7%	0				2.5			8			1	
61531	Subdural implantation of strip	090	511	530	19	4%	16.41	18.46	2.05	12%	-2				1	1		2	1	1	1	
61533	Craniotomy with elevation of	090	537	598.5	61.5	11%	21.46	24.62	3.16	15%	0				2			9.5			1	
61534	Craniotomy with elevation of	090	619.5	689.5	70	11%	23.01	26.58	3.57	15%	0				2.5			10.5			1	
61535	Craniotomy with elevation of	090	414	465.5	51.5	12%	13.15	15.83	2.68	20%	0				2			7.5			1	
61536	Craniotomy with elevation of	090	759.5	837	77.5	10%	37.72	41.65	3.93	10%	0				2.5			12			1	
61537	Craniotomy with elevation of	090	614	644	30	5%	36.45	38.49	2.04	6%	0				2			4	1		1	
61538	Craniotomy with elevation of	090	679	709	30	4%	39.45	41.49	2.04	5%	0				2			4	1		1	
61539	Craniotomy with elevation of	090	758.5	836	77.5	10%	34.28	38.21	3.93	11%	0				2.5			12			1	
61540	Craniotomy with elevation of	090	655	668	13	2%	31.43	33.17	1.74	6%	0			1	2			1	2		1	
61541	Craniotomy with elevation of	090	675.5	748	72.5	11%	30.94	34.63	3.69	12%	0				2.5			11			1	
61543	Craniotomy with elevation of	090	666.5	739	72.5	11%	31.31	35.00	3.69	12%	0				2.5			11			1	
61544	Craniotomy with elevation of	090	598	664.5	66.5	11%	27.36	30.76	3.40	12%	0				2			10.5			1	
61545	Craniotomy with elevation of	090	775	821	46	6%	46.43	49.77	3.34	7%	0				4			5	1	1	1	
61546	Craniotomy for hypophysecto	090	703.5	778.5	75	11%	33.44	37.25	3.81	11%	0				2.5			11.5			1	
61548	Hypophysectomy or excision	090	553	597	44	8%	23.37	25.69	2.32	10%	0				2			6			1	
61550	Craniectomy for craniosynost	090	279	300	21	8%	15.59	16.69	1.10	7%	0				3						0.5	
61552	Craniectomy for craniosynost	090	345.5	365.5	20	6%	20.40	21.57	1.17	6%	0				2.5			0.5			1	
61556	Craniotomy for craniosynosto	090	692	701	9	1%	24.09	26.58	2.49	10%	-2		1	1	1			3	3	1	1	
61557	Craniotomy for craniosynosto	090	510	546	36	7%	23.31	25.24	1.93	8%	0				3			3			1	
61558	Extensive craniectomy for mu	090	661	707	46	7%	26.50	28.91	2.41	9%	0				3			5			1	
61559	Extensive craniectomy for mu	090	665	713	48	7%	34.02	36.52	2.50	7%	0				4			4			1	
61563	Excision, intra and extracrania	090	656	659	3	0%	28.44	30.25	1.81	6%	-2		1	1	1			1	2	1	1	
61564	Excision, intra and extracrania	090	623	664	41	7%	34.74	36.91	2.17	6%	0				3			4			1	
61566	Craniotomy with elevation of	090	610	642	32	5%	32.45	34.71	2.26	7%	0			1	2			4	1		1	
61567	Craniotomy with elevation of	090	681	715	34	5%	37.00	39.48	2.48	7%	0			2	2			4	1		1	
61570	Craniectomy or craniotomy; v	090	585.5	650.5	65	11%	26.51	29.84	3.33	13%	0				2.5			9.5			1	
61571	Craniectomy or craniotomy; v	090	635.5	705.5	70	11%	28.42	31.99	3.57	13%	0				2.5			10.5			1	
61575	Transoral approach to skull ba	090	762.5	840	77.5	10%	36.56	40.49	3.93	11%	0				2.5			12			1	
61576	Transoral approach to skull ba	090	915	974	59	6%	55.31	58.73	3.42	6%	0				4			7	1		1	
61580	Craniofacial approach to ante	090	1078.3	1072.3	-6	-1%	34.51	38.03	3.52	10%	-2		1	2	2				3	4	1	
61581	Craniofacial approach to ante	090	1214.4	1227.4	13	1%	39.13	43.31	4.18	11%	-4		1	2	2	1		1	1	5	1	
61582	Craniofacial approach to ante	090	1010.3	1040.3	30	3%	35.14	38.75	3.61	10%	0			2	3			4	3	1	1	
61583	Craniofacial approach to ante	090	906.4	952.4	46	5%	38.50	41.59	3.09	8%	-2		1	1	1			8		1	1	
61584	Orbitocranial approach to ant	090	842.4	843.4	1	0%	37.70	40.35	2.65	7%	-2		1	1	1			2	3	2	1	
61585	Orbitocranial approach to ant	090	1101.7	1096.7	-5	0%	42.57	45.60	3.03	7%	0			2	1			1	3	3	1	
61586	Bicoronal, transzygomatic and	090	720	760	40	6%	27.48	30.38	2.90	11%	0				4			4	2		1	
61590	Infratemporal pre-auricular a	090	1418.4	1420.4	2	0%	47.04	51.40	4.36	9%	-2		1	2	2			1		7	1	
61591	Infratemporal post-auricular a	090	1254.85	1269.85	15	1%	47.02	49.64	2.62	6%	-4		2	1	2			3	4		1	
61592	Orbitocranial zygomatic appro	090	1002.8	998.8	-4	0%	43.08	45.49	2.41	6%	-4		2	1	1			1	3	2	1	
61595	Transtemporal approach to p	090	1077.8	1071.8	-6	-1%	33.74	37.26	3.52	10%	-2		1	2	2				3	4	1	
61596	Transcochlear approach to po	090	1188.3	1179.3	-9	-1%	39.43	42.66	3.23	8%	-2		1	2	1			1	4	3	1	
61597	Transcondylar (far lateral) ap	090	1041.4	1061.4	20	2%	40.82	43.70	2.88	7%	0			3				5	2	1	1	
61598	Transpetrosal approach to po	090	1048.1	1054.1	6	1%	36.53	39.00	2.47	7%	-2		1	2	1			2	3	1	1	

61600	Resection or excision of neop	090	1101.4	1101.4	0	0%	30.01	33.73	3.72	12%	-2		1	2	2					6	1	
61601	Resection or excision of neop	090	854.9	859.9	5	1%	31.14	33.59	2.45	8%	-4		2	1	1			2	2	2	1	
61605	Resection or excision of neop	090	1052.6	1074.6	22	2%	32.57	35.41	2.84	9%	-2		1	2	2			3	2	1	1	
61606	Resection or excision of neop	090	926.9	937.9	11	1%	42.05	44.76	2.71	6%	0			2	1			3	3	1	1	
61607	Resection or excision of neop	090	1201.2	1190.2	-11	-1%	40.93	44.52	3.59	9%	0			2	1				1	6	1	
61608	Resection or excision of neop	090	1042	1045	3	0%	45.54	48.54	3.00	7%	0			3				3	3	2	1	
61613	Obliteration of carotid aneury	090	1102	1095	-7	-1%	45.03	48.55	3.52	8%	0			3				1		6	1	
61615	Resection or excision of neop	090	1092.2	1096.2	4	0%	35.77	38.95	3.18	9%	-2		1	1	2			2	4	2	1	
61616	Resection or excision of neop	090	1116.8	1146.8	30	3%	46.74	49.84	3.10	7%	-2		1	1	2			5	2	1	1	
61618	Secondary repair of dura for c	090	573.1	574.1	1	0%	18.69	20.68	1.99	11%	0			2	1				1	2	1	
61619	Secondary repair of dura for c	090	587.6	587.6	0	0%	22.10	24.02	1.92	9%	0			3				1	2	1	1	
61630	Balloon angioplasty, intracran	XXX	394	409	15	4%	22.07	23.39	1.32	6%	0				2			1	1		1	
61635	Transcatheter placement of in	XXX	424	430	6	1%	24.28	25.56	1.28	5%	0				2				2		1	
61640	Balloon dilatation of intracran	000	233	230	-3	-1%	12.32	12.72	0.40	3%	0									1		
61680	Surgery of intracranial arterio	090	632	674	42	7%	32.55	35.16	2.61	8%	0				3			5	1		1	
61682	Surgery of intracranial arterio	090	874	924	50	6%	63.41	66.41	3.00	5%	0				2			8	1		1	
61684	Surgery of intracranial arterio	090	717	759	42	6%	41.64	44.25	2.61	6%	0				3			5	1		1	
61686	Surgery of intracranial arterio	090	1019	1065	46	5%	67.50	70.84	3.34	5%	-2				2	1		6	1	1	1	
61690	Surgery of intracranial arterio	090	672	688	16	2%	31.34	33.48	2.14	7%	-4					2		2	3		1	
61692	Surgery of intracranial arterio	090	896	919	23	3%	54.59	57.61	3.02	6%	-4					2		4	3	1	1	
61697	Surgery of complex intracrani	090	1194	1203	9	1%	63.40	69.10	5.70	9%	-2				2	1		5	6	5	1	
61698	Surgery of complex intracrani	090	1209	1221	12	1%	69.63	74.93	5.30	8%	-2				2	1		5	6	4	1	
61700	Surgery of simple intracranial	090	949	973	24	3%	50.62	55.32	4.70	9%	-2				2	1		5	3	4	1	
61702	Surgery of simple intracranial	090	1144	1157	13	1%	60.04	65.54	5.50	9%	-2				2	1		5	5	5	1	
61703	Surgery of intracranial aneury	090	377	421	44	12%	18.80	21.12	2.32	12%	0				2			6			1	
61705	Surgery of aneurysm, vascula	090	655.5	720.5	65	10%	38.10	41.43	3.33	9%	0				2.5			9.5			1	
61708	Surgery of aneurysm, vascula	090	647.5	712.5	65	10%	37.20	40.53	3.33	9%	0				2.5			9.5			1	
61710	Surgery of aneurysm, vascula	090	551	607.5	56.5	10%	31.29	34.21	2.92	9%	0				2			8.5			1	
61711	Anastomosis, arterial, extracr	090	665.5	730.5	65	10%	38.23	41.56	3.33	9%	0				2.5			9.5			1	
61720	Creation of lesion by stereota	090	384	408	24	6%	17.62	18.98	1.36	8%	0				2			2			1	
61735	Creation of lesion by stereota	090	576.5	641.5	65	11%	22.35	25.68	3.33	15%	0				2.5			9.5			1	
61737	Laser interstitial thermal ther	000	474	471	-3	-1%	22.67	23.07	0.40	2%	0									1		
61750	Stereotactic biopsy, aspiratio	090	487	543.5	56.5	12%	19.83	22.75	2.92	15%	0				2			8.5			1	
61751	Stereotactic biopsy, aspiratio	090	395	426	31	8%	18.79	20.48	1.69	9%	0				3			2			1	
61760	Stereotactic implantation of d	090	505	536	31	6%	22.39	24.08	1.69	8%	0				3			2			1	
61770	Stereotactic localization, inclu	090	517	578.5	61.5	12%	23.19	26.35	3.16	14%	0				2			9.5			1	
61790	Creation of lesion by stereota	090	282	301	19	7%	11.60	12.72	1.12	10%	0				2			1			1	
61791	Creation of lesion by stereota	090	328	349.5	21.5	7%	15.41	16.65	1.24	8%	0				2			1.5			1	
61796	Stereotactic radiosurgery (pa	090	195	209	14	7%	13.93	14.70	0.77	6%	0				2						0.5	
61798	Stereotactic radiosurgery (pa	090	225	239	14	6%	19.85	20.62	0.77	4%	0				2						0.5	
61850	Twist drill or burr hole(s) for i	090	306.5	337	30.5	10%	13.34	15.02	1.68	13%	0				1.5			4			1	
61860	Craniectomy or craniotomy fo	090	405	451.5	46.5	11%	22.26	24.70	2.44	11%	0				2			6.5			1	
61863	Twist drill, burr hole, craniotc	090	452	470	18	4%	20.71	22.56	1.85	9%	0				3			1	2		1	
61867	Twist drill, burr hole, craniotc	090	617	635	18	3%	33.03	34.88	1.85	6%	0				3			1	2		1	
61880	Revision or removal of intracr	090	213.5	231.5	18	8%	6.95	8.03	1.08	15%	0				1.5			1.5			1	
61885	Insertion or replacement of c	090	181	195	14	8%	6.05	6.82	0.77	13%	0				2						0.5	
61886	Insertion or replacement of c	090	385	405	20	5%	9.93	11.87	1.94	20%	0				4				2		1	
61888	Revision or removal of crania	010	171	178	7	4%	5.23	5.91	0.68	13%	0			1				1			1	
62000	Elevation of depressed skull f	090	408	454.5	46.5	11%	13.93	16.37	2.44	18%	0				2			6.5			1	
62005	Elevation of depressed skull f	090	470	519	49	10%	17.63	20.19	2.56	15%	0				2			7			1	
62010	Elevation of depressed skull f	090	519.5	572	52.5	10%	21.43	24.16	2.73	13%	0				2.5			7			1	
62100	Craniotomy for repair of dura	090	549.5	597	47.5	9%	23.53	26.02	2.49	11%	0				2.5			6			1	
62115	Reduction of craniomegalic sk	090	678	728.5	50.5	7%	22.91	25.53	2.62	11%	0				4			4.5			1	
62117	Reduction of craniomegalic sk	090	714	706	-8	-1%	28.35	30.43	2.08	7%	0			3					2	2	1	
62120	Repair of encephalocele, skul	090	523	566	43	8%	24.59	26.85	2.26	9%	0				4			3			1	
62121	Craniotomy for repair of ence	090	496	545	49	10%	23.03	25.59	2.56	11%	0				2			7			1	
62140	Cranioplasty for skull defect;	090	383	414.5	31.5	8%	14.55	16.27	1.72	12%	0				2			3.5			1	
62141	Cranioplasty for skull defect;	090	413	449.5	36.5	9%	16.07	18.03	1.96	12%	0				2			4.5			1	
62142	Removal of bone flap or prost	090	324	355.5	31.5	10%	11.83	13.55	1.72	15%	0				2			3.5			1	
62143	Replacement of bone flap or	090	371	405	34	9%	14.15	15.99	1.84	13%	0				2			4			1	
62145	Cranioplasty for skull defect v	090	490	531.5	41.5	8%	20.09	22.29	2.20	11%	0				2			5.5			1	
62146	Cranioplasty with autograft (i	090	402	438.5	36.5	9%	17.28	19.24	1.96	11%	0				2			4.5			1	
62147	Cranioplasty with autograft (i	090	473	517	44	9%	20.67	22.99	2.32	11%	0				2			6			1	
62161	Neuroendoscopy, intracranial	090	400	422	22	5%	21.23	23.01	1.78	8%	0			1	2			2	1		1	
62162	Neuroendoscopy, intracranial	090	516	534	18	3%	26.80	28.78	1.98	7%	0			1	2			2	2		1	
62164	Neuroendoscopy, intracranial	090	571	587	16	3%	29.43	31.83	2.40	8%	0			2	2			2	3		1	

62165	Neuroendoscopy, intracranial	090	490	512	22	4%	23.23	25.01	1.78	8%	0			1	2			2	1		1	
62180	Ventriculocisternostomy (Tor	090	564	596	32	6%	22.58	24.71	2.13	9%	-2				1	1		4	1		1	
62190	Creation of shunt; subarachn	090	355	389	34	10%	12.17	14.01	1.84	15%	0				2			4			1	
62192	Creation of shunt; subarachn	090	351	385	34	10%	13.35	15.19	1.84	14%	0				2			4			1	
62194	Replacement or irrigation, su	010	294	313	19	6%	5.78	6.90	1.12	19%	0				2			1			1	
62200	Ventriculocisternostomy, thir	090	388	417	29	7%	19.29	20.89	1.60	8%	0				2			3			1	
62201	Ventriculocisternostomy, thir	090	425	456	31	7%	16.04	17.73	1.69	11%	0				3			2			1	
62220	Creation of shunt; ventriculo-	090	356	390	34	10%	14.10	15.94	1.84	13%	0				2			4			1	
62223	Creation of shunt; ventriculo-	090	357	388	31	9%	14.05	15.74	1.69	12%	0				3			2			1	
62225	Replacement or irrigation, ve	090	230.5	253.5	23	10%	6.19	7.51	1.32	21%	0				1.5			2.5			1	
62230	Replacement or revision of ce	090	293.5	321.5	28	10%	11.43	12.99	1.56	14%	0				1.5			3.5			1	
62256	Removal of complete cerebro	090	233.5	256.5	23	10%	7.38	8.70	1.32	18%	0				1.5			2.5			1	
62258	Removal of complete cerebro	090	366	400	34	9%	15.64	17.48	1.84	12%	0				2			4			1	
62263	Percutaneous lysis of epidura	010	214	230	16	7%	5.00	5.99	0.99	20%	0			1	2						0.5	
62264	Percutaneous lysis of epidura	010	109	109	0	0%	4.42	4.53	0.11	2%	0										0.5	
62287	Decompression procedure, pe	090	248	269	21	8%	9.03	10.13	1.10	12%	0				3						0.5	
62292	Injection procedure for chem	090	284	308	24	8%	9.24	10.60	1.36	15%	0				2			2			1	
62294	Injection procedure, arterial,	090	336	367.5	31.5	9%	12.87	14.59	1.72	13%	0				2			3.5			1	
62350	Implantation, revision or repo	010	170	177	7	4%	6.05	6.49	0.44	7%	0				1						0.5	
62351	Implantation, revision or repo	090	449	448	-1	0%	11.66	13.96	2.30	20%	0			4						3	1	
62355	Removal of previously implan	010	140	147	7	5%	3.55	3.99	0.44	12%	0				1						0.5	
62360	Implantation or replacement	010	170	177	7	4%	4.33	4.77	0.44	10%	0				1						0.5	
62361	Implantation or replacement	010	170	177	7	4%	5.00	5.44	0.44	9%	0				1						0.5	
62362	Implantation or replacement	010	170	177	7	4%	5.60	6.04	0.44	8%	0				1						0.5	
62365	Removal of subcutaneous res	010	155	162	7	5%	3.93	4.37	0.44	11%	0				1						0.5	
62380	Endoscopic decompression of	090	231	245	14	6%	0.00	N/A	N/A	N/A	0				2						0.5	
63001	Laminectomy with exploratio	090	488	529.5	41.5	9%	17.61	19.81	2.20	12%	0				2			5.5			1	
63003	Laminectomy with exploratio	090	485	526.5	41.5	9%	17.74	19.94	2.20	12%	0				2			5.5			1	
63005	Laminectomy with exploratio	090	450	477	27	6%	16.43	18.32	1.89	12%	0				3			2	1		1	
63011	Laminectomy with exploratio	090	415.5	458	42.5	10%	15.91	18.16	2.25	14%	0				2.5			5			1	
63012	Laminectomy with removal of	090	441.5	486.5	45	10%	16.85	19.22	2.37	14%	0				2.5			5.5			1	
63015	Laminectomy with exploratio	090	465	492	27	6%	20.85	22.74	1.89	9%	0				3			2	1		1	
63016	Laminectomy with exploratio	090	665.5	715.5	50	8%	22.03	24.64	2.61	12%	0				2.5			6.5			1	
63017	Laminectomy with exploratio	090	437	459	22	5%	17.33	18.98	1.65	10%	0				3			1	1		1	
63020	Laminotomy (hemilaminector	090	379	403	24	6%	15.95	17.69	1.74	11%	-2				2	1		1	1		1	
63030	Laminotomy (hemilaminector	090	305	328	23	8%	13.18	14.37	1.19	9%	-2				2	1					0.5	
63040	Laminotomy (hemilaminector	090	479.5	527	47.5	10%	20.31	22.80	2.49	12%	0				2.5			6			1	
63042	Laminotomy (hemilaminector	090	400	436	36	9%	18.76	20.69	1.93	10%	0				3			3			1	
63045	Laminectomy, facetectomy ar	090	395	417	22	6%	17.95	19.60	1.65	9%	0				3			1	1		1	
63046	Laminectomy, facetectomy ar	090	395	417	22	6%	17.25	18.90	1.65	10%	0				3			1	1		1	
63047	Laminectomy, facetectomy ar	090	362	384	22	6%	15.37	17.02	1.65	11%	0				3			1	1		1	
63050	Laminoplasty, cervical, with d	090	455	477	22	5%	22.01	23.79	1.78	8%	0			1	2			2	1		1	
63051	Laminoplasty, cervical, with d	090	495	517	22	4%	25.51	27.29	1.78	7%	0			1	2			2	1		1	
63055	Transpedicular approach with	090	520.5	570.5	50	10%	23.55	26.16	2.61	11%	0				2.5			6.5			1	
63056	Transpedicular approach with	090	490.5	538	47.5	10%	21.86	24.35	2.49	11%	0				2.5			6			1	
63064	Costovertebral approach with	090	592.5	645	52.5	9%	26.22	28.95	2.73	10%	0				2.5			7			1	
63075	Discectomy, anterior, with de	090	355	367	12	3%	19.60	20.90	1.30	7%	0			1	2				1		1	
63077	Discectomy, anterior, with de	090	517.5	562.5	45	9%	22.88	25.25	2.37	10%	0				2.5			5.5			1	
63081	Vertebral corpectomy (vertet	090	622.5	675	52.5	8%	26.10	28.83	2.73	10%	0				2.5			7			1	
63085	Vertebral corpectomy (vertet	090	721.5	781.5	60	8%	29.47	32.56	3.09	10%	0				2.5			8.5			1	
63087	Vertebral corpectomy (vertet	090	682	729	47	7%	37.53	40.38	2.85	8%	0				3			6	1		1	
63090	Vertebral corpectomy (vertet	090	741	807	66	9%	30.93	34.30	3.37	11%	0				3			9			1	
63101	Vertebral corpectomy (vertet	090	671	706	35	5%	34.10	36.89	2.79	8%	0			1	3			4	2		1	
63102	Vertebral corpectomy (vertet	090	658	693	35	5%	34.10	36.89	2.79	8%	0			1	3			4	2		1	
63170	Laminectomy with myelotom	090	623.5	676	52.5	8%	22.21	24.94	2.73	12%	0				2.5			7			1	
63172	Laminectomy with drainage o	090	581	625	44	8%	19.76	22.08	2.32	12%	0				2			6			1	
63173	Laminectomy with drainage o	090	630.5	680.5	50	8%	24.31	26.92	2.61	11%	0				2.5			6.5			1	
63185	Laminectomy with rhizotomy	090	451.5	496.5	45	10%	16.49	18.86	2.37	14%	0				2.5			5.5			1	
63190	Laminectomy with rhizotomy	090	491.5	536.5	45	9%	18.89	21.26	2.37	13%	0				2.5			5.5			1	
63191	Laminectomy with section of	090	468.5	511	42.5	9%	18.92	21.17	2.25	12%	0				2.5			5			1	
63197	Laminectomy with cordotomy	090	707.5	752.5	45	6%	24.08	26.45	2.37	10%	0				2.5			5.5			1	
63200	Laminectomy, with release of	090	589.5	637	47.5	8%	21.44	23.93	2.49	12%	0				2.5			6			1	
63250	Laminectomy for excision or d	090	941.5	1004	62.5	7%	43.86	47.07	3.21	7%	0				2.5			9			1	
63251	Laminectomy for excision or d	090	983	1056.5	73.5	7%	44.64	48.37	3.73	8%	0				3			10.5			1	
63252	Laminectomy for excision or d	090	981	1054.5	73.5	7%	44.63	48.36	3.73	8%	0				3			10.5			1	
63265	Laminectomy for excision or d	090	612.5	660	47.5	8%	23.82	26.31	2.49	10%	0				2.5			6			1	

63266	Laminectomy for excision or e	090	636.5	689	52.5	8%	24.68	27.41	2.73	11%	0				2.5			7			1	
63267	Laminectomy for excision or e	090	480.5	528	47.5	10%	19.45	21.94	2.49	13%	0				2.5			6			1	
63268	Laminectomy for excision or e	090	498.5	546	47.5	10%	20.02	22.51	2.49	12%	0				2.5			6			1	
63270	Laminectomy for excision of i	090	781.5	839	57.5	7%	29.80	32.77	2.97	10%	0				2.5			8			1	
63271	Laminectomy for excision of i	090	779.5	837	57.5	7%	29.92	32.89	2.97	10%	0				2.5			8			1	
63272	Laminectomy for excision of i	090	648.5	703.5	55	8%	27.50	30.35	2.85	10%	0				2.5			7.5			1	
63273	Laminectomy for excision of i	090	648.5	703.5	55	8%	26.47	29.32	2.85	11%	0				2.5			7.5			1	
63275	Laminectomy for biopsy/excis	090	654.5	709.5	55	8%	25.86	28.71	2.85	11%	0				2.5			7.5			1	
63276	Laminectomy for biopsy/excis	090	659.5	717	57.5	9%	25.69	28.66	2.97	12%	0				2.5			8			1	
63277	Laminectomy for biopsy/excis	090	544.5	594.5	50	9%	22.39	25.00	2.61	12%	0				2.5			6.5			1	
63278	Laminectomy for biopsy/excis	090	546.5	596.5	50	9%	22.12	24.73	2.61	12%	0				2.5			6.5			1	
63280	Laminectomy for biopsy/excis	090	669	732.5	63.5	9%	30.29	33.54	3.25	11%	0				3			8.5			1	
63281	Laminectomy for biopsy/excis	090	669	732.5	63.5	9%	29.99	33.24	3.25	11%	0				3			8.5			1	
63282	Laminectomy for biopsy/excis	090	623	679	56	9%	28.15	31.04	2.89	10%	0				3			7			1	
63283	Laminectomy for biopsy/excis	090	618	674	56	9%	26.76	29.65	2.89	11%	0				3			7			1	
63285	Laminectomy for biopsy/excis	090	762	830.5	68.5	9%	38.05	41.54	3.49	9%	0				3			9.5			1	
63286	Laminectomy for biopsy/excis	090	747	813	66	9%	37.62	40.99	3.37	9%	0				3			9			1	
63287	Laminectomy for biopsy/excis	090	931	1002	71	8%	40.08	43.69	3.61	9%	0				3			10			1	
63290	Laminectomy for biopsy/excis	090	960	1033.5	73.5	8%	40.82	44.55	3.73	9%	0				3			10.5			1	
63300	Vertebral corpectomy (vertek	090	638.5	691	52.5	8%	26.80	29.53	2.73	10%	0				2.5			7			1	
63301	Vertebral corpectomy (vertek	090	950	1023.5	73.5	8%	31.57	35.30	3.73	12%	0				3			10.5			1	
63302	Vertebral corpectomy (vertek	090	871	939.5	68.5	8%	31.15	34.64	3.49	11%	0				3			9.5			1	
63303	Vertebral corpectomy (vertek	090	809.5	869.5	60	7%	33.55	36.64	3.09	9%	0				2.5			8.5			1	
63304	Vertebral corpectomy (vertek	090	845	911	66	8%	33.85	37.22	3.37	10%	0				3			9			1	
63305	Vertebral corpectomy (vertek	090	1004	1077.5	73.5	7%	36.24	39.97	3.73	10%	0				3			10.5			1	
63306	Vertebral corpectomy (vertek	090	871	939.5	68.5	8%	35.55	39.04	3.49	10%	0				3			9.5			1	
63307	Vertebral corpectomy (vertek	090	863	931.5	68.5	8%	34.96	38.45	3.49	10%	0				3			9.5			1	
63600	Creation of lesion of spinal co	090	364	398	34	9%	15.12	16.96	1.84	12%	0				2			4			1	
63620	Stereotactic radiosurgery (pa	090	195	209	14	7%	15.60	16.37	0.77	5%	0				2						0.5	
63650	Percutaneous implantation of	010	170	177	7	4%	7.15	7.59	0.44	6%	0				1						0.5	
63655	Laminectomy for implantation	090	254	270	16	6%	10.92	11.91	0.99	9%	0			1	2						0.5	
63661	Removal of spinal neurostimu	010	165	172	7	4%	5.08	5.52	0.44	9%	0				1						0.5	
63662	Removal of spinal neurostimu	090	243	259	16	7%	11.00	12.10	1.10	10%	0			1	2						1	
63663	Revision including replacemer	010	200	207	7	3%	7.75	8.19	0.44	6%	0				1						0.5	
63664	Revision including replacemer	090	273	289	16	6%	11.52	12.62	1.10	10%	0			1	2						1	
63685	Insertion or replacement of s	010	170	177	7	4%	5.19	5.63	0.44	8%	0				1						0.5	
63688	Revision or removal of implar	010	165	172	7	4%	5.30	5.74	0.44	8%	0				1						0.5	
63700	Repair of meningocele; less th	090	401	437	36	9%	17.47	19.40	1.93	11%	0				3			3			1	
63702	Repair of meningocele; larger	090	463	499	36	8%	19.41	21.34	1.93	10%	0				3			3			1	
63704	Repair of myelomeningocele;	090	609	677	68	11%	22.43	25.89	3.46	15%	0				4			8			1	
63706	Repair of myelomeningocele;	090	679	747	68	10%	25.35	28.81	3.46	14%	0				4			8			1	
63707	Repair of dural/cerebrospinal	090	377.5	420	42.5	11%	12.65	14.90	2.25	18%	0				2.5			5			1	
63709	Repair of dural/cerebrospinal	090	426.5	466.5	40	9%	15.65	17.78	2.13	14%	0				2.5			4.5			1	
63710	Dural graft, spinal	090	407.5	447.5	40	10%	15.40	17.53	2.13	14%	0				2.5			4.5			1	
63740	Creation of shunt, lumbar, su	090	378.5	416	37.5	10%	12.63	14.64	2.01	16%	0				2.5			4			1	
63741	Creation of shunt, lumbar, su	090	289	313	24	8%	9.12	10.48	1.36	15%	0				2			2			1	
63744	Replacement, irrigation or rev	090	282.5	308	25.5	9%	8.94	10.38	1.44	16%	0				1.5			3			1	
63746	Removal of entire lumbosuba	090	254.5	282.5	28	11%	7.33	8.89	1.56	21%	0				1.5			3.5			1	
64553	Percutaneous implantation of	010	160	167	7	4%	6.13	6.57	0.44	7%	0				1						0.5	
64555	Percutaneous implantation of	010	145	152	7	5%	5.76	6.20	0.44	8%	0				1						0.5	
64561	Percutaneous implantation of	010	131	140	9	7%	5.44	5.86	0.42	8%	-2					1						
64568	Open implantation of cranial	090	275	294	19	7%	9.00	10.12	1.12	12%	0				2			1			1	
64569	Revision or replacement of cr	090	312	331	19	6%	11.00	12.12	1.12	10%	0				2			1			1	
64570	Removal of cranial nerve (eg,	090	259	271	12	5%	9.10	9.89	0.79	9%	0				1			1			1	
64575	Open implantation of neurost	090	78	81	3	4%	4.42	4.75	0.33	7%	0			1.5								
64580	Open implantation of neurost	090	79	82	3	4%	4.19	4.52	0.33	8%	0			1.5								
64581	Open implantation of neurost	090	269	278	9	3%	12.20	12.73	0.53	4%	-2					1					0.5	
64582	Open implantation of hypoglo	090	294	308	14	5%	14.00	14.77	0.77	5%	0				2						0.5	
64583	Revision or replacement of hy	090	309	323	14	5%	14.50	15.27	0.77	5%	0				2						0.5	
64584	Removal of hypoglossal nerve	090	275	289	14	5%	12.00	12.77	0.77	6%	0				2						0.5	
64585	Revision or removal of periph	010	58	60	2	3%	2.11	2.33	0.22	10%	0			1								
64590	Insertion or replacement of p	010	74	76	2	3%	2.45	2.67	0.22	9%	0			1								
64595	Revision or removal of periph	010	66	68	2	3%	1.78	2.00	0.22	12%	0			1								
64600	Destruction by neurolytic age	010	77	79	2	3%	3.49	3.71	0.22	6%	0			1								
64605	Destruction by neurolytic age	010	103	105	2	2%	5.65	5.87	0.22	4%	0			1								
64610	Destruction by neurolytic age	010	140	142	2	1%	7.20	7.42	0.22	3%	0			1								

64611	Chemodenervation of parotic	010	36	38	2	6%	1.03	1.25	0.22	21%	0			1								
64612	Chemodenervation of muscle	010	41	43	2	5%	1.41	1.63	0.22	16%	0			1								
64620	Destruction by neurolytic age	010	76	78	2	3%	2.89	3.11	0.22	8%	0			1								
64624	Destruction by neurolytic age	010	74	76	2	3%	2.50	2.72	0.22	9%	0			1								
64625	Radiofrequency ablation, ner	010	98	105	7	7%	3.39	3.83	0.44	13%	0				1						0.5	
64628	Thermal destruction of intrao	010	178	185	7	4%	7.15	7.59	0.44	6%	0				1						0.5	
64630	Destruction by neurolytic age	010	78	80	2	3%	3.05	3.27	0.22	7%	0			1								
64632	Destruction by neurolytic age	010	36	38	2	6%	1.23	1.45	0.22	18%	0			1								
64633	Destruction by neurolytic age	010	100	107	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
64635	Destruction by neurolytic age	010	100	107	7	7%	3.32	3.76	0.44	13%	0				1						0.5	
64640	Destruction by neurolytic age	010	64	66	2	3%	1.98	2.20	0.22	11%	0			1								
64680	Destruction by neurolytic age	010	98	100	2	2%	2.67	2.89	0.22	8%	0			1								
64681	Destruction by neurolytic age	010	122	132	10	8%	3.78	4.26	0.48	13%	0							2				
64702	Neuroplasty; digital, 1 or both	090	212	230	18	8%	6.26	7.47	1.21	19%	0			2	2						0.5	
64704	Neuroplasty; nerve of hand o	090	152	157	5	3%	4.69	5.24	0.55	12%	0			2.5								
64708	Neuroplasty, major peripher	090	220	233	13	6%	6.36	7.46	1.10	17%	0			3	1						0.5	
64712	Neuroplasty, major peripher	090	294	307.5	13.5	5%	8.07	9.31	1.24	15%	0			3				1.5			1	
64713	Neuroplasty, major peripher	090	429	446	17	4%	11.40	12.87	1.47	13%	0			3.5				2			1	
64714	Neuroplasty, major peripher	090	364	373.5	9.5	3%	10.55	11.66	1.11	11%	0			3.5				0.5			1	
64716	Neuroplasty and/or transposi	090	182	198	16	9%	6.99	7.87	0.88	13%	0			1	2							
64718	Neuroplasty and/or transposi	090	250	278	28	11%	7.26	8.69	1.43	20%	0				4						0.5	
64719	Neuroplasty and/or transposi	090	149	154	5	3%	4.97	5.52	0.55	11%	0			2.5								
64721	Neuroplasty and/or transposi	090	171	187	16	9%	4.97	5.96	0.99	20%	0			1	2						0.5	
64722	Decompression; unspecified r	090	159	164	5	3%	4.82	5.48	0.66	14%	0			2.5							0.5	
64726	Decompression; plantar digita	090	151	155	4	3%	4.27	4.82	0.55	13%	0			2							0.5	
64732	Transection or avulsion of; su	090	132.5	143	10.5	8%	4.89	5.50	0.61	12%	0				1.5						0.5	
64734	Transection or avulsion of; int	090	186	200	14	8%	5.55	6.43	0.88	16%	0				2						1	
64736	Transection or avulsion of; m	090	139	153	14	10%	5.23	5.89	0.66	13%	0				2							
64738	Transection or avulsion of; int	090	173	187	14	8%	6.36	7.13	0.77	12%	0				2						0.5	
64740	Transection or avulsion of; lin	090	166	180	14	8%	6.22	6.99	0.77	12%	0				2						0.5	
64742	Transection or avulsion of; fa	090	179	193	14	8%	6.85	7.62	0.77	11%	0				2						0.5	
64744	Transection or avulsion of; gr	090	192.5	203	10.5	5%	5.72	6.44	0.72	13%	0				1.5						1	
64746	Transection or avulsion of; ph	090	177	191	14	8%	6.56	7.33	0.77	12%	0				2						0.5	
64755	Transection or avulsion of; va	090	360	377	17	5%	15.05	17.14	2.09	14%	0			1	1			3	1	1	1	
64760	Transection or avulsion of; va	090	212	226	14	7%	7.59	8.47	0.88	12%	0				2						1	
64763	Transection or avulsion of ob	090	210	224	14	7%	7.56	8.33	0.77	10%	0				2						0.5	
64766	Transection or avulsion of ob	090	239.5	257	17.5	7%	9.47	10.41	0.94	10%	0				2.5						0.5	
64771	Transection or avulsion of oth	090	236.5	254	17.5	7%	8.15	9.09	0.94	11%	0				2.5						0.5	
64772	Transection or avulsion of oth	090	245	259	14	6%	7.84	8.72	0.88	11%	0				2						1	
64774	Excision of neuroma; cutaneo	090	174	188	14	8%	5.80	6.57	0.77	13%	0				2						0.5	
64776	Excision of neuroma; digital n	090	158.5	169	10.5	7%	5.60	6.21	0.61	11%	0				1.5						0.5	
64782	Excision of neuroma; hand or	090	235	249	14	6%	6.86	7.74	0.88	13%	0				2						1	
64784	Excision of neuroma; major p	090	257.5	275	17.5	7%	10.62	11.56	0.94	9%	0				2.5						0.5	
64786	Excision of neuroma; sciatic n	090	291.5	309	17.5	6%	16.25	17.19	0.94	6%	0				2.5						0.5	
64788	Excision of neurofibroma or n	090	183	197	14	8%	5.24	6.01	0.77	15%	0				2						0.5	
64790	Excision of neurofibroma or n	090	331.5	349	17.5	5%	12.10	13.04	0.94	8%	0				2.5						0.5	
64792	Excision of neurofibroma or n	090	416	437	21	5%	15.86	17.07	1.21	8%	0				3						1	
64802	Sympathectomy, cervical	090	354.5	389.5	35	10%	10.37	12.26	1.89	18%	0				2.5			3.5			1	
64804	Sympathectomy, cervicothora	090	389.5	427	37.5	10%	15.91	17.92	2.01	13%	0				2.5			4			1	
64809	Sympathectomy, thoracolumb	090	336	367.5	31.5	9%	14.71	16.43	1.72	12%	0				2			3.5			1	
64818	Sympathectomy, lumbar	090	345	376.5	31.5	9%	11.34	13.06	1.72	15%	0				2			3.5			1	
64820	Sympathectomy; digital arter	090	268	277	9	3%	10.74	11.29	0.55	5%	-4		2	1	1							
64821	Sympathectomy; radial artery	090	269	287	18	7%	9.33	10.78	1.45	16%	0			3	1			1			1	
64822	Sympathectomy; ulnar artery	090	269	287	18	7%	9.33	10.78	1.45	16%	0			3	1			1			1	
64823	Sympathectomy; superficial p	090	299	317	18	6%	10.94	12.39	1.45	13%	0			3	1			1			1	
64831	Suture of digital nerve, hand	090	237	255	18	8%	9.16	10.37	1.21	13%	0			2	2						0.5	
64834	Suture of 1 nerve; hand or fo	090	226	240	14	6%	10.81	11.69	0.88	8%	0				2						1	
64835	Suture of 1 nerve; median mo	090	259.5	277	17.5	7%	11.73	12.78	1.05	9%	0				2.5						1	
64836	Suture of 1 nerve; ulnar moto	090	260.5	278	17.5	7%	11.73	12.78	1.05	9%	0				2.5						1	
64840	Suture of posterior tibial nerv	090	356	379.5	23.5	7%	14.02	15.35	1.33	9%	0				3			0.5			1	
64856	Suture of major peripheral ne	090	415.5	453	37.5	9%	15.07	17.08	2.01	13%	0				2.5			4			1	
64857	Suture of major peripheral ne	090	428.5	468.5	40	9%	15.82	17.95	2.13	13%	0				2.5			4.5			1	
64858	Suture of sciatic nerve	090	442.5	482.5	40	9%	17.82	19.95	2.13	12%	0				2.5			4.5			1	
64861	Suture of; brachial plexus	090	549	600	51	9%	20.89	23.54	2.65	13%	0				3			6			1	
64862	Suture of; lumbar plexus	090	531	582	51	10%	21.09	23.74	2.65	13%	0				3			6			1	
64864	Suture of facial nerve; extrac	090	321	345	24	7%	13.41	14.77	1.36	10%	0				2			2			1	

64865	Suture of facial nerve; infrate	090	365.5	385.5	20	5%	16.09	17.26	1.17	7%	0				2.5			0.5			1	
64866	Anastomosis; facial-spinal acc	090	391.5	421.5	30	8%	16.83	18.48	1.65	10%	0				2.5			2.5			1	
64868	Anastomosis; facial-hypoglos	090	351	375	24	7%	14.90	16.26	1.36	9%	0				2			2			1	
64885	Nerve graft (includes obtainir	090	325	339	14	4%	17.60	18.48	0.88	5%	0				2						1	
64886	Nerve graft (includes obtainir	090	411	426	15	4%	20.82	22.14	1.32	6%	0				2			1	1		1	
64890	Nerve graft (includes obtainir	090	403.5	433.5	30	7%	16.24	17.89	1.65	10%	0				2.5			2.5			1	
64891	Nerve graft (includes obtainir	090	424.5	459.5	35	8%	17.35	19.24	1.89	11%	0				2.5			3.5			1	
64892	Nerve graft (includes obtainir	090	396.5	426.5	30	8%	15.74	17.39	1.65	10%	0				2.5			2.5			1	
64893	Nerve graft (includes obtainir	090	439.5	477	37.5	9%	16.87	18.88	2.01	12%	0				2.5			4			1	
64895	Nerve graft (includes obtainir	090	458.5	491	32.5	7%	20.39	22.16	1.77	9%	0				2.5			3			1	
64896	Nerve graft (includes obtainir	090	523	566.5	43.5	8%	21.96	24.25	2.29	10%	0				3			4.5			1	
64897	Nerve graft (includes obtainir	090	480.5	513	32.5	7%	19.38	21.15	1.77	9%	0				2.5			3			1	
64898	Nerve graft (includes obtainir	090	531	574.5	43.5	8%	20.97	23.26	2.29	11%	0				3			4.5			1	
64905	Nerve pedicle transfer; first s	090	383.5	413.5	30	8%	15.11	16.76	1.65	11%	0				2.5			2.5			1	
64907	Nerve pedicle transfer; secon	090	404.5	439.5	35	9%	20.03	21.92	1.89	9%	0				2.5			3.5			1	
64910	Nerve repair; with synthetic c	090	257	280	23	9%	10.52	11.84	1.32	13%	0			1	3						0.5	
64911	Nerve repair; with autogenou	090	292	315	23	8%	14.00	15.32	1.32	9%	0			1	3						0.5	
64912	Nerve repair; with nerve allog	090	272	295	23	8%	12.00	13.32	1.32	11%	0			1	3						0.5	
65091	Evisceration of ocular content	090	164.5	182	17.5	11%	7.26	8.20	0.94	13%	0				2.5						0.5	
65093	Evisceration of ocular content	090	214	221	7	3%	7.04	8.03	0.99	14%	0			3.5							1	
65101	Enucleation of eye; without in	090	232	260	28	12%	8.30	9.73	1.43	17%	0				4						0.5	
65103	Enucleation of eye; with impl	090	237	265	28	12%	8.84	10.27	1.43	16%	0				4						0.5	
65105	Enucleation of eye; with impl	090	269.5	301	31.5	12%	9.93	11.53	1.60	16%	0				4.5						0.5	
65110	Exenteration of orbit (does no	090	370.5	409	38.5	10%	15.70	17.74	2.04	13%	0				5.5						1	
65112	Exenteration of orbit (does no	090	434.5	482.5	48	11%	18.51	21.00	2.49	13%	0				6.5			0.5			1	
65114	Exenteration of orbit (does no	090	446.5	494.5	48	11%	19.65	22.14	2.49	13%	0				6.5			0.5			1	
65125	Modification of ocular implan	090	148	154	6	4%	3.27	3.93	0.66	20%	0			3								
65130	Insertion of ocular implant se	090	200	228	28	14%	8.42	9.74	1.32	16%	0				4							
65135	Insertion of ocular implant se	090	207	235	28	14%	8.60	9.92	1.32	15%	0				4							
65140	Insertion of ocular implant se	090	255.5	287	31.5	12%	9.46	11.06	1.60	17%	0				4.5						0.5	
65150	Reinsertion of ocular implant,	090	187	194	7	4%	6.43	7.31	0.88	14%	0			3.5							0.5	
65155	Reinsertion of ocular implant,	090	259.5	291	31.5	12%	10.10	11.59	1.49	15%	0				4.5							
65175	Removal of ocular implant	090	174.5	199	24.5	14%	7.40	8.56	1.16	16%	0				3.5							
65235	Removal of foreign body, intr	090	185.5	217	31.5	17%	9.01	10.50	1.49	16%	0				4.5							
65260	Removal of foreign body, intr	090	270	305	35	13%	12.54	14.30	1.76	14%	0				5						0.5	
65265	Removal of foreign body, intr	090	291.5	330	38.5	13%	14.34	16.16	1.82	13%	0				5.5							
65270	Repair of laceration; conjunct	010	67	69	2	3%	1.95	2.17	0.22	11%	0			1								
65272	Repair of laceration; conjunct	090	115.5	133	17.5	15%	4.62	5.45	0.83	18%	0				2.5							
65273	Repair of laceration; conjunct	090	164.5	182	17.5	11%	5.16	6.21	1.05	20%	0				2.5						1	
65275	Repair of laceration; cornea, r	090	146	167	21	14%	6.29	7.28	0.99	16%	0				3							
65280	Repair of laceration; cornea a	090	249.5	281	31.5	13%	9.10	10.70	1.60	18%	0				4.5						0.5	
65285	Repair of laceration; cornea a	090	353	397	44	12%	15.36	17.67	2.31	15%	0			1	6						0.5	
65286	Repair of laceration; applicati	090	172.5	197	24.5	14%	6.63	7.79	1.16	17%	0				3.5							
65290	Repair of wound, extraocular	090	178.5	203	24.5	14%	6.53	7.69	1.16	18%	0				3.5							
65400	Excision of lesion, cornea (ker	090	189.5	221	31.5	17%	7.50	8.99	1.49	20%	0				4.5							
65420	Excision or transposition of pt	090	149	157	8	5%	4.36	5.24	0.88	20%	0			4								
65426	Excision or transposition of pt	090	162.5	170.5	8	5%	6.05	7.04	0.99	16%	0			4							0.5	
65436	Removal of corneal epitheliur	090	101	115	14	14%	4.82	5.48	0.66	14%	0				2							
65450	Destruction of lesion of corne	090	117	125	8	7%	3.47	4.35	0.88	25%	0			4								
65600	Multiple punctures of anterio	090	115.5	133	17.5	15%	4.20	5.03	0.83	20%	0				2.5							
65710	Keratoplasty (corneal transpla	090	317	363	46	15%	14.45	16.61	2.16	15%	-4				4	2						
65730	Keratoplasty (corneal transpla	090	322	368	46	14%	16.35	18.51	2.16	13%	-4				4	2						
65750	Keratoplasty (corneal transpla	090	288	330	42	15%	16.90	18.88	1.98	12%	0				6							
65755	Keratoplasty (corneal transpla	090	288	330	42	15%	16.79	18.77	1.98	12%	0				6							
65756	Keratoplasty (corneal transpla	090	255	282	27	11%	16.84	18.60	1.76	10%	0			3	3						0.5	
65770	Keratoprosthesis	090	456.5	507	50.5	11%	19.74	22.35	2.61	13%	0				6.5			1			1	
65772	Corneal relaxing incision for c	090	128.5	146	17.5	14%	5.09	5.92	0.83	16%	0				2.5							
65775	Corneal wedge resection for c	090	168.5	193	24.5	15%	6.91	8.07	1.16	17%	0				3.5							
65780	Ocular surface reconstruction	090	230	254	24	10%	7.81	9.68	1.87	24%	0			5	2						0.5	
65781	Ocular surface reconstruction	090	354	374	20	6%	18.14	20.45	2.31	13%	0			10							0.5	
65782	Ocular surface reconstruction	090	331	349	18	5%	15.43	17.52	2.09	14%	0			9							0.5	
65785	Implantation of intrastromal c	090	134	147	13	10%	5.39	6.38	0.99	18%	0			3	1							
65810	Paracentesis of anterior cham	090	142	163	21	15%	5.82	6.81	0.99	17%	0				3							
65815	Paracentesis of anterior cham	090	152	173	21	14%	6.00	6.99	0.99	17%	0				3							
65820	Goniotomy	090	244	264	20	8%	8.91	10.23	1.32	15%	0			3	2							
65850	Trabeculotomy ab externo	090	233	243	10	4%	11.39	12.71	1.32	12%	0			5							1	

65855	Trabeculoplasty by laser surg	010	61	63	2	3%	3.00	3.22	0.22	7%	0			1								
65860	Severing adhesions of anteric	090	120	122	2	2%	3.59	3.81	0.22	6%	0			1								
65865	Severing adhesions of anteric	090	135	142	7	5%	5.77	6.54	0.77	13%	0			3.5								
65870	Severing adhesions of anteric	090	165.5	190	24.5	15%	7.39	8.55	1.16	16%	0				3.5							
65875	Severing adhesions of anteric	090	178	206	28	16%	7.81	9.13	1.32	17%	0				4							
65880	Severing adhesions of anteric	090	185	213	28	15%	8.36	9.68	1.32	16%	0				4							
65900	Removal of epithelial downgr	090	246	281	35	14%	12.51	14.16	1.65	13%	0				5							
65920	Removal of implanted materi	090	214	249	35	16%	9.99	11.64	1.65	17%	0				5							
65930	Removal of blood clot, anteri	090	176	197	21	12%	8.39	9.49	1.10	13%	0				3						0.5	
66020	Injection, anterior chamber o	010	52	54	2	4%	1.64	1.86	0.22	13%	0			1								
66030	Injection, anterior chamber o	010	51	53	2	4%	1.30	1.52	0.22	17%	0			1								
66130	Excision of lesion, sclera	090	131	137	6	5%	7.83	8.49	0.66	8%	0			3								
66150	Fistulization of sclera for glau	090	269	318	49	18%	10.53	12.84	2.31	22%	0				7							
66155	Fistulization of sclera for glau	090	284	333	49	17%	10.52	12.94	2.42	23%	0				7						0.5	
66160	Fistulization of sclera for glau	090	266	315	49	18%	12.39	14.70	2.31	19%	0				7							
66170	Fistulization of sclera for glau	090	278	321	43	15%	13.94	16.58	2.64	19%	0			4	5						0.5	
66172	Fistulization of sclera for glau	090	325	372	47	14%	14.84	17.92	3.08	21%	0			6	5						0.5	
66174	Transluminal dilation of aque	090	173	203	30	17%	7.62	9.27	1.65	22%	0			1	4						0.5	
66175	Transluminal dilation of aque	090	184	214	30	16%	9.34	10.99	1.65	18%	0			1	4						0.5	
66179	Aqueous shunt to extraocular	090	272	313	41	15%	14.00	16.42	2.42	17%	0			3	5						0.5	
66180	Aqueous shunt to extraocular	090	277	318	41	15%	15.00	17.42	2.42	16%	0			3	5						0.5	
66183	Insertion of anterior segment	090	257	298	41	16%	13.20	15.62	2.42	18%	0			3	5						0.5	
66184	Revision of aqueous shunt to	090	254	288	34	13%	9.58	11.67	2.09	22%	0			3	4						0.5	
66185	Revision of aqueous shunt to	090	259	293	34	13%	10.58	12.67	2.09	20%	0			3	4						0.5	
66225	Repair of scleral staphyloma \	090	294	329	35	12%	12.63	14.28	1.65	13%	0				5							
66250	Revision or repair of operativ	090	175.5	200	24.5	14%	7.10	8.26	1.16	16%	0				3.5							
66500	Iridotomy by stab incision (se	090	103	108	5	5%	3.83	4.38	0.55	14%	0			2.5								
66505	Iridotomy by stab incision (se	090	108	114	6	6%	4.22	4.88	0.66	16%	0			3								
66600	Iridectomy, with corneoscleral	090	211.5	243	31.5	15%	10.12	11.61	1.49	15%	0				4.5							
66605	Iridectomy, with corneoscleral	090	221.5	253	31.5	14%	14.22	15.71	1.49	10%	0				4.5							
66625	Iridectomy, with corneoscleral	090	132	139	7	5%	5.30	6.07	0.77	15%	0			3.5								
66630	Iridectomy, with corneoscleral	090	171.5	196	24.5	14%	7.28	8.44	1.16	16%	0				3.5							
66635	Iridectomy, with corneoscleral	090	167.5	192	24.5	15%	7.37	8.53	1.16	16%	0				3.5							
66680	Repair of iris, ciliary body (as	090	159	180	21	13%	6.39	7.38	0.99	15%	0				3							
66682	Suture of iris, ciliary body (se	090	169.5	194	24.5	14%	7.33	8.49	1.16	16%	0				3.5							
66700	Ciliary body destruction; diath	090	146	155	9	6%	5.14	5.69	0.55	11%	0			1	1							
66710	Ciliary body destruction; cyclo	090	140	149	9	6%	5.14	5.69	0.55	11%	0			1	1							
66711	Ciliary body destruction; cyclo	090	191	221	30	16%	5.62	7.27	1.65	29%	0			1	4						0.5	
66720	Ciliary body destruction; cryo	090	146	155	9	6%	4.75	5.74	0.99	21%	0			4.5								
66740	Ciliary body destruction; cyclo	090	140	149	9	6%	5.14	5.69	0.55	11%	0			1	1							
66761	Iridotomy/iridectomy by laser	010	66	75	9	14%	3.00	3.55	0.55	18%	0			1	1							
66762	Iridoplasty by photocoagulati	090	123.5	141	17.5	14%	5.38	6.21	0.83	15%	0				2.5							
66770	Destruction of cyst or lesion i	090	132	153	21	16%	6.13	7.12	0.99	16%	0				3							
66820	Discission of secondary meml	090	113	118	5	4%	4.01	4.56	0.55	14%	0			2.5								
66821	Discission of secondary meml	090	82	96	14	17%	3.42	4.08	0.66	19%	0				2							
66825	Repositioning of intraocular le	090	219	239	20	9%	9.01	10.33	1.32	15%	0			3	2							
66830	Removal of secondary membr	090	189	217	28	15%	9.47	10.79	1.32	14%	0				4							
66840	Removal of lens material; aspi	090	183	211	28	15%	9.18	10.50	1.32	14%	0				4							
66850	Removal of lens material; pha	090	207.5	239	31.5	15%	10.55	12.04	1.49	14%	0				4.5							
66852	Removal of lens material; par	090	206.5	238	31.5	15%	11.41	12.90	1.49	13%	0				4.5							
66920	Removal of lens material; intr	090	188	216	28	15%	10.13	11.45	1.32	13%	0				4							
66930	Removal of lens material; intr	090	210.5	242	31.5	15%	11.61	13.10	1.49	13%	0				4.5							
66940	Removal of lens material; ext	090	198.5	230	31.5	16%	10.37	11.86	1.49	14%	0				4.5							
66982	Extracapsular cataract remov	090	175	198	23	13%	10.25	11.57	1.32	13%	0			1	3						0.5	
66984	Extracapsular cataract remov	090	126	142	16	13%	7.35	8.34	0.99	13%	0			1	2						0.5	
66985	Insertion of intraocular lens p	090	227	262	35	15%	9.98	11.63	1.65	17%	0				5							
66989	Extracapsular cataract remov	090	176	199	23	13%	12.13	13.45	1.32	11%	0			1	3						0.5	
66991	Extracapsular cataract remov	090	172	195	23	13%	9.23	10.55	1.32	14%	0			1	3						0.5	
67005	Removal of vitreous, anterior	090	147	155	8	5%	5.89	6.77	0.88	15%	0			4								
67010	Removal of vitreous, anterior	090	156	164	8	5%	7.06	7.94	0.88	12%	0			4								
67015	Aspiration or release of vitreo	090	171	180	9	5%	7.14	8.13	0.99	14%	0			4.5								
67025	Injection of vitreous substitut	090	190	218	28	15%	8.11	9.43	1.32	16%	0				4							
67027	Implantation of intravitreal dr	090	244	264	20	8%	11.62	12.94	1.32	11%	0			3	2							
67030	Discission of vitreous strands	090	167	195	28	17%	6.11	7.43	1.32	22%	0				4							
67031	Severing of vitreous strands,	090	109.5	127	17.5	16%	4.47	5.30	0.83	18%	0				2.5							
67036	Vitrectomy, mechanical, pars	090	250	285	35	14%	12.13	13.89	1.76	15%	0				5						0.5	

67039	Vitrectomy, mechanical, pars	090	260	295	35	13%	13.20	14.96	1.76	13%	0				5						0.5	
67040	Vitrectomy, mechanical, pars	090	273	308	35	13%	14.50	16.26	1.76	12%	0				5						0.5	
67041	Vitrectomy, mechanical, pars	090	260	295	35	13%	16.33	18.09	1.76	11%	0				5						0.5	
67042	Vitrectomy, mechanical, pars	090	260	295	35	13%	16.33	18.09	1.76	11%	0				5						0.5	
67043	Vitrectomy, mechanical, pars	090	275	310	35	13%	17.40	19.16	1.76	10%	0				5						0.5	
67101	Repair of retinal detachment,	010	145	159	14	10%	3.50	4.27	0.77	22%	0				2						0.5	
67105	Repair of retinal detachment,	010	97	111	14	14%	3.39	4.05	0.66	19%	0				2							
67107	Repair of retinal detachment,	090	290	325	35	12%	16.00	17.76	1.76	11%	0				5						0.5	
67108	Repair of retinal detachment,	090	295	330	35	12%	17.13	18.89	1.76	10%	0				5						0.5	
67110	Repair of retinal detachment,	090	196	238	42	21%	10.25	12.23	1.98	19%	0				6							
67113	Repair of complex retinal det	090	348	390	42	12%	19.00	21.09	2.09	11%	0				6						0.5	
67115	Release of encircling material	090	158.5	183	24.5	15%	6.11	7.27	1.16	19%	0				3.5							
67120	Removal of implanted materi	090	162.5	187	24.5	15%	7.10	8.26	1.16	16%	0				3.5							
67121	Removal of implanted materi	090	280	315	35	13%	12.25	13.90	1.65	13%	0				5							
67141	Prophylaxis of retinal detachr	010	77	91	14	18%	2.53	3.19	0.66	26%	0				2							
67145	Prophylaxis of retinal detachr	010	76	90	14	18%	2.53	3.19	0.66	26%	0				2							
67208	Destruction of localized lesion	090	137	158	21	15%	7.65	8.64	0.99	13%	0				3							
67210	Destruction of localized lesion	090	106	127	21	20%	6.36	7.35	0.99	16%	0				3							
67218	Destruction of localized lesion	090	464	476	12	3%	20.36	22.85	2.49	12%	0			3	1			2	2	1	1	
67220	Destruction of localized lesion	090	117.5	138.5	21	18%	6.36	7.35	0.99	16%	0				3							
67227	Destruction of extensive or pr	010	93	100	7	8%	3.50	3.94	0.44	13%	0				1						0.5	
67228	Treatment of extensive or pro	010	81	88	7	9%	4.39	4.72	0.33	8%	0				1							
67229	Treatment of extensive or pro	090	353.5	391.5	38	11%	16.30	18.70	2.40	15%	0				6				1		1	
67250	Scleral reinforcement (separa	090	210	231	21	10%	9.61	10.60	0.99	10%	0				3							
67255	Scleral reinforcement (separa	090	216	243	27	13%	8.38	10.14	1.76	21%	0			3	3						0.5	
67311	Strabismus surgery, recessior	090	144	155	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67312	Strabismus surgery, recessior	090	159	170	11	7%	9.50	10.38	0.88	9%	0			2	1						0.5	
67314	Strabismus surgery, recessior	090	145	156	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67316	Strabismus surgery, recessior	090	164	175	11	7%	10.31	11.19	0.88	9%	0			2	1						0.5	
67318	Strabismus surgery, any proc	090	166	182	16	10%	9.80	10.79	0.99	10%	0			1	2						0.5	
67343	Release of extensive scar tiss	090	167.5	192	24.5	15%	8.47	9.63	1.16	14%	0				3.5							
67345	Chemodenervation of extraoc	010	58	60	2	3%	3.01	3.23	0.22	7%	0			1								
67400	Orbitotomy without bone flap	090	255.5	287	31.5	12%	11.20	12.80	1.60	14%	0				4.5						0.5	
67405	Orbitotomy without bone flap	090	209	237	28	13%	9.20	10.63	1.43	16%	0				4						0.5	
67412	Orbitotomy without bone flap	090	234.5	252	17.5	7%	10.30	11.24	0.94	9%	0				2.5						0.5	
67413	Orbitotomy without bone flap	090	220	230	10	5%	10.24	11.34	1.10	11%	0			5								
67414	Orbitotomy without bone flap	090	347	361	14	4%	17.94	19.33	1.39	8%	-2			1	1	1			1		1	
67420	Orbitotomy with bone flap or	090	468	513	45	10%	21.87	24.22	2.35	11%	0				5			2			1	
67430	Orbitotomy with bone flap or	090	353	395	42	12%	15.29	17.27	1.98	13%	0				6							
67440	Orbitotomy with bone flap or	090	336.5	375	38.5	11%	14.84	16.77	1.93	13%	0				5.5						0.5	
67445	Orbitotomy with bone flap or	090	352	366	14	4%	19.12	20.51	1.39	7%	-2			1	1	1			1		1	
67450	Orbitotomy with bone flap or	090	366	408	42	11%	15.41	17.50	2.09	14%	0				6						0.5	
67550	Orbital implant (implant outsi	090	282	317	35	12%	11.77	13.42	1.65	14%	0				5							
67560	Orbital implant (implant outsi	090	276	311	35	13%	12.18	13.83	1.65	14%	0				5							
67570	Optic nerve decompression (e	090	294	314	20	7%	14.40	15.59	1.19	8%	-2			2	1	1						
67700	Blepharotomy, drainage of ab	010	59	61	2	3%	1.40	1.62	0.22	16%	0			1								
67710	Severing of tarsorrhaphy	010	39	41	2	5%	1.07	1.29	0.22	21%	0			1								
67715	Canthotomy (separate proce	010	41	43	2	5%	1.27	1.49	0.22	17%	0			1								
67800	Excision of chalazion; single	010	46	47	1	2%	1.41	1.52	0.11	8%	0			0.5								
67801	Excision of chalazion; multiple	010	48	49	1	2%	1.91	2.02	0.11	6%	0			0.5								
67805	Excision of chalazion; multiple	010	78	80	2	3%	2.27	2.49	0.22	10%	0			1								
67808	Excision of chalazion; under g	090	126.5	144	17.5	14%	4.60	5.43	0.83	18%	0				2.5							
67825	Correction of trichiasis; epilat	010	47	49	2	4%	1.43	1.65	0.22	15%	0			1								
67830	Correction of trichiasis; incisi	010	56	58	2	4%	1.75	1.97	0.22	13%	0			1								
67835	Correction of trichiasis; incisi	090	154	160	6	4%	5.70	6.36	0.66	12%	0			3								
67840	Excision of lesion of eyelid (ex	010	56	58	2	4%	2.09	2.31	0.22	11%	0			1								
67850	Destruction of lesion of lid ma	010	48	50	2	4%	1.74	1.96	0.22	13%	0			1								
67880	Construction of intermarginal	090	114.5	132	17.5	15%	4.60	5.43	0.83	18%	0				2.5							
67882	Construction of intermarginal	090	156	177	21	13%	6.02	7.01	0.99	16%	0				3							
67900	Repair of brow ptosis (suprac	090	177	193	16	9%	6.82	7.70	0.88	13%	0			1	2							
67901	Repair of blepharoptosis; fror	090	188	196	8	4%	7.59	8.58	0.99	13%	0			4							0.5	
67902	Repair of blepharoptosis; fror	090	221	234	13	6%	9.82	10.92	1.10	11%	0			3	1						0.5	
67903	Repair of blepharoptosis; (tar	090	145	151	6	4%	6.51	7.17	0.66	10%	0			3								
67904	Repair of blepharoptosis; (tar	090	185	198	13	7%	7.97	9.07	1.10	14%	0			3	1						0.5	
67906	Repair of blepharoptosis; sup	090	134	140	6	4%	6.93	7.59	0.66	10%	0			3								
67908	Repair of blepharoptosis; con	090	136	143	7	5%	5.30	6.07	0.77	15%	0			3.5								

67909	Reduction of overcorrection c	090	136	143	7	5%	5.57	6.34	0.77	14%	0			3.5								
67911	Correction of lid retraction	090	183	191	8	4%	7.50	8.49	0.99	13%	0			4							0.5	
67912	Correction of lagophthalmos,	090	166	182	16	10%	6.36	7.35	0.99	16%	0			1	2						0.5	
67914	Repair of ectropion; suture	090	129	140	11	9%	3.75	4.63	0.88	23%	0			2	1						0.5	
67915	Repair of ectropion; thermoc	090	70	74	4	6%	2.03	2.47	0.44	22%	0			2								
67916	Repair of ectropion; excision	090	134	145	11	8%	5.48	6.36	0.88	16%	0			2	1						0.5	
67917	Repair of ectropion; extensive	090	142	153	11	8%	5.93	6.81	0.88	15%	0			2	1						0.5	
67921	Repair of entropion; suture	090	124	135	11	9%	3.47	4.35	0.88	25%	0			2	1						0.5	
67922	Repair of entropion; thermoc	090	75	79	4	5%	2.03	2.47	0.44	22%	0			2								
67923	Repair of entropion; excision	090	134	145	11	8%	5.48	6.36	0.88	16%	0			2	1						0.5	
67924	Repair of entropion; extensiv	090	149	160	11	7%	5.93	6.81	0.88	15%	0			2	1						0.5	
67930	Suture of recent wound, eyeli	010	77	79	2	3%	3.65	3.87	0.22	6%	0			1								
67935	Suture of recent wound, eyeli	090	150	156	6	4%	6.36	7.02	0.66	10%	0			3								
67938	Removal of embedded foreig	010	48	50	2	4%	1.38	1.60	0.22	16%	0			1								
67950	Canthoplasty (reconstruction	090	144	151	7	5%	5.99	6.76	0.77	13%	0			3.5								
67961	Excision and repair of eyelid,	090	167	174	7	4%	5.86	6.63	0.77	13%	0			3.5								
67966	Excision and repair of eyelid,	090	200	213	13	6%	8.97	10.07	1.10	12%	0			3	1						0.5	
67971	Reconstruction of eyelid, full	090	235	244	9	4%	10.01	11.00	0.99	10%	0			4.5								
67973	Reconstruction of eyelid, full	090	253	264	11	4%	13.13	14.34	1.21	9%	0			5.5								
67974	Reconstruction of eyelid, full	090	255	266	11	4%	13.10	14.31	1.21	9%	0			5.5								
67975	Reconstruction of eyelid, full	090	197	206	9	5%	9.35	10.34	0.99	11%	0			4.5								
68020	Incision of conjunctiva, draina	010	41	43	2	5%	1.42	1.64	0.22	15%	0			1								
68110	Excision of lesion, conjunctiva	010	58	60	2	3%	1.82	2.04	0.22	12%	0			1								
68115	Excision of lesion, conjunctiva	010	68	70	2	3%	2.41	2.63	0.22	9%	0			1								
68130	Excision of lesion, conjunctiva	090	132	139	7	5%	5.10	5.87	0.77	15%	0			3.5								
68135	Destruction of lesion, conjunc	010	58	60	2	3%	1.89	2.11	0.22	12%	0			1								
68320	Conjunctivoplasty; with conju	090	209	237	28	13%	6.64	7.96	1.32	20%	0				4							
68325	Conjunctivoplasty; with bucca	090	217	245	28	13%	8.63	9.95	1.32	15%	0				4							
68326	Conjunctivoplasty, reconstruc	090	211	239	28	13%	8.42	9.74	1.32	16%	0				4							
68328	Conjunctivoplasty, reconstruc	090	231	259	28	12%	9.45	10.77	1.32	14%	0				4							
68330	Repair of symblepharon; conj	090	154	175	21	14%	5.78	6.77	0.99	17%	0				3							
68335	Repair of symblepharon; with	090	216	244	28	13%	8.46	9.78	1.32	16%	0				4							
68340	Repair of symblepharon; divis	090	134.5	152	17.5	13%	4.97	5.80	0.83	17%	0				2.5							
68360	Conjunctival flap; bridge or pa	090	138.5	156	17.5	13%	5.17	6.00	0.83	16%	0				2.5							
68362	Conjunctival flap; total (such a	090	203	231	28	14%	8.61	9.93	1.32	15%	0				4							
68371	Harvesting conjunctival allogr	010	150	158	8	5%	5.09	6.08	0.99	19%	0			4							0.5	
68400	Incision, drainage of lacrimal	010	56	58	2	4%	1.74	1.96	0.22	13%	0			1								
68420	Incision, drainage of lacrimal	010	61	63	2	3%	2.35	2.57	0.22	9%	0			1								
68440	Snip incision of lacrimal punct	010	35	37	2	6%	0.99	1.21	0.22	22%	0			1								
68500	Excision of lacrimal gland (dac	090	260.5	299	38.5	15%	12.77	14.59	1.82	14%	0				5.5							
68505	Excision of lacrimal gland (dac	090	262.5	301	38.5	15%	12.69	14.51	1.82	14%	0				5.5							
68520	Excision of lacrimal sac (dacry	090	212	240	28	13%	8.78	10.10	1.32	15%	0				4							
68530	Removal of foreign body or d	010	89	91	2	2%	3.70	3.92	0.22	6%	0			1								
68540	Excision of lacrimal gland tum	090	263	298	35	13%	12.18	13.83	1.65	14%	0				5							
68550	Excision of lacrimal gland tum	090	328	370	42	13%	15.16	17.14	1.98	13%	0				6							
68700	Plastic repair of canaliculi	090	201	229	28	14%	7.87	9.19	1.32	17%	0				4							
68705	Correction of everted punctu	010	55	57	2	4%	2.11	2.33	0.22	10%	0			1								
68720	Dacryocystorhinostomy (fistu	090	235	258	23	10%	9.96	11.17	1.21	12%	0			1	3							
68745	Conjunctivorhinostomy (fistul	090	212	240	28	13%	9.90	11.22	1.32	13%	0				4							
68750	Conjunctivorhinostomy (fistul	090	233.5	265	31.5	13%	10.10	11.59	1.49	15%	0				4.5							
68760	Closure of the lacrimal punctu	010	37	39	2	5%	1.78	2.00	0.22	12%	0			1								
68761	Closure of the lacrimal punctu	010	38	40	2	5%	1.41	1.63	0.22	16%	0			1								
68770	Closure of lacrimal fistula (se	090	181	209	28	15%	8.29	9.61	1.32	16%	0				4							
68801	Dilation of lacrimal punctum,	010	33	35	2	6%	0.82	1.04	0.22	27%	0			1								
68810	Probing of nasolacrimal duct,	010	43	45	2	5%	1.54	1.76	0.22	14%	0			1								
68811	Probing of nasolacrimal duct,	010	74.5	74.5	0	0%	1.74	1.85	0.11	6%	-2	1									0.5	
68815	Probing of nasolacrimal duct,	010	108	112	4	4%	2.70	3.25	0.55	20%	0		2								0.5	
68816	Probing of nasolacrimal duct,	010	83	83	0	0%	2.10	2.21	0.11	5%	-2	1									0.5	
68840	Probing of lacrimal canaliculi,	010	39	41	2	5%	1.30	1.52	0.22	17%	0		1									
69000	Drainage external ear, absces	010	49	51	2	4%	1.50	1.72	0.22	15%	0		1									
69005	Drainage external ear, absces	010	62	64	2	3%	2.16	2.38	0.22	10%	0		1									
69020	Drainage external auditory ca	010	40	42	2	5%	1.53	1.75	0.22	14%	0		1									
69110	Excision external ear; partial,	090	91	95	4	4%	3.53	3.97	0.44	12%	0		2									
69120	Excision external ear; comple	090	109	113	4	4%	4.14	4.58	0.44	11%	0		2									
69140	Excision exostosis(es), extern	090	185	192	7	4%	8.14	9.02	0.88	11%	0		3.5								0.5	
69145	Excision soft tissue lesion, ext	090	72	75	3	4%	2.70	3.03	0.33	12%	0		1.5									

69150	Radical excision external audi	090	285	293	8	3%	13.61	14.71	1.10	8%	0			4							1	
69155	Radical excision external audi	090	745	805	60	8%	23.35	26.93	3.58	15%	-4			1	2	2		6	1		1	
69205	Removal foreign body from e	010	25.5	25.5	0	0%	1.21	1.21	-	0%	-1		0.5									
69222	Debridement, mastoidectomy	010	48	50	2	4%	1.45	1.67	0.22	15%	0			1								
69300	Otoplasty, protruding ear, wit	YYY	227	236	9	4%	6.44	6.86	0.42	7%	-4		1			1						
69310	Reconstruction of external au	090	220	228	8	4%	10.97	11.85	0.88	8%	0			4								
69320	Reconstruction external audit	090	359	369	10	3%	17.18	18.39	1.21	7%	0			5							0.5	
69420	Myringotomy including aspira	010	37	39	2	5%	1.38	1.60	0.22	16%	0			1								
69421	Myringotomy including aspira	010	38	40	2	5%	1.78	2.00	0.22	12%	0			1								
69433	Tympanostomy (requiring ins	010	56	63	7	13%	1.57	1.90	0.33	21%	0				1							
69436	Tympanostomy (requiring ins	010	64	66	2	3%	2.01	2.23	0.22	11%	0			1								
69440	Middle ear exploration throu	090	185	191	6	3%	7.71	8.48	0.77	10%	0			3							0.5	
69450	Tympanolysis, transcanal	090	116	121	5	4%	5.69	6.24	0.55	10%	0			2.5								
69501	Transmastoid antrotomy (sim	090	206	212	6	3%	9.21	9.98	0.77	8%	0			3							0.5	
69502	Mastoidectomy; complete	090	299	307	8	3%	12.56	13.66	1.10	9%	0			4							1	
69505	Mastoidectomy; modified rad	090	321	329	8	2%	13.17	14.27	1.10	8%	0			4							1	
69511	Mastoidectomy; radical	090	318	326	8	3%	13.70	14.80	1.10	8%	0			4							1	
69530	Petrous apicectomy including	090	563	592	29	5%	20.38	22.55	2.17	11%	0			4.5				4			1	
69535	Resection temporal bone, ext	090	770	825	55	7%	37.42	40.90	3.48	9%	0			5				9			1	
69540	Excision aural polyp	010	43	45	2	5%	1.25	1.47	0.22	18%	0			1								
69550	Excision aural glomus tumor;	090	234	241	7	3%	11.15	12.03	0.88	8%	0			3.5							0.5	
69552	Excision aural glomus tumor;	090	396	411.5	15.5	4%	19.81	21.27	1.46	7%	0			4				1.5			1	
69554	Excision aural glomus tumor;	090	1024	1078	54	5%	35.97	39.53	3.56	10%	-4				2	2		6	2		1	
69601	Revision mastoidectomy; resu	090	330	339	9	3%	13.45	14.66	1.21	9%	0			4.5							1	
69602	Revision mastoidectomy; resu	090	325	333	8	2%	13.76	14.86	1.10	8%	0			4							1	
69603	Revision mastoidectomy; resu	090	319	327	8	3%	14.20	15.30	1.10	8%	0			4							1	
69604	Revision mastoidectomy; resu	090	336	344	8	2%	14.20	15.30	1.10	8%	0			4							1	
69610	Tympanic membrane repair, v	010	90	92	2	2%	4.47	4.69	0.22	5%	0			1								
69620	Myringoplasty (surgery confir	090	158	164	6	4%	6.03	6.69	0.66	11%	0			3								
69631	Tympanoplasty without mast	090	245	253	8	3%	10.05	11.04	0.99	10%	0			4							0.5	
69632	Tympanoplasty without mast	090	274	283	9	3%	12.96	14.06	1.10	8%	0			4.5							0.5	
69633	Tympanoplasty without mast	090	275	284	9	3%	12.31	13.41	1.10	9%	0			4.5							0.5	
69635	Tympanoplasty with antroton	090	292	300	8	3%	13.51	14.50	0.99	7%	0			4							0.5	
69636	Tympanoplasty with antroton	090	332	341	9	3%	15.43	16.53	1.10	7%	0			4.5							0.5	
69637	Tympanoplasty with antroton	090	340	349	9	3%	15.32	16.42	1.10	7%	0			4.5							0.5	
69641	Tympanoplasty with mastoide	090	341	349	8	2%	12.89	13.99	1.10	9%	0			4							1	
69642	Tympanoplasty with mastoide	090	376	386	10	3%	17.06	18.38	1.32	8%	0			5							1	
69643	Tympanoplasty with mastoide	090	369	380.5	11.5	3%	15.59	16.92	1.33	9%	0			4.5				0.5			1	
69644	Tympanoplasty with mastoide	090	399	410.5	11.5	3%	17.23	18.56	1.33	8%	0			4.5				0.5			1	
69645	Tympanoplasty with mastoide	090	377	391	14	4%	16.71	18.16	1.45	9%	0			4.5				1			1	
69646	Tympanoplasty with mastoide	090	416	432.5	16.5	4%	18.37	19.94	1.57	9%	0			4.5				1.5			1	
69650	Stapes mobilization	090	181	187	6	3%	9.80	10.57	0.77	8%	0			3							0.5	
69660	Stapedectomy or stapedotom	090	202	208	6	3%	12.03	12.80	0.77	6%	0			3							0.5	
69661	Stapedectomy or stapedotom	090	276	284	8	3%	15.92	17.02	1.10	7%	0			4							1	
69662	Revision of stapedectomy or	090	249	256	7	3%	15.60	16.59	0.99	6%	0			3.5							1	
69666	Repair oval window fistula	090	206	212	6	3%	9.89	10.77	0.88	9%	0			3							1	
69667	Repair round window fistula	090	206	212	6	3%	9.90	10.78	0.88	9%	0			3							1	
69670	Mastoid obliteration (separat	090	280	289.5	9.5	3%	11.73	12.84	1.11	9%	0			3.5				0.5			1	
69676	Tympanic neurectomy	090	196	203	7	4%	9.69	10.57	0.88	9%	0			3.5							0.5	
69700	Closure postauricular fistula,	090	181	187	6	3%	8.37	9.14	0.77	9%	0			3							0.5	
69711	Removal or repair of electron	090	249	257	8	3%	10.62	11.61	0.99	9%	0			4							0.5	
69714	Implantation, osseointegrate	090	146	155	9	6%	8.00	8.66	0.66	8%	0			1	1						0.5	
69716	Implantation, osseointegrate	090	168	177	9	5%	9.03	9.69	0.66	7%	0			1	1						0.5	
69717	Replacement (including remo	090	159	168	9	6%	8.48	9.14	0.66	8%	0			1	1						0.5	
69719	Replacement (including remo	090	174	183	9	5%	9.46	10.12	0.66	7%	0			1	1						0.5	
69720	Decompression facial nerve, i	090	357	371	14	4%	14.71	16.16	1.45	10%	0			4.5				1			1	
69725	Decompression facial nerve, i	090	695	730	35	5%	27.64	30.30	2.66	10%	0				4			3	2		1	
69726	Removal, entire osseointegra	090	150	159	9	6%	7.50	8.16	0.66	9%	0			1	1						0.5	
69727	Removal, entire osseointegra	090	170	179	9	5%	7.38	8.04	0.66	9%	0			1	1						0.5	
69740	Suture facial nerve, intratemp	090	374	387.5	13.5	4%	16.27	17.51	1.24	8%	0			3				1.5			1	
69745	Suture facial nerve, intratemp	090	435	449.5	14.5	3%	17.02	18.37	1.35	8%	0			3.5				1.5			1	
69805	Endolymphatic sac operation;	090	347	370	23	7%	14.71	16.14	1.43	10%	-2			1	1	1		1			1	
69806	Endolymphatic sac operation;	090	309	321	12	4%	12.63	13.86	1.23	10%	0			3.5				1			1	
69905	Labyrinthectomy; transcanal	090	233	240	7	3%	11.26	12.25	0.99	9%	0			3.5							1	
69910	Labyrinthectomy; with masto	090	315	327	12	4%	13.91	15.14	1.23	9%	0			3.5				1			1	
69915	Vestibular nerve section, tran	090	573	606	33	6%	22.77	25.07	2.30	10%	0			4				5			1	

69930	Cochlear device implantation	090	387	403	16	4%	17.73	18.59	0.86	5%	-2				1	1					0.5	
69950	Vestibular nerve section, tran	090	669	701	32	5%	27.63	30.27	2.64	10%	-4			1		2		4	2		1	
69955	Total facial nerve decompress	090	755	795	40	5%	29.42	32.32	2.90	10%	0				4			4	2		1	
69960	Decompression internal audit	090	675	715	40	6%	29.42	32.32	2.90	10%	0				4			4	2		1	
69970	Removal of tumor, temporal l	090	793	833	40	5%	32.41	35.31	2.90	9%	0				4			4	2		1	
77427	Radiation treatment manager	XXX	101.39	105.23	3.84	4%	3.37	3.55	0.18	5%	-0.34				0.33	0.17						
77750	Infusion or instillation of radi	090	100	104	4	4%	5.00	5.44	0.44	9%	0			2								
77761	Intracavitary radiation source	090	82	84	2	2%	3.85	4.07	0.22	6%	0			1								
77762	Intracavitary radiation source	090	113	115	2	2%	5.76	5.98	0.22	4%	0			1								
77763	Intracavitary radiation source	090	160	164	4	2%	8.66	9.10	0.44	5%	0			2								
77789	Surface application of low do	000	53	55	2	4%	1.14	1.36	0.22	19%	0			1								
92986	Percutaneous balloon valvulo	090	463	489	26	6%	22.60	24.05	1.45	6%	0				3			1			1	
92987	Percutaneous balloon valvulo	090	329	350	21	6%	23.38	24.37	0.99	4%	0				3							
92990	Percutaneous balloon valvulo	090	393	414	21	5%	18.27	19.26	0.99	5%	0				3							
157X1	Implantation of absorbable m	000	213	209	-4	-2%	8.00	8.20	0.20	2%	0								1			
49X06	Repair of anterior abdominal	000	310	307	-3	-1%	20.00	20.40	0.40	2%	0									1		
49X10	Repair of anterior abdominal	000	275	271	-4	-1%	16.50	16.70	0.20	1%	0								1			
49X11	Repair of anterior abdominal	000	288	284	-4	-1%	16.97	17.17	0.20	1%	0								1			
49X12	Repair of anterior abdominal	000	335	332	-3	-1%	24.00	24.40	0.40	2%	0									1		
49X13	Repair of parastomal hernia,	000	235	240	5	2%	14.24	14.48	0.24	2%	0							1				
49X14	Repair of parastomal hernia,	000	285	281	-4	-1%	18.00	18.20	0.20	1%	0								1			
558XX	Laparoscopy, surgical prostat	090	354	368	14	4%	19.53	20.30	0.77	4%	0				2						0.5	
69XX0	Implantation, osseointegrate	090	181	190	9	5%	9.97	10.63	0.66	7%	0			1	1						0.5	
69XX1	Replacement (including remo	090	186	195	9	5%	10.25	10.91	0.66	6%	0			1	1						0.5	
69XX2	Removal, entire osseointegra	090	178	187	9	5%	8.50	9.16	0.66	8%	0			1	1						0.5	
G0342	Laparoscopy for islet cell tran	090	238	247	9	4%	11.92	12.58	0.66	6%	0			1	1						0.5	
G0343	Laparotomy for islet cell trans	090	588	590	2	0%	19.85	22.28	2.43	12%	0			2	1			1	2	2	1	
G0412	Open treatment of iliac spine	090	388	405	17	4%	10.45	12.12	1.67	16%	0			2	1			2	1		1	
G0413	Percutaneous skeletal fixation	090	393	427	34	9%	15.73	18.08	2.35	15%	0			1	3			3	1		1	
G0414	Open treatment of anterior p	090	443	477	34	8%	14.65	17.00	2.35	16%	0			1	3			3	1		1	
G0415	Open treatment of posterior	090	543	587	44	8%	20.93	23.76	2.83	14%	0			1	3			5	1		1	

*Codes highlighted in blue were reviewed by the RUC for CPT 2023. The surgical procedure times and values included for these codes are the RUC recommendations for CPT 2023. Also, any code that is being deleted for CPT 2023 was removed from this analysis.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2022

Inpatient Consultations – Tab 14

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

In February 2021, the CPT Editorial Panel deleted two consultation codes and revised eight consultation codes to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient consultation, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing the patient are summed to select the appropriate code. The inpatient consultation services were initially surveyed for the October 2021 RUC meeting. The inpatient consultation survey time captured the total time on the date of encounter by calendar date. In October 2021, the RUC referred the inpatient and observation consultation services to be resurveyed, because the survey did not include a request for distinct fields for time before and after floor/unit time, and therefore could not be compared to previous RUC surveys of these services. The specialty societies revised their survey instrument by working with the Research Subcommittee. The RUC completed its review of the office or other outpatient consultation codes (99242-99245) at the October 2021 meeting and submitted recommendations for 99242-99245 to CMS only for those services.

Although the recommended work RVUs for codes 99252-99255 are not greater than the current values, the specialty societies noted, and the RUC agreed, that the compelling evidence of a change in the patient population and a change in technology that supported the increased work RVUs for the inpatient visit codes (99221-99239) also provides support for an increase in intensity of work for inpatient consultation codes. Specifically, that there has been a change in the patient population as Medicare patients have increasing rates of comorbidities that in turn increase the complexity and intensity of work. In addition to high prevalence of diabetes, hypertension, and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%). There has also been a change in technology. The establishment of EHRs since these codes were last reviewed has dramatically

changed care, allowing for more information requiring review and analysis. Patients present at a hospital with acute problems or exacerbation of current problems. Assessment of the problem needs to be performed expeditiously. The increased knowledge base in EHRs has increased intensity and complexity of patient care by requiring review and analysis of more data in the same or shorter amount of time. The American Hospital Association reported that in 2017, 95% of hospitals had some form of EHR implemented. This is a significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Since the inception of the Medicare Physician Payment Schedule, the work RVUs for the inpatient consultation codes have always been valued higher than the inpatient visit E/M codes; the Harvard study acknowledged a relative difference in work in 1991 and the RUC confirmed a relative difference in work in 2006.

SURVEY PROCESS AND DATA ANALYSIS

The customized survey, vignettes, and reference service lists (RSL) were developed and approved by the Research Subcommittee in conjunction with the CPT/RUC Workgroup on E/M and input from the surveying specialties. The RSLs were specifically developed in an objective manner to represent relativity within the Medicare Physician Payment Schedule. The Research Subcommittee considered requests from the surveying specialties to add or remove codes from the initial lists originally developed by the Workgroup. The vignettes were developed by the CPT/RUC Workgroup on E/M and approved by the CPT Editorial Panel and the RUC's Research Subcommittee. Approximately 90% of respondents agreed that the vignettes described their typical patient.

The survey was the concerted effort of 25 specialty societies and other health care professional organizations. The RUC analyzed the responses and noted that the number of survey responses received per specialty correlated with those who perform inpatient consultation care visits in the Medicare Physician Payment Schedule, based on 2009 utilization data (when these services were last covered by Medicare). These data were summarized by categories of specialties (hospital, surgical, primary care, and medicine/other).

To ensure that survey respondents understood the new CPT guidelines and descriptors and the impact that these changes may have on their work, the RUC survey instrument required that each respondent carefully read the new descriptors/guidelines and attest that they had read the information before being allowed to proceed with the survey. The survey respondents understood that code selection could be based on either MDM or time on the date of the patient encounter. While the history and physical is no longer required for purposes of documentation, it is expected that a medically appropriate history and physical exam is performed during the visit.

For the inpatient or observation consultation codes (CPT codes 99252-99255) all time is on the date of encounter, thus intra-service time only for the purposes of . The survey instrument was revised to specify that "unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the "unit/floor". The survey asked about the different components of time to ensure that the respondents considered all appropriate time for these services before floor time, floor time and after floor time. The respondents then needed to confirm that the summed time of the components was the accurate total time on the date of encounter for each service to proceed with the survey. Additional details on the survey tool questions and responses are provided in the letter from the specialty societies.

99252 ***Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.***
The RUC reviewed the survey results from 206 physicians and other qualified health care professionals (QHPs) and determined the survey median work RVU of 1.50 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 35 minutes total time. The RUC noted that CPT code 99251 has been deleted and some or all its previous utilization will now be reported with CPT code 99252. The 2009 Medicare utilization of CPT code 99251 was only 27% of the Medicare utilization for 99252, thus the typical patient for a 99252 will not change.

The specialties noted, and the RUC concurred, that inpatient and observation consultation codes should be valued somewhat higher than the analogous inpatient or observation new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. However, it was noted that the revised descriptor for CPT code 99221 (RUC recommended work RVU = 1.63, 40 minutes total time) is for straightforward or low medical decision making, whereas inpatient consultation code 99252 is only for a straightforward level of medical decision making, justifying a somewhat lower valuation for 99252 relative to 99221. The report prepared by the consultation physician would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests to be performed.

To justify a work RVU of 1.50, the RUC compared the surveyed code to the top key reference service and MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 20 minutes total time) and determined that CPT code 99252 typically requires substantially more physician work and 15 more minutes of total time, thus would be valued appropriately higher with a work value of 1.50. The RUC compared the surveyed code to the 2nd key reference service and MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and noted that although both services involve an identical amount of total time, the surveyed code involves a lower level of medical decision making relative to the reference code (straightforward vs. low), and therefore maintains relativity with this reference service. **The RUC recommends a work RVU of 1.50 for CPT code 99252.**

99253 ***Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 219 physicians and other QHPs and determined the survey median work RVU of 2.00 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 45 minutes total time.

The specialties noted, and the RUC concurred, that inpatient and observation consultation codes should be valued somewhat higher than the analogous inpatient or observation new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. However, it was noted that the revised descriptor for CPT code 99221(RUC recommended

work RVU = 1.63, 40 minutes total time) is for straightforward or low medical decision making, whereas inpatient consultation code 99253 is only for a low level of medical decision making, justifying a higher valuation for 99253 relative to 99221. The report prepared by the consultation physician would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests to be performed.

To justify a work RVU of 2.00, the RUC compared the surveyed code to the top key reference service and MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and determined that CPT code 99253 typically requires more physician work and time, thus would be valued appropriately higher with a work value of 2.00. The RUC also compared the surveyed code to MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU= 1.92, total time of 47 minutes) and noted that the reference code typically involves 2 more minutes of total time and is for a moderate level of medical decision making. However, the surveyed code is for both new and established patients, is in the inpatient setting, and is a consultation, which collectively is more work than the level of medical decision making and minor time differentials when compared with 99214. In addition, the RUC compared the surveyed code to MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 35 minutes total time) as additional support of the recommended value. **The RUC recommends a work RVU of 2.00 for CPT code 99253.**

99254 ***Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.***
The RUC reviewed the survey results from 234 physicians and other QHPs and determined the survey 25th percentile work RVU of 2.72 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 60 minutes total time.

To justify a work RVU of 2.72, the RUC compared the surveyed code to top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes) and concurred that, even though both services have identical total time, code 99254 should be valued with a slightly higher work RVU relative to 99204 to account for the increased intensity and complexity of the hospitalized patient. The RUC referenced that 78% of the survey respondents that selected this top key reference service had indicated that 99254 is more intense/complex. The RUC also compared the surveyed code to 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU= 2.80, total time of 70 minutes) and noted that the reference code typically involves 10 more minutes of total time and is for a high level of medical decision making. However, the surveyed code is for both new and established patients, is in the inpatient setting and is a consultation, which combined nearly offset the level of medical decision making and time differentials. **The RUC recommends a work RVU of 2.72 for CPT code 99254.**

99255 ***Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.***

The RUC reviewed the survey results from 223 physicians and other QHPs and determined that the survey median work RVU somewhat overestimated and the survey 25th percentile underestimated the physician and QHP work typically required to perform this service. , The RUC agreed that a value between the survey 25th percentile and survey median would most appropriately account for the physician and other QHP work required to perform this service. The RUC recommends a direct work RVU crosswalk to CPT code 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)* (work RVU= 3.86, total time of 75 minutes), agreeing that although the reference code involves slightly more total time, both services involve a comparable amount of physician work. The RUC recommends 80 minutes total time.

In support of the crosswalk value, the RUC also compared the surveyed code to top key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU= 3.50, total time of 88 minutes) and concurred that 99255 should be valued higher based on a slightly higher intensity relative to 99205 and referenced that 83% of the survey respondents that selected this top key reference service had indicated that 99255 is more intense/complex. The specialties noted, and the RUC concurred, that inpatient consultation codes should be valued somewhat higher than the office or other outpatient new patient visit with the same level of medical decision making to account for the more acute work in the inpatient setting and the work of generating and sending a written report to the requesting physician. The report provides recommendations for the management of the patient and identify additional labs, imaging and/or tests to perform. The specialties also noted that a consultation typically involves a greater amount of data to review at the high-level decision-making level relative to new patient office visit code 99205. **The RUC recommends a work RVU of 3.86 for CPT code 99255.**

CPT Descriptor Time for Inpatient Consultations

The RUC recommends the following total times on the date of encounter for the outpatient consultation CPT descriptors based on the survey medians. The times in the CPT descriptors are rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code		Time on the Date of Encounter Recommendation to CPT
99252	Inpatient or Observation Consultation, new or est pt, straightforward MDM	35
99253	Inpatient or Observation Consultation, new or est pt, low MDM	45
99254	Inpatient or Observation Consultation, new or est pt, moderate MDM	60
99255	Inpatient or Observation Consultation, new or est pt, high MDM	80

Practice Expense

The RUC recommends no direct practice expense inputs for CPT codes 99252-99255 as they are facility-only services.

Work Neutrality
Based on the 2009 Medicare utilization data from when these services were last covered by Medicare, the RUC's recommendation for this family of codes would result in an overall work savings.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Consultations** A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to ~~either~~ recommend care for a specific condition or problem ~~or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem~~. A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. A "consultation" initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (eg, ~~physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist,~~ non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes ~~but may be reported using the office visit, home service, or domiciliary/rest home care codes as appropriate~~. ~~The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source.~~ The consultant's opinion and any services that were ordered or performed must also be ~~documented in the patient's medical record and~~ communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source. *If a consultation is mandated (eg, by a third-party payer) modifier 32 should also be reported.* ~~Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.~~ ~~If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate **Evaluation and Management** services code for the site of service should be reported. In the hospital or nursing facility setting, the consultant should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital or nursing facility care codes. In the office setting, the consultant should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.~~				

To report services when ~~provided to~~ a patient ~~who~~ is admitted to ~~a~~ hospital inpatient, or observation status, or to a nursing facility in the course of an encounter in another setting ~~the office or other ambulatory facility~~, see ~~the notes for~~ **Initial Hospital Inpatient or Observation Care** ~~(page 23)~~ or **Initial Nursing Facility Care** ~~(page 33)~~.

For definitions of ~~key components and~~ commonly used terms, ~~please~~ see **Evaluation and Management Services Guidelines.**

~~***Coding Tip***~~

~~**Definition of Transfer of Care**~~

~~Transfer of care is the process whereby a physician or other qualified health care professional who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified health care professional transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician or other qualified health care professional who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Concurrent Care and Transfer of Care~~

Inpatient or Observation Consultations
New or Established Patient

~~The following~~ ~~c~~Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation level patients, residents of nursing facilities, or patients in a partial hospital setting and when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician.

Only one consultation ~~should~~ may be reported by a consultant per admission. Subsequent consultation services during the same admission are reported using subsequent hospital inpatient or observation care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).~~,~~ ~~including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem.~~ ~~Use subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310) to report transfer of care services (see page 5, Concurrent Care and Transfer of Care definitions).~~

~~When an inpatient consultation is performed on a date that a patient is admitted to a hospital or nursing facility all evaluation and management services provided by the consultant related to the admission are reported with the inpatient consultation service code (99251-99255). If a patient is admitted after an outpatient consultation (office, emergency department, etc), and the patient is not seen on the unit on the date of admission, only report the outpatient consultation code (99241-99245). If the patient is seen by the consultant on the unit on the date of admission, report all evaluation and management services provided by the consultant related to the admission with either the inpatient consultation code (99251-99255) or with the initial inpatient admission service code (99221-99223). Do not report both an outpatient consultation (99241-99245) and inpatient consultation (99251-99255) for services related to the same inpatient stay. When transfer of care services are provided on a date subsequent to the outpatient consultation, use the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).~~

(For an inpatient or observation consultation requiring prolonged services, use 993X0)

~~99251~~	-	~~**Inpatient consultation** for a new or established 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. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99251 has been deleted. To report, use 99252)	~~XXX~~	~~N/A~~
▲99252	G5	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~these 3 key components:~~ ~~• **An expanded problem focused history;**~~ ~~• **An expanded problem focused examination; and**~~ ~~• **Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	XXX	1.50 (No Change)

▲99253	G6	**Inpatient or observation consultation** for a new or established patient, which requires t a medically appropriate history and/or examination and low level of medical decision making. ~~these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	XXX	2.00

▲99254	G7	**Inpatient <u>or observation</u> consultation** for a new or established patient, which requires <u>a medically appropriate history and/or examination and moderate level of medical decision making.</u> ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.</u>	XXX	2.72

▲99255	G8	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded. (For services 95 minutes or longer, use prolonged services code 993X0)	XXX	3.86

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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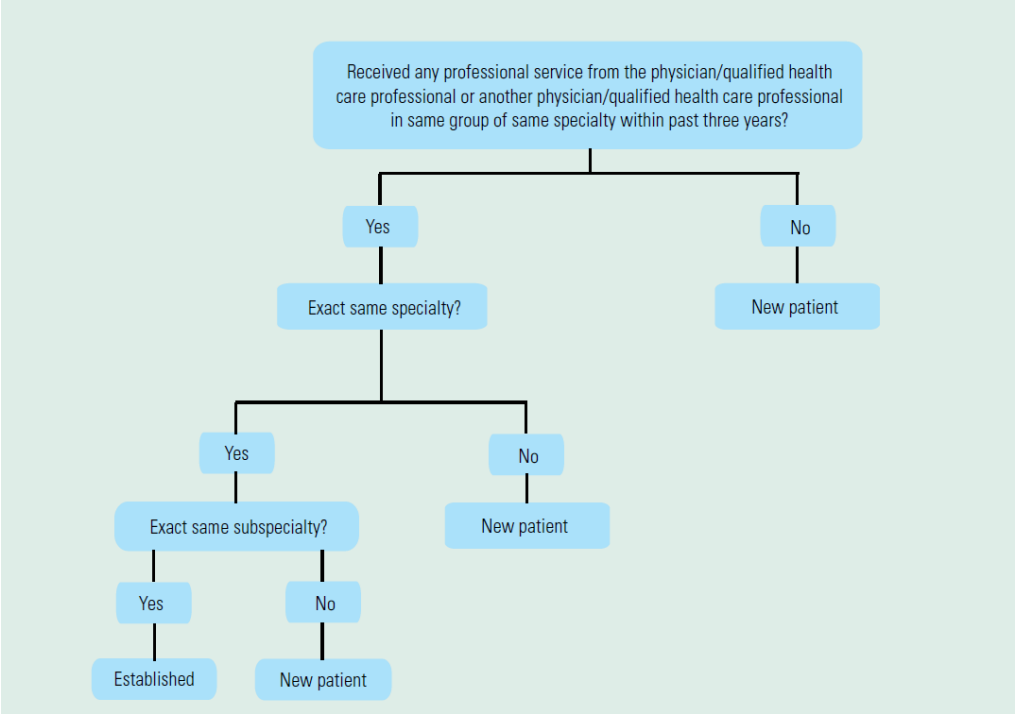
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

December 14, 2021

To: Ezequiel Silva III, MD
Chair, AMA/Specialty Society RVU Update Committee (RUC)

From: Survey Societies for Inpatient Consultation Codes

Re: Tab 14, Supplemental Information

When compared with the prior October 2021 survey, additional text and questions were added to the survey instrument by the Research Subcommittee. On behalf of the surveying societies, a discussion of each survey revision and additional questions is provided below, along with additional survey statistics, for information.

1. *A new question (highlighted in red below) was added by the Research Subcommittee following the question about whether the vignette describes a typical patient. This is the first time that this question has been included in an E/M survey. The statistics from this survey question are presented below for informational purposes. We do not believe, however, that any conclusion can be drawn from these data because this question was placed after the "typical patient" question and not in the context of total time on the date of encounter (ie, Question 2B). It is possible that some respondents may have interpreted this question to ask if only one physician/QHP is responsible for the typical patient on a given day, independent of the specialty. Said another way, the question does not specify whether the response should be reflective of more than one physician/QHP in a group that is reporting a single code on a date.*

On a single calendar day, will there typically (ie, more than 50% of the time) be more than one physician/QHP who spends time providing CPT code <auto populate> for the typical patient described above?

	99252		99253		99254		99255	
Yes	81	40%	105	48%	166	71%	161	72%
No	124	60%	114	52%	68	29%	62	28%

2. *When compared with the prior survey, additional text was added to the general background information to make it clear that: the code changes will not be effective until 2023; the codes will include both inpatient and observation consultations; and all time on the date of encounter is included—not just unit/floor time.*

Background for Question 2 [Revised text highlighted in red]

Physician/other qualified health care professional time includes the following activities, when performed, whether on or off the unit/floor:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

DO NOT include time for work related to another service, procedure, or evaluation and management code that is separately reportable.

"Physician work" does not include the services provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical assistants, receptionists, or technicians; these services are included in the practice expense relative values, a different component of the Resource-Based Relative Value Scale (RBRVS).

When total time on the date of encounter is used to select the appropriate level of an inpatient and observation consultation service code, both the face-to-face and non-face-to-face time personally spent by the physician or QHP and other physicians or QHPs in the same group and same subspecialty that is reporting the single inpatient/observation consultation are summed to select the appropriate code. Please consider all the time spent on the service for a full calendar day.

"Unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the unit /floor.

Hospital Inpatient/Observation Consultation Services

Services PRIOR to work on the unit/floor ON THE DATE OF THE ENCOUNTER:

This includes services that are not performed on the patient's hospital unit or floor, including: communications with other professionals and the patient's family; obtaining and/or reviewing the results of diagnostic and other studies; and written and telephone reports.

Services ON the unit/floor ON THE DATE OF THE ENCOUNTER:

This includes the services provided while you are present on the patient's hospital unit or floor, including: reviewing the patient's chart; seeing the patient, writing orders or performing documentation, and communicating with other professionals and the patient's family.

Services AFTER work on the unit/floor ON THE DATE OF THE ENCOUNTER:

This includes services that are not provided on the patient's hospital unit or floor, including: communicating further with other professionals and the patient's family; obtaining and/or reviewing the results of diagnostic and other studies; writing orders or performing documentation and other written or telephone reports.

3. Question 2 was expanded to include Question 2A to be used as a "worksheet" for considering time based on the definitions of time. This was followed by Question 2B which automatically populated the total time based on Question 2A, requesting that the survey respondent confirm the total time was accurate (or go back and adjust times in Question 2A. Question 2B was meant to establish a total time for the revised codes as arrayed, with confirmation by the respondent prior to proceeding with the survey.

   The statistics for Question 2A are shown below—for information. There is not a way to calculate the median based on medians of subsets of the whole and still be statistically accurate. It is statistically incorrect to sum the median statistic of individual components for the same day of service and call that sum the median of total time. This is because each respondent "arranged" their day of service time based on their particular experience. In Question 2B the respondents were asked to focus on total time and confirm that total time was accurate. The goal of the survey time question was to collect total time. As comparison, it is also incorrect to sum the minimum or maximum statistic and state the sum is the minimum or maximum of total time. For example, considering code 99253, no respondent indicated 7 minutes for total time; the minimum total time for any respondent was 15 minutes.

Question 2A Data

TIME	Before Floor 99252	On Floor 99252	After Floor 99252	Before Floor 99253	On Floor 99253	After Floor 99253	Before Floor 99254	On Floor 99254	After Floor 99254	Before Floor 99255	On Floor 99255	After Floor 99255
Min	0	3	0	2	5	0	4	5	0	5	5	0
25th	5	10	5	10	15	10	10	20	11	15	26	15
Median	10	15	10	10	20	11	15	30	15	20	35	20
75th	10	20	12	15	30	15	20	36	20	30	48	30
Max	30	61	40	45	63	60	55	81	75	64	110	100

Question 2B Data

TIME	Total Time 99252	Total Time 99253	Total Time 99254	Total Time 99255
Min	5	15	25	40
25th	25	37	50	63
Median	35	45	60	80
75th	45	57	75	100
Max	121	165	205	250

Question 2 text revisions are highlighted in red

Question 2A

How much physician/QHP time on the date of encounter is required per patient treated for each of the following steps in patient care related to the survey code(s)? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Type in your answers (in minutes) in each box below. If no time is typically spent on a listed time period, please enter 0 minutes. It is important that you list all the time on a calendar date and, if more than one physician/QHP is performing the single service, to sum the time spent on the date.

Please refer to the definitions of physician time above.

~~IMPORTANT: Beginning in 2023, when total time on the date of encounter is used to select the appropriate level of a Inpatient or Observation Consultation Service code, both the face-to-face and non-face-to-face time personally spent by the physician and/or QHP are summed to select the appropriate code.~~

DO NOT include the time provided by clinical staff, such as RNs, LPNs, MAs and technicians, as their time is measured separately from this survey and do not include time for services that are separately reported.

	Place your time (in minutes) below
✶ Physician/QHP time on date of encounter PRIOR to work on the unit/floor (in minutes)	
Physician/QHP time on date of encounter ON the unit/floor (in minutes)	
Physician/QHP time on Date of Encounter AFTER work on the unit/floor (in minutes)	

Question 2B

Below is the TOTAL physician/QHP time you estimated that is typically performed on the date of encounter (this is the aggregate of your responses for each code in the previous question). “Unit/floor time” is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the unit/floor. Also, these estimated times should not include time for services that are separately reported and also should NOT include the time provided by clinical staff, such as RNs, LPNs, MAs and technicians, as their time is measured separately from this survey.

CPT Code	Descriptor	TOTAL Physician/QHP time on Date of Encounter from Your Estimate
<auto populate>	<auto populate>	<auto populate>

Please confirm that the above Total Time estimates, which aggregated your responses to the previous survey question, represent the total physician/QHP time on the date of encounter that is required per patient treated for each of the following steps in patient care related to the survey code(s). If you wish to adjust any of your time estimates after reviewing the Total Time, click the BACK button below, and update your estimates as needed.

- ○ I confirm that I have reviewed the above Total Time estimates and they appropriately reflect the total physician/QHP time on the date of encounter.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99252 Tracking Number G5 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.50** RUC Recommended RVU: **1.50**

CPT Descriptor: Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested inpatient consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be self-limited. A report is generated and sent to the requesting provider.

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:

Description of Intra-Service Work: Review the referring physician/QHP request for the consultant's expert opinion for management of a specific medical problem. Review available prior medical records, including labs and imaging. Order and review additional records, diagnostic labs, imaging and/or other tests as necessary for the consultation. Incorporate pertinent information into the medical record. Coordinate with other members of the health care team. Visit patient location (e.g., floor, observation area, unit), confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis requiring straightforward medical decision making [MDM]. Discuss the findings with the patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the consultation. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Don Selzer, MD (ACS), Richard Wright, MD (ACC), Marianna Spanaki, MD (AAN), Phillip Rodgers, MD (AAHP), Bruce Cameron, MD (AGA), Matthew Sideman, MD (SVS), Karin Swartz, MD (NASS)					
Specialty Society(ies):	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG, ACNM, ACOG, ACS, AGA, ASCO, ASCRS (colon), ASGE, ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS					
CPT Code:	99252					
Sample Size:	29527	**Resp N:**	206			
Description of Sample:	random samples from each society					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**10.00**	25.00	1000.00	
Survey RVW:	0.18	1.00	**1.50**	2.00	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:	5.00	25.00	**35.00**	45.00	121.00	
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:	99252	**Recommended Physician Work RVU: 1.50**		
		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:		**35.00**		

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? 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
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78072	XXX	1.60	**RUC Time**	12,267

CPT Descriptor 1 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92014	XXX	1.42	**RUC Time**	12,589,511

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
99392	XXX	1.50	**RUC Time**

CPT Descriptor Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)

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: 73 **% of respondents:** 35.4 **%**

Number of respondents who choose 2nd Key Reference Code: 39 **% of respondents:** 18.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 99252	Top Key Reference CPT Code: 99202	2nd Key Reference CPT Code: **99203**
Median Pre-Service Time	0.00	2.00	5.00
Median Intra-Service Time	35.00	15.00	25.00
Median Immediate Post-service Time	0.00	3.00	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	**35.00**	**20.00**	**35.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	5%	6%	58%	34%	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	5%	59%	36%

and analyzed • Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	79%	14%
Physical effort required	4%	68%	28%

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%	55%	37%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	41%	46%	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%	46%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	64%	28%
Physical effort required	5%	64%	31%

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%	56%	39%

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 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the inpatient consultation codes were approved:

- Deletion of code 99251
- Revision of codes 99252-99255 to align with changes to office/outpatient visit codes (99202-99215) including:
    - Performing a medically appropriate history and/or examination
    - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process
AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the inpatient consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the inpatient consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the inpatient consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the inpatient consultation codes. Over 250 responses for physician work were received for each code.

Concerns, however, arose at the October 2021 RUC meeting about the accuracy of the times provided by respondents because of the survey tool utilized. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation consultation services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the four codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. Both survey tools are included in the RUC materials.

Discussion of Increased Intensity

Change in Technology
Although the recommended work RVUs for codes 99252-99255 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for the inpatient consultation codes, specifically, a change in technology. The establishment of EHRs since these codes were last reviewed has dramatically changed care, allowing for more information requiring review and analysis. Patients present at a hospital with acute problems or exacerbation of current problems. Assessment of the problem needs to be performed expeditiously. The increased knowledge base in EHRs has increased intensity and complexity of patient care by requiring review and analysis of more data in the same or shorter amount of time. We believe the intensity of this work is greater than the intensity of work when compared with office visits – or at a minimum not less intense.

Accuracy of RUC Database Times
Setting aside the concerns about the survey tool used for the October survey, we are concerned with the accuracy of the existing times. The current times are based on a 2006 survey of 600 individuals with only 45 responses from five specialties (ASH, IDSA, AAN, AOA, and ACP). The dominant specialty (cardiology) did not participate in the survey,

and no surgical specialties participated, reflective of a flawed survey methodology. It is reasonable to conclude that changes in technology, changes in practice patterns, and changes in surveying specialties for the current survey have resulted in times and intensities that are more accurate when compared to surveys from 15 years ago.

Survey Analysis

Survey Time
Due to the CPT changes, all time reported for an inpatient/observation consultation is considered to be on the date of that service and is considered to be intra-service time for purposes of time included in the RUC database and time to be included in the CPT code descriptor. Stated another way, for E/M services, intra-time is the date of encounter time and RUC database pre-and post-time (if applicable) is time spent on day(s) before or day(s) after the date of encounter. Therefore, the intra-service time for the consult services is equal to the total time on the date of encounter, since no time is allowed for day(s) before or after for this set of codes.

Key References
The key reference services chosen by respondents were all office visit codes that had been revalued effective 2021. This is important because the work RVU of the office visit codes are reflective of time collected for a ten-day period. However, the office visit code descriptors only include a range of time for the day of the encounter (e.g., for 99213 the range is 20-29 minutes). To be clear, the office visit code descriptor time is day of service, but there is additional time that survey respondents are not aware of for three days before the date of the visit to seven days after the date of the visit. This has confused the survey process and the comparison between office visit codes and other E/M codes because the survey respondent only knows about the time in the code descriptor and not the additional times that are in the RUC database. In addition, the office visit code descriptor times, which are a range of times, were established by the CPT Panel **prior** to the survey of the office visit codes, which is different than how all the other E/M surveys were conducted (i.e., without time included in the descriptors).

This means that the survey intra-service time for the inpatient consultations is NOT comparable to the sum of the pre, intra, and post-service times of the office visit codes that were chosen as reference services. This is a key point because comparing the survey times to the total time of the reference services (i.e., the sum of the pre, intra, and post-service times of the office visit codes) is NOT appropriate and should not be made. Again, the respondents only saw the CPT descriptor with a time range for the office codes that were picked as reference services. Those descriptors include the CPT Panel assigned typical time range and not survey times (ie, there is a disconnect between the code descriptor time and the survey time components).

This means the most relevant comparison should primarily be magnitude estimation based on MDM, followed by a comparison with the intra-service time of the office visits. The expert panel concluded that the pre- and post-service time of the office visit reference services should be ignored in any analysis of magnitude estimation for work. For example, if a key reference service has a survey intra-service time of 30 minutes, a code descriptor that says the typical time is “30-39 minutes” and the inpatient code being surveyed has an intra/total time of 35 minutes, the time of the inpatient survey code is within the range of the time for the reference service.

The expert panel concluded that this was the only way the survey data could be appropriately compared to the key reference services (i.e., so there would be a true apples-to-apples comparison) and to account for the fact that the reference services are based on work performed over ten days even though the code descriptors and CPT guidelines do not indicate that fact.

The expert panel also agreed that as a general matter, the inpatient consultation codes require more work than the equivalent non-consultation inpatient codes to account for the additional expert opinion report.

Panel Recommendations

99252

The expert panel reviewed the intensity/complexity measures. Most respondents reported that the overall intensity and complexity of 99252 was identical or more intense/complex than office visit services. Very few of the respondents reported that 99252 was less intense/complex than the reference services. This is important because most of the

respondents are familiar with both office and facility E/M services and therefore, there is good fitness to rate and compare intensity/complexity and work.

The key reference services were 99202 (time range 15-29) and 99203 (time range 30-44) The expert panel noted that the time of 35 minutes is squarely within the time range for 99203 (30-44 minutes) and that 99202 and 99252 both have straightforward level MDM. However, the intraservice time spent on the date of service for 99252 is 75% more than the total service time of 20 minutes for 99202. When compared to second key reference service 99203, surveyed code 99252 has identical total time and a slightly lower median work RVU. This comparison also makes sense, as a Level 2 inpatient consult is reasonably estimated to be more work than a Level 2 new patient office visit and similar or slightly less than a Level 3 new patient office visit.

Therefore, the expert panel recommends the survey total time of 35 minutes and the survey median RVU of 1.50.

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) 99251/99252

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 General Surgery How often? Commonly

Specialty Internal Medicine How often? Commonly

Specialty Podiatry How often? Commonly

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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National utilization 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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for inpatient visit consult codes. If CMS agrees to revise its policy, the last page of this SOR includes the 2009 utilization and specialty distribution for code 99252 for informational purposes.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99252

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

CPT	SPEC	PCT
	2009 Utilization	**896,106**
99252	GENERAL SURGERY	12%
99252	INTERNAL MEDICINE	11%
99252	PODIATRY	10%
99252	ORTHOPEDIC SURGERY	8%
99252	CARDIOLOGY	7%
99252	UROLOGY	6%
99252	GASTROENTEROLOGY	5%
99252	PSYCHIATRY	5%
99252	PHYSICAL MEDICINE AND REHABILITATION	4%
99252	FAMILY PRACTICE	3%

99252	NURSE PRACTITIONERS	3%
99252	NEPHROLOGY	2%
99252	OTOLARYNGOLOGY	2%
99252	PHYSICIANS ASSISTANT	2%
99252	NEUROLOGY	2%
99252	VASCULAR SURGERY	2%
99252	PULMONARY DISEASE	2%
99252	DERMATOLOGY	2%
99252	NEUROSURGERY	2%
99252	INFECTIOUS DISEASE	2%
99252	HEMATOLOGY/ONCOLOGY	1%
99252	THORACIC SURGERY	1%
99252	ANESTHESIOLOGY	1%
99252	PLASTIC AND RECONSTUCTIVE SURGERY	1%
99252	CARDIAC SURGERY	1%
99252	OBSTETRICS/GYNECOLOGY	1%
99252	OPHTHALMOLOGY	1%
99252	ENDOCRINOLOGY	1%
99252	GENERAL PRACTICE	1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99253 Tracking Number G6 Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
Global Period: XXX Current Work RVU: **2.27** RUC Recommended RVU: **2.00**

CPT Descriptor: Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested inpatient consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be an acute uncomplicated illness or injury. A report is generated and sent to the requesting provider.

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:

Description of Intra-Service Work: Review the referring physician/QHP request for the consultant's expert opinion for management of a specific medical problem. Review available prior medical records, including labs and imaging. Order and review additional records, diagnostic labs, imaging and/or other tests as necessary for the consultation. Incorporate pertinent information into the medical record. Coordinate with other members of the health care team. Visit patient location (e.g., floor, observation area, unit), confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis requiring low level medical decision making [MDM]. Discuss the findings with the patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the consultation. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Don Selzer, MD (ACS), Richard Wright, MD (ACC), Marianna Spanaki, MD (AAN), Phillip Rodgers, MD (AAHP), Bruce Cameron, MD (AGA), Matthew Sideman, MD (SVS), Karin Swartz, MD (NASS)
Specialty Society(ies):	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG, ACNM, ACOG, ACS, AGA, ASCO, ASCRS (colon), ASGE, ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS
CPT Code:	99253
Sample Size: 29527	**Resp N:** 219
Description of Sample:	random samples from each society

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**25.00**	100.00	3200.00
Survey RVW:	0.60	1.60	**2.00**	2.75	12.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	37.00	**45.00**	57.00	165.00

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: 99253	**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:	**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? 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
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**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 low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
72158	XXX	2.29	**RUC Time**	244,364

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92004	XXX	1.82	**RUC Time**	2,208,242

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**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 moderate level of medical decision making. When using time for code selection, 30- 39 minute

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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: 77 **% of respondents:** 35.1 **%**

Number of respondents who choose 2nd Key Reference Code: 38 **% of respondents:** 17.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99253	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	0.00	5.00	5.00
Median Intra-Service Time	45.00	25.00	20.00
Median Immediate Post-service Time	0.00	5.00	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	**45.00**	**35.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	36%	56%	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	1%	53%	46%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	78%	17%
Physical effort required	3%	58%	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	6%	42%	52%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	58%	39%	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	5%	61%	34%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	84%	11%
Physical effort required	8%	79%	13%

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	11%	53%	36%

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 2023 Changes

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- Deletion of code 99251
- Revision of codes 99252-99255 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Performing a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the inpatient consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the inpatient consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the inpatient consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the inpatient consultation codes. Over 250 responses for physician work were received for each code.

Concerns, however, arose at the October 2021 RUC meeting about the accuracy of the times provided by respondents because of the survey tool utilized. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation consultation services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the four codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. Both survey tools are included in the RUC materials.

Discussion of Increased Intensity

Change in Technology

Although the recommended work RVUs for codes 99252-99255 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for the inpatient consultation codes, specifically, a change in technology. The establishment of EHRs since these codes were last reviewed has dramatically changed care, allowing for more information requiring review and analysis. Patients present at a hospital with acute problems or exacerbation of current problems. Assessment of the problem needs to be performed expeditiously. The increased knowledge base in EHRs has increased intensity and complexity of patient care by requiring review and analysis of more data in the same or shorter amount of time. We believe the intensity of this work is greater than the intensity of work when compared with office visits – or at a minimum not less intense.

Accuracy of RUC Database Times

Setting aside the concerns about the survey tool used for the October survey, we are concerned with the accuracy of the existing times. The current times are based on a 2006 survey of 600 individuals with only 45 responses from five specialties (ASH, IDSA, AAN, AOA, and ACP). The dominant specialty (cardiology) did not participate in the survey, and no surgical specialties participated, reflective of a flawed survey methodology. It is reasonable to conclude that changes in technology, changes in practice patterns, and changes in surveying specialties for the current survey have resulted in times and intensities that are more accurate when compared to surveys from 15 years ago.

Survey Analysis

Survey Time

Due to the CPT changes, all time reported for an inpatient/observation consultation is considered to be on the date of that service and is considered to be intra-service time for purposes of time included in the RUC database and time to be included in the CPT code descriptor. Stated another way, for E/M services, intra-time is the date of encounter time and RUC database pre-and post-time (if applicable) is time spent on day(s) before or day(s) after the date of encounter. Therefore, the intra-service time for the consult services is equal to the total time on the date of encounter, since no time is allowed for day(s) before or after for this set of codes.

Key References

The key reference services chosen by respondents were all office visit codes that had been revalued effective 2021. This is important because the work RVU of the office visit codes are reflective of time collected for a ten-day period. However, the office visit code descriptors only include a range of time for the day of the encounter (e.g., for 99213 the range is 20-29 minutes). To be clear, the office visit code descriptor time is day of service, but there is additional time that survey respondents are not aware of for three days before the date of the visit to seven days after the date of the visit. This has confused the survey process and the comparison between office visit codes and other E/M codes because the survey respondent only knows about the time in the code descriptor and not the additional times that are in the RUC database. In addition, the office visit code descriptor times, which are a range of times, were established by the CPT Panel **prior** to the survey of the office visit codes, which is different than how all the other E/M surveys were conducted (i.e., without time included in the descriptors).

This means that the survey intra-service time for the inpatient consultations is NOT comparable to the sum of the pre, intra, and post-service times of the office visit codes that were chosen as reference services. This is a key point because comparing the survey times to the total time of the reference services (i.e., the sum of the pre, intra, and post-service times of the office visit codes) is NOT appropriate and should not be made. Again, the respondents only saw the CPT descriptor with a time range for the office codes that were picked as reference services. Those descriptors include the CPT Panel assigned typical time range and not survey times (ie, there is a disconnect between the code descriptor time and the survey time components).

This means the most relevant comparison should primarily be magnitude estimation based on MDM, followed by a comparison with the intra-service time of the office visits. The expert panel concluded that the pre- and post-service time of the office visit reference services should be ignored in any analysis of magnitude estimation for work. For example, if a key reference service has a survey intra-service time of 30 minutes, a code descriptor that says the typical time is “30-39 minutes” and the inpatient code being surveyed has an intra/total time of 35 minutes, the time of the inpatient survey code is within the range of the time for the reference service.

The expert panel concluded that this was the only way the survey data could be appropriately compared to the key reference services (i.e., so there would be a true apples-to-apples comparison) and to account for the fact that the reference services are based on work performed over ten days even though the code descriptors and CPT guidelines do not indicate that fact.

The expert panel also agreed that as a general matter, the inpatient consultation codes require more work than the equivalent non-consultation inpatient codes to account for the additional expert opinion report.

Panel Recommendations

99253

The expert panel reviewed the intensity/complexity measures. Well over 50% of respondents reported that the overall intensity and complexity of these services was somewhat, or much more than the office visit services. Virtually none of the respondents reported that the services were less intense/complex than the reference services. This confirmed the expert panel’s understanding that inpatient visits are more intense the outpatient office visits. This is important because most of the respondents are familiar with both office and facility E/M services and therefore, there is good fitness to rate and compare intensity/complexity and work.

The key reference services were 99203 (time range 30-44) and 99213 (time range 20-29). The expert panel noted that the time of 45 minutes for 99253 is just beyond the time range for 99203 (30-44 minutes) and that 99203 and 99253 both have low-level MDM. The intraservice time spent on the date of service for 99253 is longer than that of 99203. This comparison makes sense, as a Level 3 inpatient consult is reasonably estimated to be more work than a Level 3 new patient office visit and above a Level 3 existing patient office visit.

Therefore, the expert panel recommends the survey intra/total time of 45 minutes and the survey median RVU of 2.00.

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) 99253

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 Internal Medicine How often? Commonly

Specialty Gastroenterology How often? Commonly

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 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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for inpatient visit consult codes. If CMS agrees to revise its policy, the last page of this SOR includes the 2009 utilization and specialty distribution for code 99253 for informational purposes.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99253

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

CPT	SPEC	PCT
	2009 Utilization	**3,265,358**
99253	CARDIOLOGY	12%
99253	INTERNAL MEDICINE	12%
99253	GASTROENTEROLOGY	10%
99253	GENERAL SURGERY	8%
99253	PHYSICAL MEDICINE AND REHABILITATION	6%
99253	ORTHOPEDIC SURGERY	5%
99253	UROLOGY	5%
99253	NEPHROLOGY	5%
99253	PULMONARY DISEASE	4%
99253	INFECTIOUS DISEASE	4%
99253	NEUROLOGY	4%
99253	PSYCHIATRY	3%
99253	FAMILY PRACTICE	2%
99253	NURSE PRACTITIONERS	2%
99253	OTOLARYNGOLOGY	2%
99253	PODIATRY	2%
99253	HEMATOLOGY/ONCOLOGY	2%
99253	VASCULAR SURGERY	1%
99253	PHYSICIANS ASSISTANT	1%
99253	NEUROSURGERY	1%

99253	ENDOCRINOLOGY	1%
99253	THORACIC SURGERY	1%
99253	OPHTHALMOLOGY	1%
99253	CARDIAC SURGERY	1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99254 Tracking Number G7 Original Specialty Recommended RVU: **3.00**
Presented Recommended RVU: **3.00**
Global Period: XXX Current Work RVU: **3.29** RUC Recommended RVU: **2.72**

CPT Descriptor: Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested inpatient consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be an undiagnosed new problem with uncertain prognosis or chronic illness with progression. A report is generated and sent to the requesting provider.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Review the referring physician/QHP request for the consultant's expert opinion for management of a specific medical problem. Review available prior medical records, including labs and imaging. Order and review additional records, diagnostic labs, imaging and/or other tests as necessary for the consultation. Incorporate pertinent information into the medical record. Coordinate with other members of the health care team. Visit patient location (e.g., floor, observation area, unit), confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis requiring moderate level medical decision making [MDM]. Discuss the findings with the patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the consultation. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	Don Selzer, MD (ACS), Richard Wright, MD (ACC), Marianna Spanaki, MD (AAN), Phillip Rodgers, MD (AAHP), Bruce Cameron, MD (AGA), Matthew Sideman, MD (SVS), Karin Swartz, MD (NASS)					
Specialty Society(ies):	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG, ACNM, ACOG, ACS, AGA, ASCO, ASCRS (colon), ASGE, ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS					
CPT Code:	99254					
Sample Size:	29527	**Resp N:**	234			
Description of Sample:	random samples from each society					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**25.00**	63.00	1000.00	
Survey RVW:	1.00	2.72	**3.00**	3.50	38.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	25.00	50.00	**60.00**	75.00	205.00	
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:	99254	**Recommended Physician Work RVU: 2.72**		
		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:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	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**
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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
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

Other Reference CPT Code	Global	Work RVU	Time Source

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: 97 **% of respondents:** 41.4 **%**

Number of respondents who choose 2nd Key Reference Code: 52 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99254	**Top Key Reference CPT Code:** 99204	**2nd Key Reference CPT Code:** **99205**
Median Pre-Service Time	0.00	10.00	14.00
Median Intra-Service Time	60.00	40.00	59.00
Median Immediate Post-service Time	0.00	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**	**60.00**	**88.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	22%	57%	21%

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	0%	69%	31%
Physical effort required	1%	45%	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	1%	27%	72%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	31%	50%	15%

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%	36%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	56%	38%
Physical effort required	2%	46%	52%

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%	25%	69%

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.*

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included in the CPT code descriptor. Stated another way, for E/M services, intra-time is the date of encounter time and RUC database pre-and post-time (if applicable) is time spent on day(s) before or day(s) after the date of encounter. Therefore, the intra-service time for the consult services is equal to the total time on the date of encounter, since no time is allowed for day(s) before or after for this set of codes.

Key References
The key reference services chosen by respondents were all office visit codes that had been revalued effective 2021. This is important because the work RVU of the office visit codes are reflective of time collected for a ten-day period. However, the office visit code descriptors only include a range of time for the day of the encounter (e.g., for 99213 the range is 20-29 minutes). To be clear, the office visit code descriptor time is day of service, but there is additional time that survey respondents are not aware of for three days before the date of the visit to seven days after the date of the visit. This has confused the survey process and the comparison between office visit codes and other E/M codes because the survey respondent only knows about the time in the code descriptor and not the additional times that are in the RUC database. In addition, the office visit code descriptor times, which are a range of times, were established by the CPT Panel **prior** to the survey of the office visit codes, which is different than how all the other E/M surveys were conducted (i.e., without time included in the descriptors).

This means that the survey intra-service time for the inpatient consultations is NOT comparable to the sum of the pre, intra, and post-service times of the office visit codes that were chosen as reference services. This is a key point because comparing the survey times to the total time of the reference services (i.e., the sum of the pre, intra, and post-service times of the office visit codes) is NOT appropriate and should not be made. Again, the respondents only saw the CPT descriptor with a time range for the office codes that were picked as reference services. Those descriptors include the CPT Panel assigned typical time range and not survey times (ie, there is a disconnect between the code descriptor time and the survey time components).

This means the most relevant comparison should primarily be magnitude estimation based on MDM, followed by a comparison with the intra-service time of the office visits. The expert panel concluded that the pre- and post-service time of the office visit reference services should be ignored in any analysis of magnitude estimation for work. For example, if a key reference service has a survey intra-service time of 30 minutes, a code descriptor that says the typical time is "30-39 minutes" and the inpatient code being surveyed has an intra/total time of 35 minutes, the time of the inpatient survey code is within the range of the time for the reference service.

The expert panel concluded that this was the only way the survey data could be appropriately compared to the key reference services (i.e., so there would be a true apples-to-apples comparison) and to account for the fact that the reference services are based on work performed over ten days even though the code descriptors and CPT guidelines do not indicate that fact.

The expert panel also agreed that as a general matter, the inpatient consultation codes require more work than the equivalent non-consultation inpatient codes to account for the additional expert opinion report.

Panel Recommendations

99254

The expert panel reviewed the intensity/complexity measures. Well over 50% of respondents reported that the overall intensity and complexity of these services was somewhat, or much more than the office visit services. Virtually none of the respondents reported that the services were less intense/complex than the reference services. This confirmed the expert panel's understanding that inpatient visits are more intense the outpatient office visits. This is important because most of the respondents are familiar with both office and facility E/M services and therefore, there is good fitness to rate and compare intensity/complexity and work.

The key reference services were 99204 (time range 45-59) and 99205 (time range 60-74). The expert panel noted that the time of 60 minutes for 99254 is just beyond the time range for 99204 (45-59 minutes) and that 99204 and 99254 both have moderate-level MDM. The intraservice time spent on the date of service for 99254 is higher than that of 99204. This comparison makes sense, as a Level 4 inpatient consult is reasonably estimated to be more work than a Level 4 new patient office visit and less work than a Level 5 new patient office visit.

Therefore, the expert panel recommends the survey intra/total time of 60 minutes and the survey median RVU of 3.00.

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) 99254

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 Internal Medicine How often? Commonly

Specialty Gastroenterology How often? Commonly

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 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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for inpatient visit consult codes. If CMS agrees to revise its policy, the last page of this SOR includes the 2009 utilization and specialty distribution for code 99254 for informational purposes.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

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:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99254

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

CPT	SPEC	PCT
	2009 Utilization	**5,859,333**
99254	CARDIOLOGY	20%
99254	INTERNAL MEDICINE	11%
99254	GASTROENTEROLOGY	10%
99254	PULMONARY DISEASE	9%
99254	NEUROLOGY	8%
99254	INFECTIOUS DISEASE	7%
99254	NEPHROLOGY	7%
99254	GENERAL SURGERY	4%
99254	PHYSICAL MEDICINE AND REHABILITATION	3%
99254	HEMATOLOGY/ONCOLOGY	2%
99254	PSYCHIATRY	2%
99254	UROLOGY	2%
99254	ENDOCRINOLOGY	2%
99254	NURSE PRACTITIONERS	2%
99254	ORTHOPEDIC SURGERY	1%
99254	FAMILY PRACTICE	1%
99254	PHYSICIANS ASSISTANT	1%
99254	VASCULAR SURGERY	1%
99254	NEUROSURGERY	1%
99254	CRITICAL CARE (INTENSIVISTS)	1%
99254	MEDICAL ONCOLOGY	1%

99254	THORACIC SURGERY	1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99255 Tracking Number G8 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: XXX Current Work RVU: **4.00** RUC Recommended RVU: **3.86**

CPT Descriptor: Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested inpatient consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be a chronic illness with severe exacerbation, progression or side effects of treatment. A report is generated and sent to the requesting provider.

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: Review the referring physician/QHP request for the consultant's expert opinion for management of a specific medical problem. Review available prior medical records, including labs and imaging. Order and review additional records, diagnostic labs, imaging and/or other tests as necessary for the consultation. Incorporate pertinent information into the medical record. Coordinate with other members of the health care team. Visit patient location (e.g., floor, observation area, unit), confirm patient's identity. Review the medical history with the patient and/or family/caregiver. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis requiring high level medical decision making [MDM]. Discuss the findings with the patient and family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the consultation. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Don Selzer, MD (ACS), Richard Wright, MD (ACC), Marianna Spanaki, MD (AAN), Phillip Rodgers, MD (AAHP), Bruce Cameron, MD (AGA), Matthew Sideman, MD (SVS), Karin Swartz, MD (NASS)
Specialty Society(ies):	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG, ACNM, ACOG, ACS, AGA, ASCO, ASCRS (colon), ASGE, ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS
CPT Code:	99255
Sample Size: 29527	**Resp N:** 223
Description of Sample:	random samples from each society

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	200.00	2000.00
Survey RVW:	1.20	3.55	**4.00**	4.50	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:	40.00	63.00	**80.00**	100.00	250.00

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: 99255	**Recommended Physician Work RVU: 3.86**		
	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:	**80.00**		

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? 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
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and 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.

Other Reference CPT Code	Global	Work RVU	Time Source

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: 117 **% of respondents:** 52.4 **%**

Number of respondents who choose 2nd Key Reference Code: 47 **% of respondents:** 21.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99255	Top Key Reference CPT Code: 99205	2nd Key Reference CPT Code: 99291
Median Pre-Service Time	0.00	14.00	15.00
Median Intra-Service Time	80.00	59.00	40.00
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	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	**80.00**	**88.00**	**70.00**
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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	17%	35%	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	1%	27%	72%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	57%	42%
Physical effort required	1%	42%	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	1%	21%	78%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	15%	38%	15%	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	17%	34%	49%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	15%	51%	34%
Physical effort required	15%	34%	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	15%	30%	55%

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 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the inpatient consultation codes were approved:

- Deletion of code 99251
- Revision of codes 99252-99255 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Performing a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the inpatient consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the inpatient consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the inpatient consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the inpatient consultation codes. Over 250 responses for physician work were received for each code.

Concerns, however, arose at the October 2021 RUC meeting about the accuracy of the times provided by respondents because of the survey tool utilized. The societies believed that some respondents may have only been considering floor/unit time and not the time before or after floor/unit time on the date of encounter. The RUC agreed with the specialty societies to resurvey the inpatient and observation consultation services, after revision of the survey tool to include definitions of time before and after floor/unit time. This would allow better comparison to prior surveys that included these time components. It should be noted that although the revised survey tool included a worksheet question asking for separate on/off floor times on the date of service, this question was followed by a question that included the summed total time for respondent confirmation that the total time was accurate. If the respondent did not agree with the total time for one or more of the four codes as arrayed, then the respondent was asked to return to the worksheet question and adjust the times as needed. The respondent could not move forward in the survey before affirming that the total times on the date of encounter were accurate. Both survey tools are included in the RUC materials.

Discussion of Increased Intensity

Change in Technology

Although the recommended work RVUs for codes 99252-99255 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for the inpatient consultation codes, specifically, a change in technology. The establishment of EHRs since these codes were last reviewed has dramatically changed care, allowing for more information requiring review and analysis. Patients present at a hospital with acute problems or exacerbation of current problems. Assessment of the problem needs to be performed expeditiously. The increased knowledge base in EHRs has increased intensity and complexity of patient care by requiring review and analysis of more data in the same or shorter amount of time. We believe the intensity of this work is greater than the intensity of work when compared with office visits – or at a minimum not less intense.

Accuracy of RUC Database Times

Setting aside the concerns about the survey tool used for the October survey, we are concerned with the accuracy of the existing times. The current times are based on a 2006 survey of 600 individuals with only 45 responses from five specialties (ASH, IDSA, AAN, AOA, and ACP). The dominant specialty (cardiology) did not participate in the survey, and no surgical specialties participated, reflective of a flawed survey methodology. It is reasonable to conclude that changes in technology, changes in practice patterns, and changes in surveying specialties for the current survey have resulted in times and intensities that are more accurate when compared to surveys from 15 years ago.

Survey Analysis

Survey Time

Due to the CPT changes, all time reported for an inpatient/observation consultation is considered to be on the date of that service and is considered to be intra-service time for purposes of time included in the RUC database and time to be

included in the CPT code descriptor. Stated another way, for E/M services, intra-time is the date of encounter time and RUC database pre-and post-time (if applicable) is time spent on day(s) before or day(s) after the date of encounter. Therefore, the intra-service time for the consult services is equal to the total time on the date of encounter, since no time is allowed for day(s) before or after for this set of codes.

Key References

The key reference services chosen by respondents were all office visit codes that had been revalued effective 2021. This is important because the work RVU of the office visit codes are reflective of time collected for a ten-day period. However, the office visit code descriptors only include a range of time for the day of the encounter (e.g., for 99213 the range is 20-29 minutes). To be clear, the office visit code descriptor time is day of service, but there is additional time that survey respondents are not aware of for three days before the date of the visit to seven days after the date of the visit. This has confused the survey process and the comparison between office visit codes and other E/M codes because the survey respondent only knows about the time in the code descriptor and not the additional times that are in the RUC database. In addition, the office visit code descriptor times, which are a range of times, were established by the CPT Panel **prior** to the survey of the office visit codes, which is different than how all the other E/M surveys were conducted (i.e., without time included in the descriptors).

This means that the survey intra-service time for the inpatient consultations is NOT comparable to the sum of the pre, intra, and post-service times of the office visit codes that were chosen as reference services. This is a key point because comparing the survey times to the total time of the reference services (i.e., the sum of the pre, intra, and post-service times of the office visit codes) is NOT appropriate and should not be made. Again, the respondents only saw the CPT descriptor with a time range for the office codes that were picked as reference services. Those descriptors include the CPT Panel assigned typical time range and not survey times (ie, there is a disconnect between the code descriptor time and the survey time components).

This means the most relevant comparison should primarily be magnitude estimation based on MDM, followed by a comparison with the intra-service time of the office visits. The expert panel concluded that the pre- and post-service time of the office visit reference services should be ignored in any analysis of magnitude estimation for work. For example, if a key reference service has a survey intra-service time of 30 minutes, a code descriptor that says the typical time is "30-39 minutes" and the inpatient code being surveyed has an intra/total time of 35 minutes, the time of the inpatient survey code is within the range of the time for the reference service.

The expert panel concluded that this was the only way the survey data could be appropriately compared to the key reference services (i.e., so there would be a true apples-to-apples comparison) and to account for the fact that the reference services are based on work performed over ten days even though the code descriptors and CPT guidelines do not indicate that fact.

The expert panel also agreed that as a general matter, the inpatient consultation codes require more work than the equivalent non-consultation inpatient codes to account for the additional expert opinion report.

Panel Recommendations

99255

The expert panel reviewed the intensity/complexity measures. Well over 50% of respondents reported that the overall intensity and complexity of these services was somewhat, or much more than the office visit services. Virtually none of the respondents reported that the services were less intense/complex than the reference services. This confirmed the expert panel's understanding that inpatient visits are more intense the outpatient office visits. This is important because most of the respondents are familiar with both office and facility E/M services and therefore, there is good fitness to rate and compare intensity/complexity and work.

The key reference services were 99205 (time range 60-74) and 99291, the first hour of critical care. The expert panel noted that the time of 80 minutes for 99255 is beyond the time range for 99205 and that 99205 and 99255 both have high-level MDM. The intraservice time spent on the date of service for 99255 is longer than the intraservice time of 99205. This comparison makes sense, as a Level 5 inpatient consult is reasonably estimated to be more intense and more work than a Level 5 new patient office visit and less work than an hour of critical care.

Therefore, the expert panel recommends the survey intra/total time of 80 minutes and the survey median RVU of 4.00.

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) 99255

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 Pulmonology How often? Commonly

Specialty Internal Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
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 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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for inpatient visit consult codes. If CMS agrees to revise its policy, the last page of this SOR includes the 2009 utilization and specialty distribution for code 99255 for informational purposes.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Hospital visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99255

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

CPT	SPEC	PCT
	2009 Utilization	**2,849,126**
99255	CARDIOLOGY	21%
99255	PULMONARY DISEASE	12%
99255	INTERNAL MEDICINE	12%
99255	NEUROLOGY	11%
99255	INFECTIOUS DISEASE	8%
99255	NEPHROLOGY	8%
99255	HEMATOLOGY/ONCOLOGY	5%
99255	GASTROENTEROLOGY	4%
99255	GENERAL SURGERY	3%
99255	PSYCHIATRY	2%
99255	MEDICAL ONCOLOGY	1%
99255	ENDOCRINOLOGY	1%
99255	PHYSICAL MEDICINE AND REHABILITATION	1%
99255	CRITICAL CARE (INTENSIVISTS)	1%
99255	CARDIAC SURGERY	1%
99255	NURSE PRACTITIONERS	1%
99255	NEUROSURGERY	1%
99255	THORACIC SURGERY	1%
99255	FAMILY PRACTICE	1%
99255	UROLOGY	1%
99255	ORTHOPEDIC SURGERY	1%

99255	PHYSICIANS ASSISTANT	1%
99255	VASCULAR SURGERY	1%

ISSUE: Inpatient/Observation Consultations

TAB: 14

Source	RUC Year	CPT	Global	DESC	MDM	CPT Time	Resp	IWPUT	Work Per Unit Time	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	% Typ	2009 Util	2019 Util
1st REF	2019	99202	XXX	Office or other outpatient visit fo	SF	15-29	73	0.045	0.047			0.93			20	2					15			3								2,352,028	2,490,658
2nd REF	2018	99203	XXX	Office or other outpatient visit fo	LOW	30-44	39	0.046	0.046			1.60			35	5					25			5								5,468,748	11,452,897
CURRENT	2006	99251	XXX	Inpatient consultation for a new	SF	20		0.078	0.050			1.00			20	5					10			5								246,304	n/a
CURRENT	2006	99252	XXX	Inpatient consultation for a new	SF	40		0.047	0.038			1.50			40	5					25			10								896,106	n/a
SVY		99252	XXX	Inpatient or observation consult	SF		206	0.043	0.043	0.18	1.00	1.50	2.00	10.00	35				5	25	35	45	121		0	1	10	25	1000	88%		
REC		99252	XXX	Inpatient or observation consult	SF			0.043	0.043			1.50			35						35											
medicine		*99252*	*XXX*	*KRS=99202*			*68*	*0.037*	*0.037*	*0.20*	*0.95*	*1.35*	*1.65*	*5.00*	*36*				*5*	*26*	*36*	*45*	*100*		*0*	*0*	*5*	*18*	*200*	*91%*		
surgery		*99252*	*XXX*	*KRS=99203*			*124*	*0.047*	*0.047*	*0.18*	*1.00*	*1.50*	*2.00*	*2.00*	*32*				*11*	*25*	*32*	*42*	*121*		*0*	*1*	*11*	*30*	*1000*	*85%*		
hospital		*99252*	*XXX*	*KRS=99202*			*1*	*0.024*	*0.024*	*0.90*	*0.90*	*0.90*	*0.90*	*0.90*	*37*				*37*	*37*	*37*	*37*	*37*		*0*	*1*	*11*	*30*	*1000*	*100%*		
PCP		*99252*	*XXX*	*KRS=99212/99213*			*13*	*0.029*	*0.029*	*0.70*	*0.93*	*1.00*	*1.30*	*2.40*	*35*				*25*	*34*	*35*	*42*	*65*		*0*	*2*	*10*	*30*	*50*	*92%*		
1st REF	2019	99203	XXX	Office or other outpatient visit fo	LOW	30-44	77	0.046	0.046			1.60			35	5					25			5								5,468,748	11,452,897
2nd REF	2019	99213	XXX	Office or other outpatient visit fo	LOW	20-29	38	0.043	0.043			1.30			30	5					20			5								101,611,504	92,217,549
CURRENT	2006	99253	XXX	Inpatient consultation for a new	LOW	55		0.057	0.041			2.27			55	10					30			15								3,265,358	n/a
SVY		99253	XXX	Inpatient or observation consult	LOW		219	0.044	0.044	0.60	1.60	2.00	2.75	12.00	45				15	37	45	57	165		0	2	25	100	3200	92%		
REC		99253	XXX	Inpatient or observation consult	LOW			0.044	0.044			2.00			45						45											
medicine		*99253*	*XXX*	*KRS=99203*			*69*	*0.040*	*0.040*	*0.60*	*1.60*	*1.99*	*2.50*	*6.00*	*50*				*15*	*37*	*50*	*56*	*120*		*0*	*8*	*20*	*50*	*550*	*94%*		
surgery		*99253*	*XXX*	*KRS=99203*			*133*	*0.050*	*0.050*	*0.75*	*1.70*	*2.25*	*3.00*	*12.00*	*45*				*18*	*37*	*45*	*57*	*165*		*0*	*10*	*25*	*50*	*1000*	*90%*		
hospital		*99253*	*XXX*	*KRS=99497*			*1*	*0.020*	*0.020*	*1.12*	*1.12*	*1.12*	*1.12*	*1.12*	*55*				*55*	*55*	*55*	*55*	*55*		*523*	*523*	*523*	*523*	*523*	*100%*		
PCP		*99253*	*XXX*	*KRS=99213*			*16*	*0.035*	*0.035*	*0.80*	*1.34*	*1.55*	*2.58*	*4.00*	*44*				*21*	*38*	*44*	*51*	*85*		*0*	*7*	*30*	*83*	*100*	*94%*		
1st REF	2019	99204	XXX	Office or other outpatient visit fo	MOD	45-59	97	0.043	0.043			2.60			60	10					40			10								3,426,345	10,714,246
2nd REF	2019	99205	XXX	Office or other outpatient visit fo	HIGH	60-74	52	0.040	0.040			3.50			88	14					59			15								1,018,170	2,923,626
CURRENT	2006	99254	XXX	Inpatient consultation for a new	MOD	80		0.056	0.041			3.29			80	15					45			20								5,859,333	n/a
SVY		99254	XXX	Inpatient or observation consult	MOD		234	0.050	0.050	1.00	2.72	3.00	3.50	38.00	60				25	50	60	75	205		0	10	25	63	1000	98%		
REC		99254	XXX	Inpatient or observation consult	MOD			0.045	0.045			2.72			60						60											
medicine		*99254*	*XXX*	*KRS=99204*			*80*	*0.051*	*0.051*	*1.10*	*2.74*	*3.00*	*3.40*	*38.00*	*59*				*25*	*46*	*59*	*70*	*160*		*0*	*15*	*50*	*118*	*750*	*96%*		
surgery		*99254*	*XXX*	*KRS=99204*			*137*	*0.048*	*0.048*	*1.00*	*2.75*	*3.10*	*4.00*	*15.00*	*65*				*30*	*50*	*65*	*75*	*205*		*0*	*11*	*35*	*100*	*1000*	*100%*		
hospital		*99254*	*XXX*	*KRS=99205*			*1*	*0.015*	*0.015*	*1.40*	*1.40*	*1.40*	*1.40*	*1.40*	*92*				*92*	*92*	*92*	*92*	*92*		*556*	*556*	*556*	*556*	*556*	*100%*		
PCP		*99254*	*XXX*	*KRS=99204*			*16*	*0.045*	*0.045*	*1.50*	*2.00*	*2.95*	*3.13*	*4.50*	*65*				*33*	*50*	*65*	*80*	*110*		*0*	*24*	*63*	*113*	*180*	*94%*		
1st REF	2019	99205	XXX	Office or other outpatient visit fo	HIGH	60-74	117	0.040	0.040			3.50			88	14					59			15								1,018,170	2,923,626
2nd REF	2006	99291	XXX	Critical care, evaluation and mar	n/a	30-74	47	0.096	0.064			4.50			70	15					40			15								4,320,255	5,905,780
CURRENT	2006	99255	XXX	Inpatient consultation for a new	HIGH	110		0.050	0.038			4.00			105	20					60			25								2,849,126	n/a
SVY		99255	XXX	Inpatient or observation consult	HIGH		223	0.050	0.050	1.20	3.55	4.00	4.50	20.00	80				40	63	80	100	250		0	20	50	200	2000	96%		
REC		99255	XXX	Inpatient or observation consult	HIGH			0.048	0.048			3.86			80						80											
XWALK	2018	95720	XXX	Electroencephalogram (EEG), co				0.062	0.051			3.86			75	10					55			10									
medicine		*99255*	*XXX*	*KRS=99205*			*77*	*0.052*	*0.052*	*1.20*	*3.50*	*3.90*	*4.20*	*8.00*	*75*				*40*	*60*	*75*	*100*	*190*		*0*	*10*	*40*	*150*	*800*	*97%*		
surgery		*99255*	*XXX*	*KRS=99205*			*129*	*0.050*	*0.050*	*1.50*	*3.60*	*4.15*	*4.70*	*20.00*	*84*				*43*	*65*	*84*	*100*	*250*		*0*	*10*	*30*	*50*	*600*	*95%*		
hospital		*99255*	*XXX*	*KRS=99291*			*1*	*0.015*	*0.015*	*2.26*	*2.26*	*2.26*	*2.26*	*2.26*	*150*				*150*	*150*	*150*	*150*	*150*		*515*	*515*	*515*	*515*	*515*	*100%*		
PCP		*99255*	*XXX*	*KRS=99205*			*16*	*0.042*	*0.042*	*1.75*	*2.95*	*3.75*	*4.13*	*15.00*	*90*				*45*	*70*	*90*	*123*	*210*		*2*	*20*	*55*	*113*	*325*	*94%*		

SOURCE	Review Year	CPT	DESC	MDM	CPT TIME	wput	Rec RVW	stat	25th	RVW MED	75th	Total Time	PRE	intra	POST
RUC-2019	2019	99212	Office or other outpatient visit for the evaluatio	SF	10-19	0.044	0.70	xwalk	0.50	0.75	1.00	16	2	11	3
RUC-2021	2021	99307	Subsequent nursing facility care, per day, for	SF	10	0.050	0.70	25th	0.70	0.80	1.30	14	1	12	1
RUC-2021	2021	99347	Home or residence visit for the evaluation and	SF	20	0.030	0.90	25th	0.90	1.30	1.91	30	5	20	5
RUC-2019	2019	99202	Office or other outpatient visit for the evaluatio	SF	15-29	0.047	0.93	current	0.71	1.00	1.45	20	2	15	3
RUC-2021	2021	99341	Home or residence visit for the evaluation and	SF	15	0.037	1.00	25th	1.00	1.50	1.80	27	6	15	6
SVY	2022	99231	Subsequent hospital inpatient or observation	SF or LOW	25	0.040	1.00	25th	1.00	1.30	1.50	25		25	
SVY	2021	99242	Office or other outpatient consultation for a ne	SF	20	0.036	1.08	med	0.93	1.08	1.49	30	5	20	5
RUC-2019	2019	99213	Office or other outpatient visit for the evaluatio	LOW	20-29	0.043	1.30	med	1.00	1.30	1.75	30	5	20	5
RUC-2021	2021	99308	Subsequent nursing facility care, per day, for	LOW	15	0.048	1.30	25th	1.30	1.44	1.85	27	5	18	4
SVY	2022	99252	Inpatient or observation consultation for a new	SF	35	0.043	1.50	med	1.00	1.50	2.00	35		35	
RUC-2021	2021	99304	Initial nursing facility care, per day, for the eva	SF or LOW	25	0.042	1.50	25th	1.50	1.70	2.00	36	6	25	5
RUC-2021	2021	99348	Home or residence visit for the evaluation and	LOW	30	0.033	1.50	25th	1.50	1.92	2.13	46	7	29	9.5
SVY	2022	99232	Subsequent hospital inpatient or observation	MOD	35	0.044	1.59	25th	1.59	2.00	2.46	36		36	
RUC-2019	2019	99203	Office or other outpatient visit for the evaluatio	LOW	30-44	0.046	1.60	med	1.25	1.60	2.20	35	5	25	5
SVY	2022	99221	Initial hospital inpatient or observation care, p	SF or LOW	40	0.048	1.63	25th	1.63	1.95	2.50	40		40	
RUC-2021	2021	99342	Home or residence visit for the evaluation and	LOW	30	0.032	1.65	25th	1.65	2.00	2.60	52	10	32	10
SVY	2021	99243	Office or other outpatient consultation for a ne	LOW	30	0.041	1.80	med	1.60	1.80	2.00	44	7	30	7
RUC-2019	2019	99214	Office or other outpatient visit for the evaluatio	MOD	30-39	0.041	1.92	xwalk	1.50	2.00	2.56	47	7	30	10
RUC-2021	2021	99309	Subsequent nursing facility care, per day, for	MOD	30	0.041	1.92	25th	1.92	2.09	2.60	47	7	30	10
SVY	2022	99234	Hospital inpatient or observation care, for the	SF or LOW	45	0.051	2.00	25th	2.00	2.60	3.00	50		45	5
SVY	2022	99253	Inpatient or observation consultation for a new	LOW	45	0.044	2.00	med	1.60	2.00	2.75	45		45	
SVY	2022	99233	Subsequent hospital inpatient or observation	HIGH	50	0.046	2.40	25th	2.40	2.90	3.24	52		52	
RUC-2021	2021	99349	Home or residence visit for the evaluation and	MOD	40	0.036	2.44	25th	2.44	2.70	3.05	68	12	41	15
RUC-2021	2021	99305	Initial nursing facility care, per day, for the eva	MOD	35	0.045	2.50	25th	2.50	2.75	3.00	55	10	35	10
RUC-2019	2019	99204	Office or other outpatient visit for the evaluatio	MOD	45-59	0.043	2.60	med	2.00	2.60	3.24	60	10	40	10
SVY	2022	99222	Initial hospital inpatient or observation care, p	MOD	55	0.047	2.60	25th	2.60	2.81	3.44	55		55	
SVY	2021	99244	Office or other outpatient consultation for a ne	MOD	40	0.045	2.69	crosswalk	2.60	2.80	3.10	60	10	40	10
SVY	2022	99254	Inpatient or observation consultation for a new	MOD	60	0.050	2.72	25th	2.72	3.00	3.50	60		60	
RUC-2018	2018	99495	Transitional Care Management Services with	MOD		0.051	2.78	med		2.78		54		54	
RUC-2019	2019	99215	Office or other outpatient visit for the evaluatio	HIGH	40-54	0.040	2.80	med	2.15	2.80	3.50	70	10	45	15
RUC-2021	2021	99310	Subsequent nursing facility care, per day, for	HIGH	45	0.040	2.80	25th	2.80	3.00	3.60	70	10	45	15
RUC-2021	2021	99344	Home or residence visit for the evaluation and	MOD	60	0.031	2.87	25th	2.87	3.50	3.79	92	15	60	17
SVY	2022	99235	Hospital inpatient or observation care, for the	MOD	70	0.043	3.24	current	2.88	3.50	3.83	76		68	8
RUC-2019	2019	99205	Office or other outpatient visit for the evaluatio	HIGH	60-74	0.040	3.50	med	2.80	3.50	4.00	88	14	59	15
RUC-2021	2021	99306	Initial nursing facility care, per day, for the eva	HIGH	45	0.044	3.50	25th	3.50	3.75	4.00	80	15	50	15
SVY	2022	99223	Initial hospital inpatient or observation care, p	HIGH	75	0.052	3.50	25th	3.50	4.00	4.25	74		74	
RUC-2021	2021	99350	Home or residence visit for the evaluation and	HIGH	60	0.037	3.60	med	3.10	3.60	4.00	97	17	60	20
SVY	2021	99245	Office or other outpatient consultation for a ne	HIGH	55	0.043	3.75	med	3.50	3.75	4.00	87	15	55	17
RUC2018	2018	99496	Transitional Care Management Services with	HIGH		0.051	3.79	med		3.79		75		75	
SVY	2022	99255	Inpatient or observation consultation for a new	HIGH	80	0.050	3.86	crosswalk	3.55	4.00	4.50	80		80	
RUC-2021	2021	99345	Home or residence visit for the evaluation and	HIGH	75	0.031	3.88	25th	3.88	4.00	4.50	126	25	74	26.5
SVY	2022	99236	Hospital inpatient or observation care, for the	HIGH	85	0.044	4.30	med	3.55	4.30	4.58	97		85	12
RUC-2005	2005	99291	Critical care, evaluation and management of t	HIGH	30-74	0.064	4.50	med		4.50		70	15	40	15
SVY	2022	99238	Hospital inpatient or observation discharge da	NA	<30	0.039	1.50	25th	1.50	1.90	2.50	38		28	10
RUC-2021	2021	99315	Nursing facility discharge day management; 3	NA	<30	0.038	1.50	25th	1.50	2.10	2.78	40	10	25	5
RUC-2021	2021	99316	Nursing facility discharge day management; r	NA	>30	0.040	2.50	25th	2.50	3.01	3.80	63	15	40	8
SVY	2022	99239	Hospital inpatient or observation discharge da	NA	>30	0.034	2.15	25th	2.15	2.90	3.50	64		45	19

December 13, 2021

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Avenue
Chicago, IL 60611

Re: Tab 14 Inpatient/Observation Consultations

Dear Dr. Manaker:

Tab 14 on the January 2022 RUC agenda addresses four revised codes for inpatient/observation consultations. Each of these services will be provided exclusively in the facility setting with no direct practice expense attributable to the clinician billing the service. As such, the multispecialty advisory committee for Tab 14 recommends no direct practice expense inputs.

Thank you for your consideration of this information as you prepare for the upcoming meeting. Please contact James Vavricek at jvavricek@acc.org if you have any questions.

Sincerely,

AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG, ACNM, ACOG, ACS, AGA, ASCO, ASCRS (colon), ASGE, ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Screen: CMS Request – Final Rule for 2020*

January 2022

Prolonged Services – on the Date of an E/M – Tab 15

In February 2021, the CPT Editorial Panel created prolonged inpatient service add-on code 993X0 to report prolonged face-to-face and non-face-to-face total time provided by the physician or other qualified health care professional (QHP) on the date of an inpatient service (ie, 99223, 99233, 99236, 99255, 99306, 99310). The Panel also revised CPT code 99417, so it would also be used to report prolonged office consultations, home and domiciliary visits and cognitive assessment and care plan services (in conjunction with 99245, 99345, 99350, 99483) in addition to prolonged office and other outpatient visits (with conjunction with codes 99205 and 99215). Codes 99417 and 993X0 are only to be reported when the primary service has been selected using time alone as the basis for code level selection and only after the time required to report the highest-level service has been exceeded by 15 minutes. The Panel also deleted the *Prolonged Service with Direct Patient Contact (Except with Office or Other Outpatient Services)* subsection including codes 99354-99357.

In October 2021, the specialty societies surveyed the two prolonged service on the date of an E/M codes (99417, 993X0) but did not obtain the required number of survey responses for code 993X0. The specialty noted, and the RUC concurred, that the January 2022 meeting is still within the current cycle and would not delay recommendations pertinent to the 2023 Medicare Physician Payment Schedule.

Compelling Evidence for 993X0
The specialty societies presented three points for compelling evidence that the work of providing inpatient hospital and observation care visits for the evaluation and management of patients may have changed, including for prolonged inpatient add-on code 993X0, which is part of the same code family. First, a change in the patient population, the distillation down to sicker patients who are in the hospital for a shorter period; second, a change in technology due to the widespread implementation of institutional electronic health records (EHR), which are data intensive and therefore more intense for the patient encounters; and third, a change in the providers of these services with the recent emergence of hospitalists and intensivists.

Change in Patient Population
The number of diagnoses that appear in the Medicare claims for inpatient visits (based on the 5% Medicare claims file) has increased in the last 16 years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006, the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%. Physicians are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a skilled nursing facility.

Data from the Chronic Conditions Data Warehouse also support the assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension, and COPD among Medicare

beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Technology

EHRs have significantly changed since 2006. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags in the EHR are frequent, as they are put in place for safety reasons. However, these flags require the physician/QHP rather than clinical staff to review and override any modifications to treatment, such as a medication change, before the clinical staff can continue with care of the patient. The American Hospital Association reported that in 2017[1] 95% of hospitals had some form of EHR implemented. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Change in Provider

Hospitalists are a new and growing specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital[2] and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.[3] In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.[4] New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.[5] As the field grows, the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the typical model of inpatient primary care (e.g., rounding in the hospital on their patients) in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.[6] Shift-based coverage makes at least one handoff between physicians during a 24-hour period, a ubiquitous practice. About 50% of hospitalist groups use a daytime admitter model or a hybrid for admissions,[7] meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult but reflect the reality of team-based care in many hospitals.

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[1] SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.
Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief No. 46 April 2019

[2] Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med. 1996;335(7):514–517.

[3] Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. Medicare Medicaid Res Rev. 2014;4(2):E1–E8.

[4] Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. J. Hosp. Med 2016;1;45-47. doi:10.1002/jhm.2480

[5] Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

[6] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

[7] Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.[8]

The RUC acknowledges that the existing Medicare data attributes a much smaller proportion of claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) using a recently established Medicare specialty billing code (C6), therefore underrepresenting the proportion of hospitalists who perform these services. Given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today.

The RUC agrees that there is compelling evidence based on a change in patient population, change in technology, and change in the provider of these services.

99417 ***Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management services)***
The RUC reviewed survey responses from 98 physicians and other qualified healthcare professionals and determined that a work RVU of 0.61 appropriately accounts for the physician work required to perform this service. This is the survey 25th percentile and current work RVU (for both 99417 and G2212). The RUC recommends 15 minutes of total time. It is important to note that this service may only be reported with CPT codes 99205, 99215, 99245, 99345, 99350 and 99483 and may not be reported for any time less than 15 minutes. The RUC noted that even though the CPT Editorial Panel revised the coding structure so 99417 will now also be reported with prolonged office consultations, home and domiciliary visits, and cognitive assessment and care plan services, most of the visits are expected to still be reported with the office visit codes 99205 and 99215. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits.

To justify a work RVU of 0.61, the RUC compared the surveyed code to top key reference code 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)* (work RVU= 0.70, total time of 20 minutes) and noted that although the reference code typically involves 5 more minutes of total time, the physician or QHP work described by the survey code of providing direct patient care for an office or other outpatient services for typically complex patient is more intense than time spent supervising clinical staff for a chronic care management service. Therefore, the RUC concurred with the specialties that the surveyed code is a more intense service to perform and should be assigned a work value somewhat lower than the reference code.

[8] Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

The RUC also compared the surveyed code to another office or other outpatient service, MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU= 0.70, total time of 16 minutes), and concurred with the specialties that a work RVU of 0.61 placed 99417 in proper rank order to 99212, an XXX-global code with a similar amount of total time. The RUC noted that a recommendation of 0.61 work RVUs and 15 minutes of total time would assign the surveyed code 99417 an intensity that is identical to the volume-weighted intensity assigned to office visit codes 99202-99215, the code family with which 99417 will most commonly be reported. The RUC also noted that 81% of the survey respondents concurred that the typical patient would either have a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function. The RUC concluded that the value of CPT code 99417 should be maintained at 0.61 work RVUs as supported by the survey 25th percentile. **The RUC recommends a work RVU of 0.61 with 15 minutes total time for CPT code 99417.**

993X0 ***Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services)***
The RUC reviewed survey responses from 124 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 0.81 appropriately accounts for the physician work required to perform this service. The RUC recommends 20 minutes of total time. The RUC noted that this service may only be reported with CPT codes 99223, 99233, 99236, 99255, 99306, 99310 and may not be reported for any time less than 15 minutes.

To justify a work RVU of 0.81, the RUC compared the surveyed code to top key reference code 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)* (work RVU= 0.70, total time of 20 minutes) and noted that although both add-on E/M services require the same amount of total time, however, the physician or QHP work of providing direct patient care for an inpatient or observation visit is more intense than time spent supervising clinical staff for a chronic care management service. The RUC also compared the surveyed code to second key reference 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, total time of 30 minutes) and noted that the surveyed code, with 10 less minutes of total time and somewhat less intensity, maintains the appropriate relativity to this reference service. The RUC also noted that 86% of the survey respondents concurred that the typical patient would either have a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function. **The RUC recommends a work RVU of 0.81 with 20 minutes total time for CPT code 993X0.**

Practice Expense
At the October 2021 RUC meeting, the Practice Expense Subcommittee reviewed the direct practice expenses and made modifications to remove all direct practice expense inputs from CPT code 993X0 since it is a facility-only code. The equipment input ED021 *Computer, desktop, w-monitor* was removed from CPT code 99417 on the basis that this is an indirect expense. Consistent with the current inputs for G2212 and the RUC's prior recommendations for 99417, equipment inputs EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *exam table* were included in

the recommended inputs for code 99417 in the non-facility setting. Since it is an add-on to a face-to-face evaluation and management service in the outpatient (i.e., non-facility) setting and the patient will typically be occupying an exam room during the prolonged service. At the January 2022 meeting, the Practice Expense Subcommittee affirmed its previous recommendations from the October 2021 meeting. The Practice Expense Subcommittee had confirmed that the prolonged service would typically occur with the patient still in the room, and therefore, the otoscope-ophthalmoscope and the exam table would be present in the room the entire time during the typical prolonged service visit. The Practice Expense Subcommittee discussed how these codes are being used and requested that CPT code 99417 be reviewed by the RAW once claims data becomes available so that the RUC can learn whether it is being billed as solitary units or in multiples and confirm the typical scenario in which this code is reported. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Recommendation to Delete HCPCS code G2212

Currently (for CY 2022), the Centers for Medicare & Medicaid Services (CMS) assigns CPT code 99417 a Medicare Status of "I" *Not valid for Medicare purposes.* In lieu of 99417, Medicare uses another code for reporting prolonged office or outpatient services, G2212 *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report g2212 for any time unit less than 15 minutes)*, though that code is redundant with the newly revised 99417, which has also been revised to be reported with prolonged office consultations, home and domiciliary visits and cognitive assessment and care plan services (99245, 99345, 99350, 99483) in addition to being reported with prolonged office or outpatient visit services (99205, 99215). **The RUC recommends for CMS to delete HCPCS code G2212.**

Relativity Assessment Workgroup Review

The RUC recommends that CPT code 99417 be re-reviewed by the RAW once Medicare claims data is available to learn whether it is being reported as solitary units or in multiples and confirm the typical scenario in which this code is reported. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Prolonged Services** ~~**Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)**~~ ~~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, observation or outpatient setting, except with office or other outpatient~~				

~~services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). 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. 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 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.~~

~~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.~~

~~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 office or other outpatient 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 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.)~~	~~99356 X 1~~

	~~75-104 minutes (1 hr. 15 min. – 1 hr. 44 min.)~~	~~99356 X 1 AND 99357 X 1~~		
	~~105 or more (1 hr. 45 min. or more)~~	~~99356 X 1 AND 99357 X 2 or more for each additional 30 minutes.~~		
~~+ 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 usual service; first hour (List separately in addition to code for office or other outpatient **Evaluation and Management** or psychotherapy service)~~ ~~(Use 99354 in conjunction with 90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483)~~ ~~(Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)~~	~~ZZZ~~	~~N/A~~
~~+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)~~	~~ZZZ~~	~~N/A~~
~~+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 **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)~~	~~ZZZ~~	~~N/A~~
~~+99357~~	-	~~each additional 30 minutes (List separately in addition to code for prolonged service)~~	~~ZZZ~~	~~N/A~~

		~~(Use 99357 in conjunction with 99356)~~ (99354, 99355 have been deleted. For prolonged evaluation and management services on the date of an office or other outpatient service, home and residence service, or cognitive assessment and care plan, use 99417. For prolonged psychotherapy, use 908X0) (99356, 99357 have been deleted. For prolonged service on the date of an inpatient or observation or nursing facility service, use 993X0. For prolonged psychotherapy, use 908X0)		

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management ~~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, office consultation or other outpatient evaluation and management service (ie, 99205, 99215, 99245, 99345, 99350, 99483). Code 993X0 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 an inpatient service (ie, 99223, 99233, 99236, 99255, 99306, 99310). Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service. Codes 99417 and 993X0 ~~is~~ are only used when the primary ~~office or other outpatient~~ service has been selected using time alone as the basis and only after the ~~minimum~~ time required to report the highest-level service ~~(ie, 99205 or 99215)~~ has been exceeded by 15 minutes. To report a unit of 99417 or 993X0, 15 minutes of ~~additional~~ time must have been attained. Do not report 99417 or 993X0 for any ~~additional~~ time increment of less than 15 minutes.

~~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 or 993X0, 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 primary E/M service and prolonged E/M service is not counted toward the primary E/M and ~~time to report 99205, 99215 and~~ prolonged services time.

For prolonged services on a date other than the date of a face-to-face evaluation and management 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 ~~QHP~~, see 99415, 99416. Do not report 99417 or 993X0 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 office or other outpatient service when the highest level is reached (ie, 99205, 99215).~~

✚▲99417	K5	Prolonged ~~office or other~~ outpatient evaluation and management service(s) time with or without direct patient contact beyond the ~~minimum~~ required time ~~with or without direct patient contact beyond the usual service~~ of the primary service ~~procedure encounter which~~ when the primary service level 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~~ the code of the outpatient Evaluation and Management services) (Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483) (Do not report 99417 on the same date of service as ~~99354, 99355,~~ 90833, 90836, 90838, 99358, 99359, 99415, 99416) *(Do not report 99417 for any time unit less than 15 minutes)* (For prolonged psychotherapy services, use 908X0)	ZZZ	0.61 (no change)
✚●993X0	K6	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services) (Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310) (Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359) (Do not report 993X0 for any time unit less than 15 minutes)	ZZZ	0.81

(For prolonged psychotherapy services, use 908X0)

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 minutes or more	99205 X 1 AND 99417 X 3 or more for each additional 15 minutes
Total Duration of Office or Other Outpatient Consultation Services (use with 99245)	**Code(s)**
less than XX + 15 minutes	Not reported separately
XX+15 to XX+29 minutes	99245 X 1 AND 99417 X ~~2~~1
XX+30 to XX+44	99245 X 1 and 99417 X 2
XX+45 minutes or more	99245 X 1 AND 99417 X 3 or more for each additional 15 minutes

G2212		Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report g2212 for any time unit less than 15 minutes)	XXX	**Recommend for Deletion** (2021 work RVU = 0.61)

Comparison of Prolonged Services Codes 99354, 99355, 99356, 99357, 99358, 99359, 99417 Table

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 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 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 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 or 99215 and may be reported in multiple units of at least 15 minutes					

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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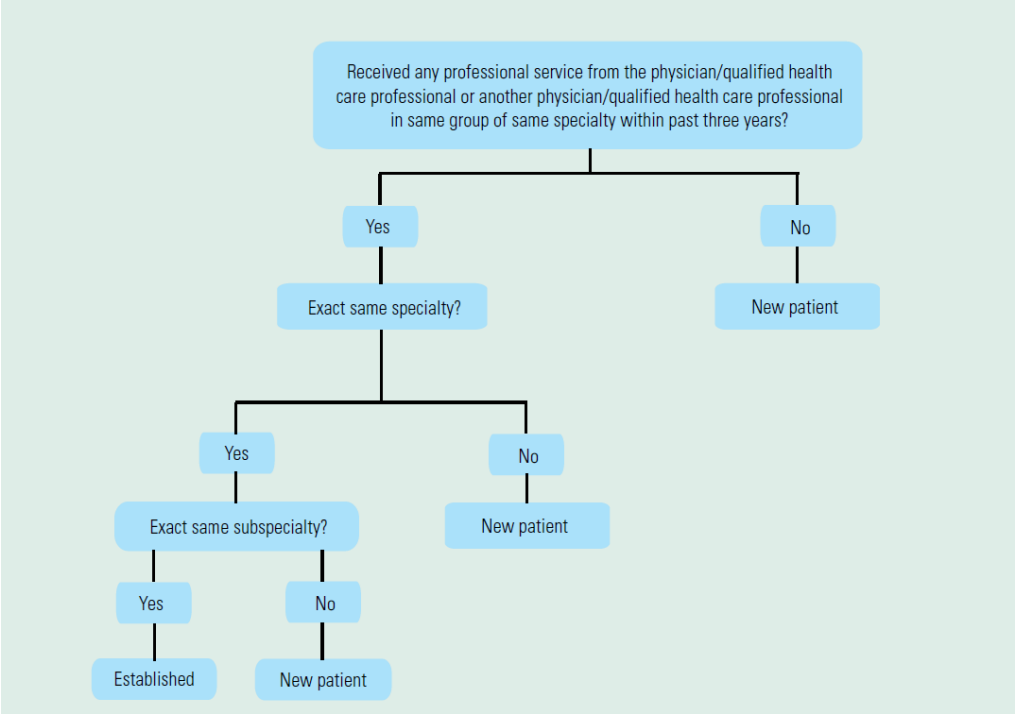
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99417 Tracking Number Original Specialty Recommended RVU: **0.61**
Presented Recommended RVU: **0.61**
Global Period: ZZZ Current Work RVU: **0.00** RUC Recommended RVU: **0.61**

CPT Descriptor: Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management services)
(Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483)
(Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)
(Do not report 99417 for any time unit less than 15 minutes)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Office visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: (not applicable)

Description of Intra-Service Work: Continue the work of evaluation and management lasting 15 minutes beyond the time of the usual service, either face-to-face or non-face-to-face. Includes tasks, such as formulating a treatment plan; discussing the diagnoses, workup, and treatment options with patient and family; providing additional patient education and responding to questions; analyzing test results; documenting the encounter in the medical record and additional discussions with other physicians and qualified health care professionals (QHPs); coordinating additional care with other physicians or members of the health care team necessary for additional work.

Description of Post-Service Work: (not applicable)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Megan Adamson, MD; Elizabeth Blanchard, MD; Audrey Chun, MD; Omar Hussain, DO; Charles Hamori, MD, FACP; Kevin Kerber, MD; Steven Krug, MD; Stephen Lahey, MD; James Levett, MD; Kano Mayer, MD; Phillip E. Rodgers, MD, FAAHPM; Fredrica Smith, MD; Karin Swartz, MD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Rob Zipper, MD
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American Association for Thoracic Surgery, American College of Physicians, American College of Rheumatology, American Geriatrics Society, American Nurses Association, American Society of Clinical Oncology, American Thoracic Society, American College of Chest Physicians, North American Spine Society, Society of Hospital Medicine, Society of Thoracic Surgeons
CPT Code:	99417
Sample Size: 23019	**Resp N:** 98
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**6.00**	29.00	1000.00
Survey RVW:	0.45	0.61	**0.97**	1.11	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:	5.00	15.00	**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:	99417	**Recommended Physician Work RVU: 0.61**		
		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
99439	ZZZ	0.70	**RUC Time**

CPT Descriptor 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; each additional 20 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)

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
74220	XXX	0.60	**RUC Time**	196,573

CPT Descriptor 1 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20552	000	0.66	**RUC Time**	350,667

CPT Descriptor 2 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(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: 65 **% of respondents:** 66.3 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99417	**Top Key Reference CPT Code:** 99439	**2nd Key Reference CPT Code:** **99292**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	20.00	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	**15.00**	**20.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	26%	44%	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	6%	27%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	45%	47%
Physical effort required	11%	48%	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	6%	29%	65%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	29%	57%	14%	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	29%	50%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	43%	50%	7%
Physical effort required	29%	57%	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	29%	43%	28%

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 prolonged services code family was surveyed because CPT created a new code, 993X0, for prolonged physician services furnished to an inpatient on the date of an inpatient visit which is to be reported based on time beyond that for 99233.

These codes, along with 99358 and 99359 were surveyed for the October 2021 RUC meeting. At that meeting, the RUC made recommendations for time and RVW for 99358 and 99359 but was unable to make recommendations for 99417 and 993X0 because the number of respondents to those surveys did not meet the minimum number of responses required by the RUC. Therefore, there was insufficient data upon which to make recommendations, and the RUC approved keeping the survey open of these two codes.

The surveys were done, and this time, a sufficient number of responses were obtained.

The surveying societies established an expert panel to review the survey data and make recommendations to the RUC.

99417

The expert panel noted that CMS does not currently recognize 99417 because it has established, G2212, Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)

For code 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)).

This code was surveyed for the October 2021 RUC meeting with the following results: there were 52 respondents of whom 77% found the vignette to be typical. 99417 is a ZZZ global so all the time is intraservice time. The survey times were 0/15/0/15, the median RVW was 0.95 and the 25th percentile RVW was 0.63.

The current survey that includes the data from the October extended survey, had 98 respondents of whom 81% found the vignette to be typical. 99417 is a ZZZ global so all the time is intra-service time. The survey times were 0/15/0/15, the median RVW was 0.97 and the 25th percentile RVW was 0.61.

The panel also noted that 99417 was surveyed for the April 2019 RUC meeting. The results of that survey were times of 0/15/0/15 and the median RVW was 0.75. That survey was conducted by over 40 specialty societies and had 1,112 respondents. The surveying specialties recommended an RVW of 0.61 to the RUC based on a direct crosswalk to 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.

G2212 has times of 0/15/0/15 and a RVW of 0.61. These values were established by CMS using a direct crosswalk for time and RVW to 99490.

The expert panel also reviewed the two key reference services, 99439, 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; each additional 20 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), which has times and RVW of 0/15/0/15/0.54, and 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), which has times and RVW of 0/30/0/30 and 2.25, respectively. The expert panel noted that 65 of the 98 respondents chose 99439 as the key reference service.

The expert panel agreed that work of 99417 has not changed since the 2019 survey and that the survey 25th percentile RVW of 0.61 (survey for this meeting) matches the existing value for G2212.

The expert panel also noted that 99439 is reported based on staff time for chronic care management under a physician's direction while 99417 is reported based on physician time and that 99417 can only be reported after the physician spends at least 15 minutes of time. Therefore, the panel agreed that the RVW for 99417 should be higher than the RVW for 99439 to maintain proper relativity.

The panel also reviewed 99490 and agreed that maintaining the current crosswalk to that code, consistent with the previous RUC recommendation and the CMS crosswalk, was appropriate

The expert panel also reviewed MPC code 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, Code 99212 has times of 2/11/3/16 and an RVW of 0.70. The specialties agreed that an RVW of 0.61 placed 99417 in proper rank order to 99212.

Lastly, the expert panel noted that 99417 is typically reported after 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. As another validation, the panel noted that the survey time of 15 minutes is 21% of the total time for 99215 and that 21% of 2.80 = 0.60.

Therefore, the expert panel recommends a total and intra time of 15 minutes, and an RVW of 0.61.

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.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99417	ZZZ	0.61	0	15	0
4.	99215	XXX	2.80	10	45	15
5.	Total		3.41	10	60	15

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G2212

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner How often? Sometimes

Specialty Family Medicine How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 10370573
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet)

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? 1,392,023 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet)

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99417

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:993X0 Tracking Number Original Specialty Recommended RVU: **0.81**
Presented Recommended RVU: **0.81**
Global Period: ZZZ Current Work RVU: **(N/A)** RUC Recommended RVU: **0.81**

CPT Descriptor: Prolonged inpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient Evaluation and Management services)
(Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)
(Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359)
(Do not report 993X0 for any time unit less than 15 minutes)
(For prolonged psychotherapy services, use 908X0)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Hospital visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: (not applicable)

Description of Intra-Service Work: Continue the work of evaluation and management lasting 15 minutes beyond the time of the usual service, either face-to-face or non-face-to-face. Includes tasks, such as formulating a treatment plan; discussing the diagnoses, workup, and treatment options with patient and family; providing additional patient education and responding to questions; analyzing test results; documenting the encounter in the medical record and additional discussions with other physicians and qualified health care professionals (QHPs); coordinating additional care with other physicians or members of the health care team necessary for additional work.

Description of Post-Service Work: (not applicable)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022
Presenter(s):	Megan Adamson, MD; Elizabeth Blanchard, MD; Audrey Chun, MD; Omar Hussain, DO; Charles Hamori, MD, FACP; Kevin Kerber, MD; Steven Krug, MD; Stephen Lahey, MD; James Levett, MD; Kano Mayer, MD; Phillip E. Rodgers, MD, FAAHPM; Fredrica Smith, MD; Karin Swartz, MD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Rob Zipper, MD
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American Association for Thoracic Surgery, American College of Physicians, American College of Rheumatology, American Geriatrics Society, American Nurses Association, American Society of Clinical Oncology, American Thoracic Society, American College of Chest Physicians, North American Spine Society, Society of Hospital Medicine, Society of Thoracic Surgeons
CPT Code:	993X0
Sample Size: 23019	**Resp N:** 124
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**9.00**	30.00	1000.00
Survey RVW:	0.10	0.81	**1.05**	1.55	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:	5.00	15.00	**20.00**	30.00	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: 993X0	**Recommended Physician Work RVU: 0.81**		
	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
99439	ZZZ	0.70	**RUC Time**

CPT Descriptor 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; each additional 20 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)

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
51797	ZZZ	0.80	**RUC Time**	116,064

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

12001	000	0.84	**RUC Time**	184,284

CPT Descriptor 2 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

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: 51 **% of respondents:** 41.1 **%**

Number of respondents who choose 2nd Key Reference Code: 41 **% of respondents:** 33.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 993X0	**Top Key Reference CPT Code:** 99439	**2nd Key Reference CPT Code:** **99292**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	20.00	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**	**20.00**	**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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	2%	2%	17%	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	5%	24%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	44%	39%
Physical effort required	24%	34%	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	5%	29%	66%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	22%	46%	20%	12%

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%	51%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	32%	49%	19%
Physical effort required	20%	61%	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	20%	44%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Additional Rationale and Comments

The prolonged services code family was surveyed because CPT created a new code, 993X0, for prolonged physician services furnished to an inpatient on the date of an inpatient visit which is to be reported based on time beyond that for 99233.

These codes, along with 99358 and 99359 were surveyed for the October 2021 RUC meeting. At that meeting, the RUC made recommendations for time and RVW for 99358 and 99359 but was unable to make recommendations for 99417 and 993X0 because the number of respondents to those surveys did not meet the minimum number of responses required by the RUC. Therefore, there was insufficient data upon which to make recommendations, and the RUC approved keeping the survey open of these two codes.

The surveys were done, and this time, a sufficient number of responses were obtained.

The surveying societies established an expert panel to review the survey data and make recommendations to the RUC.

Compelling Evidence

The surveying societies discussed with the pre-facilitation committee whether there is a need for compelling evidence associated with the recommended value for code 993X0. An initial analysis done by AMA RUC staff using values and volumes for codes 99356 and 99357 as a point of comparison suggested compelling evidence might be needed to consider the recommended value for 993X0.

Based on feedback from the pre-facilitation committee, the surveying societies believe compelling evidence is not needed to consider the recommended value of 993X0, because this code represents a different service that is not comparable to 99356 and 99357 for the following reasons:

- Per the CPT guidelines shown in the cover to this tab, "Codes 99417 and 993X0 are only used when the primary service has been selected using time alone as the basis…." No such limitation applies to 99356 and 99357.
- Codes 99356 and 99357 may be reported in addition to any level of service within the inpatient/observation code families. Code 993X0 may only be reported in addition to the highest level of service.
- Code 993X0 includes both unit/floor time and time off the unit/floor on the date of service. Codes 99356/99357 include only unit/floor time.

If the RUC reaches a different conclusion than its pre-facilitation committee and believes compelling evidence is needed to consider the recommended value for 993X0, the surveying societies would cite the same compelling evidence used to consider an increase in the value of 99233 (Tab 13), one of the codes to which 993X0 may be added.

In effect, code 993X0 is part of the inpatient/observation care family of services. It is an extension of the highest level of service in that family when the primary service level has been selected using time. As detailed in the Summary of Recommendation for code 99233, there is documentation by "Other reliable data" for a change in physician work attributable to:

a. Change in patient population evidenced by an increasing number of diagnoses
b. Change in length of hospital stay
c. Change in Technology (i.e., increasing prevalence of the inpatient electronic health record)
d. Change in Knowledge (as reflected in the advent and increasing prevalence of hospitalist provider type)

The surveying societies believe these compelling evidence arguments apply to 993X0 in much the same way they apply to the base code of 99233 and that any one of these arguments is sufficient to justify consideration of the recommended value.

993X0

The surveying societies established an expert panel to review the survey data and make recommendations to the RUC.

Code 993X0 (Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services)) is the inpatient counterpart to 99417 in that it describes the same prolonged services but is reported only after an inpatient code is reported based on total time. Therefore, it is typically reported after 99233, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

This code was surveyed for the October 2021 RUC meeting with the following results: there were 32 respondents of whom 78% found the vignette to be typical. The survey times were 0/15/0/15, the survey median RVW was 1.23, and the survey 25th percentile RVW was 0.98.

The continued survey resulted in a total of 124 respondents of whom 86% found the vignette to be typical. The survey times were 0/20/0/20, the survey median RVW was 1.05, and the survey 25th percentile RVW was 0.81.

As an initial matter, the expert panel noted that the survey time of 20 minutes was higher than the survey time of 15 minutes for the limited data in the October survey. In addition, the median and 25th percentile RVWs were lower than those for the October limited survey.

The two key reference services were 99439, 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; each additional 20 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), which has times and RVW of 0/15/0/15/0.54, and 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), with times and RVW of 0/30/0/30/2.25.

The expert panel agreed that the RVW for 993X0 should be higher than that of 99439 because the work of direct care by a QHP is more intense than time spent supervising clinical staff. The expert panel also agreed that the work of 993X0 should be higher than that of 99417 because the site of service is inpatient, and the intensity of inpatient work is higher than outpatient work.

The expert panel also noted that 993X0 will only be reported after 99233, when 99233 is reported based on time. In other words, 993X0 will only be reported for the most difficult inpatients, when the time exceeds the time for 99233.

The panel also reviewed ZZZ global, RUC reviewed codes with total and intra times of 20 minutes. There were 25 such codes. The RVWs for these 25 codes ranged from 0.37 to 2.75 with a median RVW of 1.18. The panel focused its review on four codes that were recently reviewed by the RUC and where CMS agreed with the recommendation

- 88334, Pathology consultation during surgery with an RVW of 0.73 (RUC review 2016)
- 97598, Debridement, open wound, with an RVW of 0.50 (RUC review 2018)
- 99458, Remote physiologic monitoring, each additional 20 minutes of clinical staff or QHP time, with an RVW of 0.61 (RUC review 2019)
- 10008, Fine needle aspiration, with an RVW of 1.18 (RUC review 2017)

After its review, the expert panel agreed that the 25th percentile RVW of 0.81 placed 993X0 in proper rank order to both key references services, to the MPC codes it reviewed, and to 99417.

Therefore, the expert panel recommends a time of 20 minutes, all intra-service, and an RVW of 0.81 for 993X0.

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.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	993X0	ZZZ	0.81	0	20	0
4.	99233	XXX	2.00	10	30	15

5.	5. Total	2.81	10	50	15

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (not applicable)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 28628363
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. (see attached spreadsheet)

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? 3,842,733 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (see attached spreadsheet)

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

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. 99233

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	AS	AT	AU	AV	AW
15	Medicare Volume or					RUC Review Year				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	% Typical	Source	CPT	Global	DESC		Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	N/A	1st REF	99439	ZZZ	Chronic care management services with the following required elements:	Jan 2020	65	0.035	0.035			0.70			20						20								
18	560,661	2nd REF	99292	ZZZ	Critical care, evaluation and management of the critically ill or	Aug 2005	14	0.075	0.075			2.25			30						30								
19	N/A	CURRENT	99417	ZZZ	Prolonged office or other outpatient evaluation and management service(s)	Apr 2019						0.00			0						0								
20	N/A	CURRENT CMS	G2212	ZZZ	Prolonged office or other outpatient evaluation and	CMS		0.041	0.041			0.61			15						15								
21	81%	SVY	99417	ZZZ	Prolonged office or other outpatient evaluation and management service(s)	Jan-22	98	0.065	0.065	0.45	0.61	0.97	1.11	35.00	15				5	15	15	25	120		0	1	6	29	1000
22	76%	PRIMARY CARE	99417	ZZZ	KRS 1 = 99439		41	0.047	0.047	0.50	0.54	0.70	1.00	35.00	15				10	15	15	20	120		0	2	8	38	1000
23	86%	MEDICAL	99417	ZZZ	KRS 1 = 99439		48	0.065	0.065	0.45	0.75	1.00	1.20	15.00	15.5				5	15	16	25	100		0	0	5	20	120
24	78%	SURGERY	99417	ZZZ	KRS 1 = 99439		9	0.050	0.050	0.75	0.90	1.00	1.05	1.90	20				10	15	20	20	75		0	6	18	53	120
25		REC	99417	ZZZ	Prolonged office or other outpatient evaluation and		98	0.041	0.041			0.61			15						15								
26																													
27	N/A	1st REF	99439	ZZZ	Chronic care management services with the following required elements:	Jan 2020	51	0.035	0.035			0.70			20						20								
28	560,661	2nd REF	99292	ZZZ	Critical care, evaluation and management of the critically ill	Aug 2005	41	0.075	0.075			2.25			30						30								
30	86%	SVY	993X0	ZZZ	Prolonged inpatient or observation evaluation and management service(s)	Jan-22	124	0.053	0.053	0.10	0.81	1.05	1.55	25.00	20				5	15	20	30	120		0	0	9	30	1000
31	78%	PRIMARY CARE	993X0	ZZZ	KRS 1 = 99439		42	0.050	0.050	0.40	0.80	1.00	1.48	2.25	20				8	15	20	30	120		0	0	5	29	240
32	91%	MEDICAL	993X0	ZZZ	KRS 1 = 99439		70	0.055	0.055	0.20	0.79	1.10	1.73	25.00	20				5	15	20	30	100		0	0	9	30	1000
33	85%	SURGERY	993X0	ZZZ	KRS 1 = 99292		12	0.038	0.038	0.10	0.85	1.04	1.98	3.00	27.5				10	15	28	34	75		0	10	30	45	150
34		REC	993X0	ZZZ	Prolonged inpatient or observation evaluation and		124	0.041	0.041			0.81			20						20								
35																													

Prolonged Services Frequency Data				
	Medicare Utilization		Estimated National Utilization	
99417	%	#	%	#
Total		1,392,023		10,370,573
Family Medicine	11.0%	153,123	11.0%	1,140,763
Hospice/Palliative Medicine	1.4%	19,488	1.4%	145,188
Neurology	3.4%	47,329	3.4%	352,599
Pediatrics	0.1%	1,392	0.1%	10,371
Thoracic Surgery	0.1%	1,392	0.1%	10,371
Internal Medicine	15.9%	221,332	15.9%	1,648,921
Rheumatology	0.6%	8,352	0.6%	62,223
Geriatrics	2.1%	29,232	2.1%	217,782
Nurse Practitioner	34.7%	483,032	34.7%	3,598,589
Medical Oncology	0.7%	9,744	0.7%	72,594
Pulmonology	1.3%	18,096	1.3%	134,817
Spine Surgery	0.8%	11,136	0.8%	82,965
Other (not surveying)	27.9%	388,374	27.9%	2,893,390
993X0	%	#	%	#
Total		3,842,733		28,628,363
Family Medicine	11.0%	422,701	11.0%	3,149,120
Hospice/Palliative Medicine	1.4%	53,798	1.4%	400,797
Neurology	3.4%	130,653	3.4%	973,364
Pediatrics	0.1%	3,843	0.1%	28,628
Thoracic Surgery	0.1%	3,843	0.1%	28,628
Internal Medicine	15.9%	610,995	15.9%	4,551,910
Rheumatology	0.6%	23,056	0.6%	171,770
Geriatrics	2.1%	80,697	2.1%	601,196
Nurse Practitioner	34.7%	1,333,428	34.7%	9,934,042
Medical Oncology	0.7%	26,899	0.7%	200,399
Pulmonology	1.3%	49,956	1.3%	372,169
Spine Surgery	0.8%	30,742	0.8%	229,027
Other (not surveying)	27.9%	1,072,123	27.9%	7,987,313

Notes

Medicare utilization = 10% of Medicare utilzation of base codes below; national utilization is 7.45 t
Specialty distribution assumed to be the same as for 99358, above

	2019 Medicare utilization
99205	2,923,626
99215	10,388,878
99245	-
99345	71,563
99350	490,520
99483	45,645
Total	13,920,232

Notes

Medicare utilization = 10% of Medicare utilzation of base codes below; national utilization is 7.45 t
Specialty distribution assumed to be the same as for 99358, above

	2019 Medicare utilization
99223	10,626,847
99233	24,607,697
99236	131,135
99255	-
99306	1,389,990
99310	1,671,664
Total	38,427,333

:imes Medicare utilization (based on relationship of Medicare population (44 million) to US population (3

:imes Medicare utilization (based on relationship of Medicare population (44 million) to US population (3

328 million))

328 million))

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99417, 993X0, 99358, 99359

SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2019
Tab 14 and 15 Prolonged Services
Revised: October 6, 2021

****** No PE inputs are recommended for code 993X0 ******

CPT Code	Long Descriptor	Global Period
+99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management services) (Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483) (Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416) (Do not report 99417 for any time unit less than 15 minutes)	ZZZ
+993X0	Prolonged inpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient Evaluation and Management services) (Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310) (Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359) (Do not report 993X0 for any time unit less than 15 minutes) (For prolonged psychotherapy services, use 908X0)	ZZZ
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	XXX
+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) (Use 99359 in conjunction with 99358) (Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99483, 993X0, 99417)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
+99417	Office visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.
+993X0	Hospital visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.
99358	An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99417, 993X0, 99358, 99359

SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.
+99359	An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A consensus panel consisting of RUC advisors and subject matter experts from the surveying societies met via conference calls to review any data and existing PE inputs to develop the final recommendations presented in the PE worksheet.

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Current codes, plus recent E/M April 2019 survey RUC approved and CMS final recommendations.

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 the *Billed Together* tab in the RUC Database)

   Codes 99358 and 99359 are not typically reported on the same day of service as an E/M code. Codes 99417 and 993X0 are add-on codes for certain E/M services, which are identified in parentheticals following the code descriptors.

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 the *Billed Together* tab in the RUC Database)

+99417 MEDICARE SPECIALIT (NON-FACILITY ONLY	**+993X0**	**99358** MEDICARE SPECIALITY (NON-FACILITY ONLY)		**99359** MEDICARE SPECIALITY (NON-FACILITY ONLY)	
Detail not available.	Detail not available	NURSE PRACTITIONER	33.3%	NURSE PRACTITIONER	19.0%
		INTERNAL MEDICINE	14.6%	FAMILY MEDICINE	16.9%
		FAMILY MEDICINE	13.4%	INTERNAL MEDICINE	13.1%
		CARDIOLOGY	5.0%	PSYCHIATRY	12.3%
		PHYSICIANS ASSISTANT	4.2%	PHYSICIANS ASSISTANT	9.5%
		NEUROLOGY	4.0%	GENERAL PRACTICE	4.7%
		INTERVENTIONAL PAIN MANAGEMENT	2.3%	NEUROLOGY	4.3%
				GERIATRIC MEDICINE	2.9%
		HEMATOLOGY/ONCOLOGY	1.9%	EMERGENCY MEDICINE	2.1%
		GERIATRIC MEDICINE	1.7%	DERMATOLOGY	1.9%

		PSYCHIATRY	1.7%	ALLERGY/IMMUNOLOGY	1.5%
		GENERAL PRACTICE	1.3%	CARDIOLOGY	1.4%
		ENDOCRINOLOGY	1.3%	GYNECOLOGICAL ONCOLOGY	1.0%
		PAIN MANAGEMENT	1.1%	RHEUMATOLOGY	1.0%
		PHYSICAL MEDICINE AND REHABILITATION	1.1%		
		PULMONARY DISEASE	1.1%		

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, 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:

Not applicable.

(NOTE: CMS does not currently recognize code 99417 for payment. The recommended inputs for code 99417 are the same as those that CMS currently includes in G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPTcodes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes).)

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

8. 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

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99417, 993X0, 99358, 99359

SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

9. 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

10. 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):

    c. Post-service period:

Can be a combination of additional time for additional notes in the appropriate charts, and or calls above the E/M.

11. 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

12. 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

13. 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*):

N/A

14. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99417, 993X0, 99358, 99359

SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

19. 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.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

22. 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 equipment minutes are recommended for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038.

23. 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:

The use of some space to conduct the prolonged services is necessary. We followed the guidance of the E/M outpatient services below: The specialty societies recommend the "Office Visits" equipment formula for EQ189 otoscope-ophthalmoscope (wall unit) and EF023 table, exam for code 99417.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99417, 993X0, 99358, 99359
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS
PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, 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).

- All direct practice expense inputs were removed from code 993X0 since it is a facility-only code.
- Equipment ED021, *Computer, desktop, w-monitor,* was removed from the recommended inputs for codes 99417, 99358, and 99359 on the basis that this is an indirect expense.
- Equipment EQ189, *otoscope-ophthalmoscope (wall unit)*, and EF023, *exam table*, were removed from the recommended inputs for 99358 and 99359 since the patient is not present for these services.
- Consistent with the current inputs for G2212 and the RUC's prior recommendations for 99417, equipment EQ189, *otoscope-ophthalmoscope (wall unit)*, and EF023, *exam table*, were included in the recommended inputs for code 99417 in the non-facility setting, since it is an add-on to a face-to-face evaluation and management service in the outpatient (i.e., non-facility) setting and the patient will typically be occupying an exam room during the prolonged service.

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE APRIL 2019 RUC approved**		**REFERENCE CODE APRIL 2019 CMS FINAL RULE**		**CURRENT RUC approved April 2019**		**CURRENT CMS 2021**		**RECOMMENDED**		**RECOMMENDED FACILITY ONLY CODE**	
2						**99215**		**99215**		**99417**		**G2212**		**99417**		**NEW 993X0**	
3		***RUC Collaboration Website***				Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or		Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure		Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure		Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary		Prolonged inpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary	
4	**Clinical Activity Code**	**Meeting Date: October 2021, January 2022 Revision Date (if applicable): Tab: 15 Prolonged Services - on the Date of an E/M Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS**	**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**				**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	L037D			**62.0**	**0.0**	**62.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**7.0**	**0.0**	**7.0**	**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**	L037D			**45.0**	**0.0**	**45.0**	**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**	L037D			**10.0**	**0.0**	**10.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**2.0**	**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		L037D														
16	CA002		L037D														
17	CA003		L037D														
18	CA004		L037D														
19	CA005		L037D														
20	CA006		L037D														
21	CA007		L037D														
22	CA008		L037D														
23	CA048		L037D			7		7									
26		*Other activity: please include short clinical description here and type*	L037D														
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		L037D			3		3									
34	CA010		L037D			5		5									
37	CA013		L037D			2		2									
40	CA016		L037D			2		2									
42	CA049		L037D			4		4									
45	CA050		L037D			14		14									
48		**Intra-service (of service period)**															
51	CA020		L037D			2		2									
56		*Other activity: please include short clinical description here and type*	L037D														
59		**Post-Service (of service period)**															
62	CA024		L037D			3		3									
75	CA051		L037D			**5**		**5**									
78	CA052		L037D			5		5									
81		**End: Patient leaves office/facility**															
82		**POST-SERVICE PERIOD**															
83		**Start: Patient leaves office/facility**															
84	CA037		L037D			10		10		2		2		2			0
85	CA038		L037D														
92	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
99		**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**					**REFERENCE CODE APRIL 2019 RUC approved**		**REFERENCE CODE APRIL 2019 CMS FINAL RULE**		**CURRENT RUC approved April 2019**		**CURRENT CMS 2021**		**RECOMMENDED**		**RECOMMENDED FACILITY ONLY CODE**	
2						**99215**		**99215**		**99417**		**G2212**		**99417**		**NEW 993X0**	
3		***RUC Collaboration Website***				Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or		Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure		Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure		Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary		Prolonged inpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary	
4	**Clinical Activity Code**	**Meeting Date: October 2021, January 2022 Revision Date (if applicable): Tab: 15 Prolonged Services - on the Date of an E/M Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS**	**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**				**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	L037D			**62.0**	**0.0**	**62.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**7.0**	**0.0**	**7.0**	**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**	L037D			**45.0**	**0.0**	**45.0**	**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**	L037D			**10.0**	**0.0**	**10.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**													
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102	SA047					1		1									
103	SM022					1		1									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**												
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
112	EQ189			Office Visits		45.0		45.0		15		**15**		15			0
113	EF023			Office Visits		45.0		45.0		15		**15**		15			0
114	ED021			Other Formula		62.0		**0.0**		15		**0**		0			0
115	EF048			Other Formula		2		2									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request – Final Rule for 2022

January 2022

Delayed Creation of Exit Site from Embedded Catheter (Review PE Only) – Tab 16

In the Final Rule for 2022, CMS requested practice expense (PE) information for the non-facility/office setting for CPT code 49436 upon public nomination that this code can be safely performed in the non-facility/office but is not priced in this setting. CMS agreed that CPT code 49436 can be safely performed in the non-facility/office. Further, valuing the code in the non-facility could ease the burden to the provider and the patient when trying to coordinate access to ambulatory surgical center (ASC) restricted schedules during the continued severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease 2019 [COVID-19]) public health emergency (PHE). CMS finalized CPT code 49436 as potentially misvalued and indicated it is appropriate to explore establishing a practice expense relative value in the non-facility/office setting. Therefore, the RUC reviewed the PE inputs for this low volume service at its January 2022 meeting.

The PE Subcommittee agreed with the specialty society that there is compelling evidence to support an increase in the direct PE inputs based on a change in site-of-service to the non-facility/office setting.

The PE Subcommittee reviewed the practice expense recommendations for this code and approved the inputs with no modifications. Several new supply items were identified, and invoices have been obtained and submitted. The clinical staff type was questioned, and ultimately supported as L051A RN, not a blend, for CA011 *Provide education/obtain consent* and CA018 *Assist physician or other qualified healthcare professional-directly related to physician work time (100%)*. According to the specialty society, a significant amount of education will be provided about the procedure and care of the externalized catheter and pending dialysis by a registered nurse who is familiar with peritoneal dialysis. A surgeon who would perform this procedure in the office setting will have a registered nurse as clinical staff available for this education. Further, the clinical staff for this surgical procedure will typically be a registered nurse who is familiar with peritoneal dialysis catheter care and who will assist 100% of the time (incision, irrigation, heparin flush, connection supplies, dressings). All of the other clinical activities would not require a nurse so they have instead been assigned the L037D RN/LPN/MTA blend staff type.

The PE Subcommittee requested clarification whether it is typical to perform a 99212 post-operative office visit within the global period for 49436. The specialty noted that this visit is typical for suture removal, to ensure the site does not get infected and is typically performed by the physician who performed the procedure. The clinical staff assist the surgeon during the post-operative office visit for a wound and catheter check. **The RUC recommends the direct practice expense inputs as submitted by the specialty society for CPT code 49436.**

Relativity Assessment Workgroup Review
The RUC recommends that the Relativity Assessment Workgroup review CPT code 49436 when three years of claims data are available to assess if there is a shift in the specialty performing these services.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
49436	Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	010	Recommended PE Inputs Only

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49436
SPECIALTY SOCIETY(IES): ACS
PRESENTER(S): Charles Mabry MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01/2022

CPT Code	Long Descriptor	Global Period
49436	Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
49436	A 26-year old male with chronic renal failure elects early placement of a subcutaneously embedded peritoneal dialysis catheter. Eleven months later, his renal function suddenly declines and he is experiencing uremic symptoms. The embedded subcutaneous segment of the catheter is urgently exteriorized. The patient immediately begins full dose peritoneal dialysis without a break-in period and successfully avoids the need for vascular catheter placement and temporary hemodialysis.

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:

   In the Final Rule for 2022, CMS received a public nomination with documentation that 49436 can be safely performed in the non-facility/office setting. CMS requested practice expense information for the nonfacility setting for this code.
   The American College of Surgeons consulted with surgical experts familiar with performing this procedure in the office setting to determine the necessary clinical staff, 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code is being used as a reference.

3. Is this code(s) typically reported with an E/M service?

   no

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

   n/a

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and

has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

no

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

When performed in the facility setting, the patient will need immediate dialysis and extensive clinical staff time (30 minutes) will be required to facilitate authorization and referral forms; obtain interval labs and prior surgical procedure operative reports for surgical planning of upcoming procedure; confirm availability of all necessary catheters and supplies; and contact patient/caregiver to provide education about the planned procedure, subsequent dialysis, need for supplies at home to care for the catheter, and regarding any changes to medications and diet prior to the procedure.

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:

no

8. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

When performed in the facility setting, the patient will need immediate dialysis and extensive clinical staff time (30 minutes) will be required to facilitate authorization and referral forms; obtain interval labs and prior surgical procedure operative reports for surgical planning of upcoming procedure; confirm availability of all necessary catheters and supplies; and contact patient/caregiver to provide education about the planned procedure, subsequent dialysis, need for supplies at home to care for the catheter, and regarding any changes to medications and diet prior to the procedure.

   b. Service period (includes pre, intra and post):

Activity	FAC	Comments
Discharge day management	**6**	When this is performed in facility setting, clinical staff will request transfer of facility records for entry into patient's office chart and contact patient/caregiver to answer questions about catheter care and activity restrictions

   c. Post-service period:

Clinical staff will assist surgeon during postop office visit for a wound and catheter check

9. 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*):

n/a

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49436
SPECIALTY SOCIETY(IES): ACS
PRESENTER(S): Charles Mabry MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

n/a

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

n/a

15. 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

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

n/a

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

n/a

18. 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

19. 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:

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49436
SPECIALTY SOCIETY(IES): ACS
PRESENTER(S): Charles Mabry MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

EF031	table, power	Office Visits
EF014	light, surgical	Office Visits

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ROW	CODE	ITEM	UNIT	FAC	COMMENT
83	SB037	pillow case	item	1	Items listed in lieu of multispecialty EM pack because non-sterile gloves are not used at postop visit
84	SB036	paper, exam table	foot	7	
85	SB004	cover, thermometer probe	item	1	
86	SB026	gown, patient	item	1	
91	SB024	gloves, sterile	pair	1	surgeon – postop visit catheter / wound check
110	SJ060	tincture of benzoin, swab	item	1	Used to re-dress catheter exit site after catheter wound check at postop visit. Prepares the skin for maximum adhesion of dressings or bandages.
111	SG074	steri-strip (6 strip uou)	item	1	Used to re-dress catheter exit site after catheter wound check at postop visit. To hold the externalized catheter in place.
112	SG037	dressing, 4in x 4.75in (Tegaderm)	item	1	Used to re-dress catheter exit site after catheter wound check at postop visit. Proxy for window transparent film dressing, 6"x 8," (eg, Covidien).
113	SG077	tape, porous-hypoallergenic 2in (Scanpore)	inch	12	Used to re-dress catheter exit site after catheter wound check at postop visit. Proxy for Hypafix tape, 2 in. x 2 yd, single use

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49436
SPECIALTY SOCIETY(IES): ACS
PRESENTER(S): Charles Mabry MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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): 49436
SPECIALTY SOCIETY(IES): ACS
PRESENTER(S): Charles Mabry MD FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01/2022

CPT Code	Long Descriptor	Global Period
49436	Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	010

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
49436	A 26-year old male with chronic renal failure elects early placement of a subcutaneously embedded peritoneal dialysis catheter. Eleven months later, his renal function suddenly declines and he is experiencing uremic symptoms. The embedded subcutaneous segment of the catheter is urgently exteriorized. The patient immediately begins full dose peritoneal dialysis without a break-in period and successfully avoids the need for vascular catheter placement and temporary hemodialysis.

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:

   In the Final Rule for 2022, CMS received a public nomination with documentation that 49436 can be safely performed in the non-facility/office setting. CMS requested practice expense information for the nonfacility setting for this code.
   The American College of Surgeons consulted with surgical experts familiar with performing this procedure in the office setting to determine the necessary clinical staff, 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code is being used as a reference, however, all of the non-facility pricing will be new. There is no other comparable office-based procedure for comparison.

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 the *Billed Together* tab in the RUC Database)

   Is this code(s) typically reported with an E/M service? **No**
   Is this code(s) typically reported with the E/M service in the nonfacility? **No**

4. What specialty is the dominant provider in the nonfacility? General Surgery
   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 the *Billed Together* tab in the RUC Database)

   What specialty is the dominant provider in the nonfacility? **General Surgery**
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? **89.8%**
   Is the dominant provider in the nonfacility different than for the global? **No**

NONFACILITY DIRECT PE INPUTS

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

\
CMS established a process for the public to nominate potentially misvalued codes. In the CY 2015 PFS final rule with comment period (79 FR 67606 through 67608), CMS modified this process whereby the public and stakeholders may nominate potentially misvalued codes for review by submitting the code with supporting documentation that address specific criteria of compelling evidence. A stakeholoder offered the following information through comments:

• ***Documentation in peer reviewed medical literature or other reliable data that demonstrate changes in physician work due to one or more of the following: technique, knowledge and technology, patient population, site-of-service, length of hospital stay, and work time.***

The July 10, 2019 "Executive Order on Advancing American Kidney Health" encourages increased use of home dialysis. The embedded catheter strategy is in alignment with this order. Office-based creation of an exit site from an embedded catheter promotes safe patient access to this service outside a facility in a community setting.

• **An anomalous relationship between the code being proposed for review and other codes.**

Code 49418 which is a similar service, is priced in the office setting even though the percentage of claims (and absolute number of claims) in an office setting is significantly lower.

• ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation.***

When code 49436 was established, it was not envisioned to be a procedure that would be performed in the office, and therefore, office-pricing was not requested. Since that time, practitioners who regularly utilize the embedded catheter strategy prefer the office location for externalization, while acknowledging that catheters may need to be externalized in the facility setting when a patient is emergently hospitalized for hyperkalemia, fluid overload, there is an urgent need for angiography, or any situation aggravated by an acute decline in renal function. The original evaluation of the code 49436 did not include practice expense inputs for the office setting for correct reimbursement of the service. The supplies are numerous, for example: site prep supplies, drapes, staff attire, local anesthetic, syringes, needles, scalpels, catheter transfer/extension set, catheter adapter, irrigation, heparin, dressings and non-disposable instruments.

CMS agreed with the stakeholder that the procedure described by 49436 can be safely performed in the nonfacility/office setting. CMS also acknowledged that the PHE for COVID-19 may be constraining access to ASC operating facilities where CPT code 49436 is performed, and if this service were to be done in the nonfacility/office setting, there may well be an ease in the burden to the provider and the patient, when trying to coordinate access with the current PHE ASC restricted schedules. The Agency noted that a nonfacility/office valuation for CPT code 49436, would include the similar supplies, equipment, and clinical labor (if any), that is part of the ASC/Hospital Outpatient

facility's service, plus the payment of the physician's work. The sum of these PEs incurred in the nonfacility/office, will likely be less than current amount paid to the ASC/Hospital Outpatient facility and may result in a net savings when CPT code 49436 is provided in the nonfacility/office setting. After considering the additional information provided by the nominator in combination with the above criteria that a code's site of service may need to change since it was last valued, the agency agreed it may be appropriate to explore establishing a value for code 49436 in the nonfacility/office setting.

We believe that the information provided above, including a request by CMS, meets compelling evidence to price code 49436 in an office setting.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

n/a

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

n/a

8. 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

9. 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

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Clinical staff will facilitate authorization and referral forms; order necessary catheter supplies; obtain interval labs and prior op report; and contact patient regarding any changes to medications/diet prior to the procedure, and need for catheter care supplies at home.
[Note that education will be provided on the day of the procedure]

NONFACILITY DIRECT PE INPUTS

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

b. Service period (includes pre, intra and post):

Activity	NF	Comments
Greet patient, provide gowning, ensure appropriate medical records are available	3	standard 3 minutes
Obtain vital signs	5	Weight, height, temperature, blood pressure, heart rate
Provide education/obtain consent	7	NURSE Clinical Staff: A significant amount of education will be provided about the procedure and care of the externalize catheter and pending dialysis by a nurse who is familiar with peritoneal dialysis. A surgeon who would perform this procedure in the office setting will have a nurse as clinical staff available for this education.
Prepare room, equipment and supplies	5	In addition to the standard 2 minutes related to setting up a room for an EM services, all the additional sterile supplies, catheters, and instruments will need to be set up in the room.
Prepare, set-up and start IV, initial positioning and monitoring of patient	2	standard 2 minutes – assist MD with positioning, draping, prepping patient
Sedate/apply anesthesia	2	standard 2 minutes – assist MD with local anesthesia
Intra-service (of service period)		
Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	15	NURSE Clinical Staff: The clinical staff for this surgical procedure will typically be a nurse who is familiar with peritoneal dialysis catheter care and who will assist 100% of the time (incision, irrigation, heparin flush, connection supplies, dressings)
Post-Service (of service period)		
Clean room/equipment by clinical staff	3	standard 3 minutes (includes monitoring patient)
Clean surgical instrument package	10	standard for basic surgical instrument package
Check dressings, catheters, wounds	1	standard 1 minute for final check of dressings and catheter prior to patient dressing
Review home care instructions, coordinate visits/prescriptions	2	standard 2 minutes for final review of take-home instructions about care of catheter and activities allowed

c. Post-service period:

Clinical staff will assist surgeon during postop office visit for a wound and catheter check.

11. 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 clinical staff for this surgical procedure will typically be a nurse who is familiar with peritoneal dialysis and who will assist 100% of the intra-time.

NONFACILITY DIRECT PE INPUTS

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12. 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

13. 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*):

n/a

14. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

dressing, 1in, 7mm hole, w-CHG (eg, Biopatch)	Sterile polyurethane 1 inch foam disk dressing impregnated with chlorhexidine gluconate (CHG), with 7 mm center hole for catheter insertion to reduce catheter-associated blood stream infection (CABSI)
peritoneal dialysis catheter locking titanium adapter	This adapter is a double sealing female Luer lock adapter with a 2-piece, combination compression fit/barbed catheter connector used to connect the PD catheter to a solution transfer set with locking connector.
peritoneal dialysis catheter transfer set	An extension tubing that attaches to the PD catheter at the skin level exit site. The transfer set remains in place between PD therapy and is replaced every 6 months or sooner if concerns regarding compromise of the transfer set integrity, post contamination episode or if recurrent/relapsing peritonitis.
peritoneal dialysis catheter mini-cap for transfer set	This device is a plastic disconnect cap for peritoneal dialysis and contains povidone-iodine intended to protect the female Luer connector of the Baxter transfer set.

18. Are you recommending a PE supply pack for this recommendation? **Yes**
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

SA088	tray, surgical skin prep, sterile	
SA043	pack, cleaning, surgical instruments	

NONFACILITY DIRECT PE INPUTS

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

19. 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.

The typical surgical skin prep tray contents per documentation sent in 2004 to CMS during PEAC review of all codes included: (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.
Notes: This is a prepackaged commercially available pack. Not all individual contents have CMS codes. All of these items are used only for skin prep and then disposed of prior to starting the procedure.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning, surgical instruments	**SA043**	**pack**	1	**12.61**
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	

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

n/a

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

n/a

22. 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

23. 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	Office visits

NONFACILITY DIRECT PE INPUTS

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EF014	light, surgical	Office visits
EF015	mayo stand	Default
EQ137	instrument pack, basic ($500-$1499)	Instrument Packs

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ROW	CODE	ITEM	UNIT	NF	COMMENT
83	SB037	pillow case	item	2	Items listed in lieu of multispecialty EM pack because non-sterile gloves are not used. For day of procedure and subsequent EM in 10 day global
84	SB036	paper, exam table	foot	14	
85	SB004	cover, thermometer probe	item	2	
86	SB026	gown, patient	item	2	
87	SB029	cap-headcover, patient	item	3	surgeon, assistant, patient
88	SB033	mask, surgical	item	3	surgeon, assistant, patient
89	SB028	gown, surgical, sterile	item	2	surgeon, assistant
90	SA088	tray, surgical skin prep, sterile	tray	1	sterile prep
91	SB024	gloves, sterile	pair	3	surgeon, assistant for day of procedure surgeon only for postop visit catheter / wound check
92	SB020	drape-towel, sterile OR blue (2 pk uou)	item	2	necessary draping
93	SB011	drape, sterile, fenestrated 16in x 29in	item	1	
94	SB014	drape, sterile, three-quarter sheet	item	1	
95	SB012	drape, sterile, for Mayo stand	item	1	
96	SK075	skin marking pen, sterile (Skin Skribe)	item	1	mark incision site, confirm with patient
97	SJ053	swab-pad, alcohol	item	2	wipe lidocaine vial wipe heparin flush
98	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	ml	5	local anesthetic
99	SC029	needle, 18-27g	item	2	two for lidocaine (draw and inject – different gage)
100	SC057	syringe 5-6ml	item	1	for local anesthetic

NONFACILITY DIRECT PE INPUTS

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101	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	item	1	catheter and wound irrigation
102	SB044	underpad 2ft x 3ft (Chux)	item	1	under patient to catch irrigation leak
103	SC018	iv infusion set	item	1	When the catheter is externalized, a trial irrigation is performed with normal saline + heparin using the IV infusion set connected straight to the catheter's transfer set. This is used to test the patency, flow function, and wash out any fibrinous debris.
104	SJ009	basin, irrigation	item	1	Used for irrigation and contamination item disposal.
105	SF007	blade, surgical (Bard-Parker)	item	1	For site incision.
106	SG056	gauze, sterile 4in x 4in (10 pack uou)	item	1	As needed throughout procedure.
107	SC053	syringe 20ml	item	1	For irrigation
108	SH067	sodium chloride 0.9% inj (250-1000ml uou)	item	1	For irrigation
109	SH040	heparin lock flush soln	item	1	For catheter prep
110	SJ060	tincture of benzoin, swab	item	2	Prepares the skin for maximum adhesion of dressings or bandages. One on day of procedure and one at postop visit.
111	SG074	steri-strip (6 strip uou)	item	2	To hold the externalized catheter in place. One on day of procedure and one at postop visit..
112	SG037	dressing, 4in x 4.75in (Tegaderm)	item	2	Proxy for window transparent film dressing, 6"x 8," (eg, Covidien). One on day of procedure and one at postop visit.
113	SG077	tape, porous-hypoallergenic 2in (Scanpore)	inch	24	Proxy for Hypafix tape, 2 in. x 2 yd, single use. On day of procedure and at postop visit.
114	SA043	pack, cleaning, surgical instruments	pack	1	For cleaning instruments.
115	new	dressing, 1in, 7mm hole, w-CHG (eg, Biopatch)	item	1	Sterile polyurethane 1 inch foam disk dressing impregnated with chlorhexidine gluconate (CHG), with 7 mm center hole for catheter insertion to reduce catheter-associated blood stream infection (CABSI)
116	new	peritoneal dialysis catheter locking titanium adapter	item	1	This adapter is a double sealing female Luer lock adapter with a 2-piece, combination compression fit/barbed catheter connector used to connect the PD catheter to a solution transfer set with locking connector.

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117	new	peritoneal dialysis catheter transfer set	item	1	An extension tubing that attaches to the PD catheter at the skin level exit site. The transfer set remains in place between PD therapy and is replaced every 6 months or sooner if concerns regarding compromise of the transfer set integrity, post contamination episode or if recurrent/relapsing peritonitis.
118	new	peritoneal dialysis catheter mini-cap for transfer set	item	1	This supply is a plastic disconnect cap for peritoneal dialysis and contains povidone-iodine to protect the female Luer connector of the Baxter transfer set.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
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	A	B	D	E	F	I	J	K	L	M
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		
2						**49436**		**49436**		
3	**Clinical Activity Code**	**Meeting Date: 01/12/2022** **Revision Date (if applicable):** 1/14/22 invoice **Tab: 16** **Specialty: ACS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Delayed creation of exit site from embedded subcutaneous segment of		Delayed creation of exit site from embedded subcutaneous segment of		
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	
5		**GLOBAL PERIOD**				**010**	**010**	**010**	**010**	
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ 226.63**	**$ -**	
7		**TOTAL CLINICAL STAFF TIME**	L037D			**0**	**63**	**71**	**63**	
8		**TOTAL CLINICAL STAFF TIME**	L051A			**0**	**0**	**22**		
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**30**	**11**	**30**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**6**	**33**	**6**	
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A			**0**	**0**	**22**		
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**27**	**27**	**27**	
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	
14		**PRE-SERVICE PERIOD**								
15		**Start: Following visit when decision for surgery/procedure made**								
16	CA001		L037D				5	5	5	
17	CA002		L037D				10	3	10	
18	CA003		L037D				5	0	5	
19	CA004		L037D				7	0	7	
20	CA005		L037D				3	3	3	
27		**End: When patient enters office/facility for surgery/procedure**								
28		**SERVICE PERIOD**								
29		**Start: When patient enters office/facility for surgery/procedure:**								
30		**Pre-Service (of service period)**								
31	CA009		L037D					3		
32	CA010		L037D					5		
33	CA011		**L051A**					7		
34	CA013		L037D					5		
35	CA016		L037D					2		
36	CA017		L037D					2		
42		**Intra-service (of service period)**								
43	CA018		**L051A**					15		
47		**Post-Service (of service period)**								
50	CA024		L037D					3		
51	CA026		L037D					10		
53	CA029		L037D					1		
54	CA035		L037D					2		
55	CA036		L037D			**n/a**	**6**	**n/a**	**6**	
61		**End: Patient leaves office/facility**								
62		**POST-SERVICE PERIOD**								
63		**Start: Patient leaves office/facility**								
66		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	
67		99211 16 minutes	16							
68		99212 27 minutes	27				1	1	1	
69		99213 36 minutes	36							
70		99214 53 minutes	53							
71		99215 63 minutes	63							
72	CA039		L037D			**0**	**27**	**27**	**27**	
79		**End: with last office visit before end of global period**								

	A	B	D	E	F	I	J	K	L	M
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		
2						**49436**		**49436**		
3	**Clinical Activity Code**	**Meeting Date: 01/12/2022** **Revision Date (if applicable):** 1/14/22 invoice **Tab: 16** **Specialty: ACS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Delayed creation of exit site from embedded subcutaneous segment of		Delayed creation of exit site from embedded subcutaneous segment of		
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	
5		**GLOBAL PERIOD**				**010**	**010**	**010**	**010**	
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ 226.63**	**$ -**	
7		**TOTAL CLINICAL STAFF TIME**	L037D			**0**	**63**	**71**	**63**	
8		**TOTAL CLINICAL STAFF TIME**	L051A			**0**	**0**	**22**		
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**30**	**11**	**30**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**6**	**33**	**6**	
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A			**0**	**0**	**22**		
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**27**	**27**	**27**	
80	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
81		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ 226.63**	**$ -**	
82	SA048						1			
83	SB037							2	1	
84	SB036							14	7	
85	SB004							2	1	
86	SB026							2	1	
87	SB029							3		
88	SB033							3		
89	SB028							2		
90	SA088							1		
91	SB024							3	1	
92	SB020							2		
93	SB011							1		
94	SB014							1		
95	SB012							1		
96	SK075							1		
97	SJ053							2		
98	SH046							5		
99	SC029							2		
100	SC057							1		
101	SH069							1		
102	SB044							1		
103	SC018							1		
104	SJ009							1		
105	SF007							1		
106	SG056							1		
107	SC053							1		
108	SH067							1		
109	SH040							1		
110	SJ060							2	1	
111	SG074							2	1	
112	SG037							2	1	
113	SG077							24	12	
114	SA043							1		
115	new	dressing, 1in, 7mm hole, w-CHG (eg, Biopatch)	9.37	item				1		
116	new	peritoneal dialysis catheter locking titanium adapter	169.74	item				1		
117	new	peritoneal dialysis catheter transfer set	47.17	item				1		
118	new	peritoneal dialysis catheter mini-cap for transfer set	0.35	item				1		
122	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
123		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	
124	EF031			Office Visits			159	70	27	
125	EF014			Office Visits			162	70	27	
126	EF015			Default				43		
127	EQ137			Instrument Packs				49		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly – 2018*

January 2022

Lumbar Laminotomy with Decompression – Tab 17

In October 2018, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar*, in which the Medicare data from 2014-2017 indicated that 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. The Relativity Assessment Workgroup requested an action plan for January 2019. In January 2019, the RUC recommended that this code be reviewed in two years (January 2021) to determine if the CPT 2017 changes to differentiate percutaneous, endoscopic, and open spine procedures were effective to for correct reporting of this service. In December 2020, the Workgroup noted that CPT code 63030 continues to be primarily reported in the outpatient setting yet still includes inpatient hospital visits. The specialty society indicated that there is still confusion, and 63030 is inappropriately being reported in the outpatient setting. The RUC recommended that CPT code 63030 be referred to the CPT Editorial Panel to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The RUC understood that this service would be surveyed after the CPT revisions and reviewed by the RUC. At the September 2021 CPT meeting, the CPT Editorial Panel did not accept the changes to the descriptors specifying hospitalization as presented by the specialty societies. Since this is a site of service issue, CPT code 63030 was surveyed with the code family for the January 2022 RUC meeting.

Compelling Evidence
The RUC agreed with the specialty societies that flawed methodology was used in the previous valuation of this service. CPT code 63035 is a Harvard-based code and the methodology that Harvard used in developing the work and times was flawed. The Harvard study method for reviewing "secondary codes" (ie, add-on codes) was to survey the primary code as a global code and the add-on code as a multiple of the primary code and then subtract one from the other to determine the additional work related to the secondary code.[1] For example, the data for CPT code 63030 surveyed as a 090-day global code was compared with the data for CPT code 63035 surveyed as a 090-day global code for two levels. The Harvard study used two different panels of neurosurgeons to survey each code resulting in data that did not make sense; some elements of work were lower for 63035 even though a hemilaminectomy of two levels was performed. Further, the difference in total time between the two surveys was 51 minutes, but the final Harvard dataset indicated 49 minutes of intra-service time for 63035. The specialty societies indicated that this was a flawed methodology to determine both the physician time and relative value for 63035, resulting in an underestimation of time and work required, which meets compelling evidence. Secondly, the Harvard study solicited responses only from neurosurgeons (n=17) even though an almost equal number of orthopaedic surgeons perform this service. **The RUC agreed there was compelling evidence that the previous methodology establishing the value for CPT code 63035 was flawed.**

[1] Appendix D4.1 of the Harvard Phase III Final Report

63020 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical***
The RUC reviewed the survey results from 79 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 15.95 appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation, 20 minutes positioning, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214 and 2-99213 visits. This service is typically performed in the hospital inpatient setting. The RUC noted that the current physician time for CPT code 63020 was not determined via a typical RUC survey but was based on operative logs and Harvard data which was validated during the 1995 Five-Year Review.

The specialty societies indicated that the first post-operative office visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed. The wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology and reassure the patient with that information. Medication management is performed including a prescription drug monitoring program (PDMP) check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants and discussing how the medication use might impact the patient's ability to work, drive, study, and provide childcare safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or over the counter (OTC)) and/or other analgesics to switch to as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals, including order therapy. The surgeon will also assess the need for bracing (eg, for foot droop). Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent herniation of the nucleus pulposus (HNP); and whether a urinalysis and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with physical medicine and rehabilitation for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their human resource (HR) specified work needs.

The second and third post-operative office visits will typically be level 99213 and include interval update of medical history, physical examination, medication management, PT/OT progress review, order revision, interval imaging as needed, and continued assessment of patient progress watching for recurrent HNP.

The RUC compared the surveyed code to the top key reference service 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37, 90 minutes intra-service time, and 362 minutes total time) and noted that both require similar physician work and the same intra-service time, however 63047 has an appropriately slightly lower work RVU to account for the difference in physician work intensity between lumbar and cervical spine surgery. The RUC noted that 72% of the survey respondents that selected the top key reference code had

indicated that the survey code is more intense and complex. The RUC compared the surveyed code to the second top key reference service 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time and 355 minutes total time). Although codes 63075 and 63020 are both cervical spine operations, code 63075 has a higher work RVU compared with 63020 to appropriately account for the added intensity and complexity of an anterior cervical approach to the spine that includes dissection and protection of the trachea, esophagus and vessels including the carotid.

For additional support, the RUC referenced MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service time and 337 minutes total time). **The RUC recommends a work RVU of 15.95 for CPT code 63020.**

63030 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar***

The RUC reviewed the survey results from 90 neurosurgeons, orthopaedic surgeons, and spine surgeons and determined that the current work RVU of 13.18, which is below the survey 25th work RVU, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes pre-service evaluation, 15 minutes positioning, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 2-99213 visits. The RUC noted that the current pre-service time was established prior to the establishment of pre-time packages and the intra-service and immediate post-service time has not changed.

This service is typically performed in the outpatient hospital setting. However, of the 82% of survey respondents who indicated that they typically perform this service in the hospital, 52% indicated that patients stay overnight (40% less than 24 hours and 12% more than 24 hours) and all respondents indicated a hospital visit occurs. Therefore, a total of 40 minutes post-service time includes the survey median time of 30 minutes plus the intra-time of 10 minutes for current code 99231. Additionally, half a 99238 discharge visit is included even though this patient will not typically be discharged on the same day and complete discharge day management work will be performed on the day after surgery.

The first post-operative office visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note, and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed. The wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology and reassure the patient with that information. Medication management is performed including a prescription drug monitoring program (PDMP) check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants and discuss how the medication use might impact the patient's ability to work, drive, study, and provide childcare safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or OTC) and/or the use of other analgesics as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals. Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent

herniation of the nucleus pulposus (HNP); and whether a urinalysis and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with pain management and rehabilitation (PM&R) for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their HR specified work needs.

The second and third post-operative office visits will typically be level 99213 and include interval update of medical history, physical examination, medication management, PT/OT progress review, order revision, interval imaging as needed, and continued assessment of patient progress watching for recurrent HNP.

The RUC compared the surveyed code to the top key reference service 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37, 90 minutes intra-service time, and 362 minutes total time) and noted that although both services typically involve an identical amount of intra-service time and similar intensity, the reference code involves much more total time as it is typically performed in the inpatient setting. The RUC compared the surveyed code to the second top key reference service 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 15.00, 90 minutes intra-service time, and 271 minutes total time) and noted that code 22867 is more intense and complex than code 63030 due to bilateral decompression as well as placement of an interlaminar/interspinous process stabilization/distraction device and therefore is appropriately valued higher even though it has a somewhat lower total time.

For additional support, the RUC referenced MPC codes 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)* (work RVU = 13.16 and 75 minutes intra-service time), 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36 and 90 minutes intra-service time) and 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.50 and 90 minutes intra-service time). The RUC concluded that the value of CPT code 63030 should be maintained at 13.18 work RVUs, below the survey 25th percentile. **The RUC recommends a work RVU of 13.18 for CPT code 63030.**

63035 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 81 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes intra-service and total time.

The RUC noted that this service was never surveyed via the RUC process and the current value and time is based on the flawed Harvard methodology as indicated in the compelling evidence.

The RUC compared the surveyed code to the top key reference service 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 and 45 minutes intra-service time) and noted that the surveyed code requires more physician time and work to perform. CPT code 63048 describes the work of extending a laminectomy to an additional level. In 63048, the skin incision is extended either higher or lower, followed by additional fascial incision and dissection of paraspinal muscles to expose the next level of the spine. Radiographic localization is not necessary since the work is routinely performed at an adjacent level. Hence the exposure in 63048 builds off the exposure used for the base code. For CPT code 63035, especially when using a tubular retractor system, the exposure is completed de novo. A new, unique fascial incision is made remotely from the fascial incision (described by the base code), followed by new dissection of paraspinal musculature and new placement of a retractor. For a tubular retractor, new radiographs are required for docking the retractor safely upon the lamina and ensuring appropriate retractor position. The exposure of CPT code 63035 is unique and does not directly build off the exposure of the base code and therefore requires more time and work when compared to CPT code 63048.

The RUC compared the surveyed code to the second top key reference service 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50 and 45 minutes of intra-service time) and noted that the surveyed service requires less physician work and is less intense.

For additional support, the RUC referenced MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) and CPT code 63621 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)* (work RVU = 4.00 and 60 minutes intra-service time). The RUC concluded CPT code 63035 should have a work RVU of 4.00 which appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 4.00 for CPT code 63035.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
63020 (f)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	090	15.95
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	090	13.18 (No Change)
63035 (f)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	ZZZ	4.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63020 Tracking Number Original Specialty Recommended RVU: **15.95**
Presented Recommended RVU: **15.95**
Global Period: 090 Current Work RVU: **16.20** RUC Recommended RVU: **15.95**

CPT Descriptor: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female presents with intractable left arm pain unresponsive to conservative therapy. Imaging identified a left C5-6 foraminal disc herniation. She undergoes a left C5-6 laminoforaminotomy.

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 97% , In the ASC 3%, 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 19% , Overnight stay-less than 24 hours 26% , Overnight stay-more than 24 hours 55%

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 84%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis, as required, are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The patient is reexamined to confirm that physical findings have not changed; the patient's medication regimen has remained the same; the patient has no new allergies; and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The site of the proposed skin incision is marked. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all imaging equipment. Coordinate antibiotic choice and timing. Transfer of the patient from gurney to operating table, and position the patient prone on an OR table: Prior to the flip, prepare the operating table for the patient's pressure points to the size of the patient, adjust the chest support, the iliac crest support, and support over the proximal part of each thigh. Place any helmet or head fixation device on the patient after anesthesia agrees the patient is ready for it. Gently rotate the patient from the gurney to the prepared operative table, protecting the head and neck. Position and hold the head using a protective helmet, Mayfield skull traction or a horseshoe head holder, secured to the table. The head of the patient is placed in gentle flexion to decrease the cervical lordosis. Flexion is achieved by maintaining the chest pads low on the chest to allow for natural flexion of the neck. Protective pads and restraints are placed, and the table is placed in a reverse Trendelenburg position to help with intraoperative bleeding. Surgical tape is applied to the shoulders and bed to provide traction of the skin and to facilitate imaging of cervical levels. The lower hairline may need to be shaved with an electric razor. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. A lateral cervical radiograph with a metallic marker is taken to confirm the correct operative level, and to mark the final plan for the surgical incision. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team. Standard sterile preparation and draping of the surgical site is completed.

Description of Intra-Service Work: An incision is made adjacent to the spinous process on the side of the abnormality over the operative level. Use lateral fluoroscopy to confirm the level. Release the deep cervical fascia with a knife or Bovie

electrocautery to enable further dissection. Reflect muscular attachments off of the vertebral lamina and medial facet complex. Secure retractors and achieve hemostasis. If using tubular dilators, instead of releasing the deep fascia through an open incision, introduce the initial dilator through the skin incision and advance to the inferomedial edge of the rostral lateral mass at the operative level. Use sequential dilators to create a working portal within the soft tissues. Center the final working tube over the lateral aspect of the lamina and medial facet joint of the appropriate operative level. Secure the working tube to a sterile arm that is attached to the bed. Use lateral fluoroscopy to confirm the level. Complete unilateral laminoforaminotomy using a high-speed burr. Perform the laminoforaminotomy with the use of a high-speed drill and a Kerrison rongeur to create a working window into the foramen. A laminotomy is performed in the caudal lamina can be used to improve visualization of the nerve root. Once the high-speed burr has been used to thin the lamina and the epidural space is accessible, a Kerrison punch is used to continue the osseous resection from medial to lateral. Use a nerve hook to superiorly retract the nerve root, and perform a discectomy and decompression; Use a curet or nerve hook to identify the proximal border of the caudal pedicle. In order to perform a complete foraminal decompression, the nerve must be decompressed fully from the medial to lateral border of the caudal pedicle. Once the top of the pedicle is identified, use a nerve hook to assess the foramen. Use a 1- or 2-mm Kerrison punch to remove bone until the amount of osseous resection and the room available to the nerve are satisfactory After the laminotomy has been completed, a nerve hook can be used to gently retract the nerve root in a cephalad direction to inspect for any disc fragments. Remove any visible, loose disc fragments with a micro-pituitary rongeur. Control bleeding with powdered Gelfoam and bipolar cautery. Copiously irrigate the wound with normal saline solution. Obtain hemostasis with electrocautery or hemostatic foam. Close the wound in layers.

Description of Post-Service Work:
Immediate postoperative care [through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with nursing staff.

Later same day hospital care visit after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Examine patient, check wound(s) and patient progress, and monitor for abnormal neurological findings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Subsequent hospital care: Each day, review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Examine patient, check wound(s) and patient progress, and monitor for abnormal neurological findings. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Discharge day management: Review interval nursing/other staff chart notes. Evaluate vital signs and intake/output. Examine patient, check wound(s) and patient progress, and assess neurological findings. Assess pain scores and adequacy of analgesia. Review postdischarge wound care and activity limitations, including planned physical therapy. Answer questions from patient and/or family, nursing, and other provider(s). Write orders for post-discharge films, medications, and therapy. Chart patient discharge notes.

Office: Examine patient and perform periodic neurological exams. Write orders for medications. Order and review follow-up films. Monitor wounds and remove staples, when appropriate. Assess pain scores and adequacy of analgesia. Check PMP registry and discuss decreasing or discontinuing opioid medications, muscle relaxants, and other analgesic management. Discuss advancing activities, including return to work/school, provide appropriate documentation when needed for return to work/school; discuss safe return to driving when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for medical chart. Answer questions from patient and/or family, and insurance staff. Discuss (oral and written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63020					
Sample Size:	2489	**Resp N:**	79			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**5.00**	10.00	100.00	
Survey RVW:	10.92	15.95	**17.50**	19.65	-3.00	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	80.00	**90.00**	120.00	180.00	
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):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 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:	63020	**Recommended Physician Work RVU: 15.95**		
		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:		**20.00**	**3.00**	**17.00**
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):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	60.00	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	38.00	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	86.00	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 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
63047	090	15.37	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63075	090	19.60	**RUC Time**

CPT Descriptor Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

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
63047	090	15.37	**RUC Time**	101,838

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; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	10,340

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	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: 32 **% of respondents:** 40.5 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 30.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 63020	**Top Key Reference CPT Code:** 63047	**2nd Key Reference CPT Code:** **63075**
Median Pre-Service Time	75.00	75.00	95.00
Median Intra-Service Time	90.00	90.00	90.00
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	60.0	60.00	40.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	86.0	69.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**379.00**	**362.00**	**355.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	25%	66%	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%	50%	47%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	34%	66%
Physical effort required	3%	47%	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%	38%	63%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	54%	38%	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	0%	79%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	13%	46%	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	0%	58%	42%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2018, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. Code 63030 was identified with Medicare data from 2014-2017e indicated that it was performed less than 50% of the time with inpatient status, yet included inpatient hospital Evaluation and Management services within the global period. In January 2019, the RUC reviewed an action plan and recommended that code 63030 be reviewed in two years (January 2021) to determine if the CPT 2017 changes were effective to ensure correct reporting of this service. In December 2020, the RAW noted that 63030 continued to have outpatient status more than 50% of the time. The specialty society indicated that there was still coding confusion and the RUC recommended that CPT code 63030 be referred to CPT to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The CPT code change application to differentiate inpatient (63030) versus outpatient (630X0) was rejected by the CPT Panel. In rejection the application, the Panel noted that the proposed descriptor changes "were not unique, well-defined, and described a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT." This resulted in code 63030 (lumbar) reverting back to the RUC for survey. The societies added code 63020 (cervical) and +63035 (additional level) as family codes for review.

Recommendation - 63020

We recommend the survey 25th percentile work RVU of 15.95. Using magnitude estimation, a value of 15.95 accounts for both the decrease in intraoperative time and increase in postoperative work. This value also compares well with the key reference code 63047 which has slight less total time, but the same intensity.

Pre-time Package 4

Evaluation time: Standard package time of 40 minutes which is less than the survey median.

Positioning time: The survey median time of 20 minutes is recommended. This is less than the time allowed for supine positioning followed by prone positioning for posterior neck surgery package SS2.

Scrub, dress, wait time: The survey median time of 15 minutes is recommended which is less than package 4 time.

Post-time Package 9B

The survey median time of 30 minutes is recommended.

Postop Office Visits

The first visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed, the wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology, and reassure the patient with that information. Medication management is performed including a PDMP check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants, and discussing how the medication use might impact the patient's ability to work, drive, study, provide child care safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or OTC) and/or other analgesics to switch to as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals, including order therapy. The surgeon will also assess the need for bracing (eg, for foot droop). Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent HNP; and whether a UA and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with PM&R for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their HR specified work needs.

The second and third visit will typically be level 99213 and include interval update of H&P, medication management, PT/OT progress review and order revision, interval imaging order as needed, and continued assessment of patient progress watching for recurrent HNP.

Key Reference Codes

KRS1 code 63047 is similar to 63020, but appropriately has a slightly lower RVW to account for the difference between lumbar and cervical spine surgery. Although KRS2 code 63075 and 63020 are both cervical spine operations, code 63075 has a higher RVW compared with 63020 to appropriately account for the added intensity and complexity of an anterior cervical approach to the spine that includes dissection and protection of the trachea, esophagus and vessels including the carotid.

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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	090	15.37	0.077	362	75	90	197
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	090	15.95	0.077	379	75	90	214
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	090	19.60	0.132	355	95	90	170

MPC Codes

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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	090	15.37	0.077	362	75	90	197
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	090	15.95	0.077	379	75	90	214
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	090	17.75	0.106	337	80	103	154

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) 63020

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization 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? 1,345
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 neurosurgery Frequency 775 Percentage 57.62 %

Specialty orthopaedic surgery Frequency 550 Percentage 40.89 %

Specialty Frequency 0 Percentage %

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:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 63020

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:63030 Tracking Number Original Specialty Recommended RVU: **13.18**
Presented Recommended RVU: **13.18**
Global Period: 090 Current Work RVU: **13.18** RUC Recommended RVU: **13.18**

CPT Descriptor: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with a 6-week history of progressive right leg pain unresponsive to conservative therapy. Imaging identified a right L5-S1 paracentral disc herniation resulting in right lateral recess stenosis. He undergoes a right L5-S1 discectomy.

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 82% , In the ASC 18%, 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 48% , Overnight stay-less than 24 hours 40% , Overnight stay-more than 24 hours 12%

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 86%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis, as required, are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The patient is reexamined to confirm that physical findings have not changed; the patient's medication regimen has remained the same; the patient has no new allergies; and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The site of the proposed skin incision is marked. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available. Transfer of the patient from gurney to operating table, and position the patient prone on an OR table: Prior to the flip, prepare the operating table for the patient's pressure points to the size of the patient, adjust the chest support, the iliac crest support, and support over the proximal part of each thigh. Protective pads and restraints are placed, and the table is placed in a reverse Trendelenburg position to help with intraoperative bleeding. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all imaging equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. A lateral radiograph with a metallic marker is taken to confirm the correct operative level and to mark the final plan for the surgical incision. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team. Standard sterile preparation and draping of the surgical site is completed.

Description of Intra-Service Work: An incision is made adjacent to the spinous process on the side of the abnormality over the operative level. Use lateral fluoroscopy to confirm the level. Release the deep lumbar fascia with a knife or Bovie electrocautery Reflect muscular attachments off of the vertebral lamina and medial facet complex. Secure retractors and achieve hemostasis. If using tubular dilators, instead of releasing the deep fascia through an open incision, introduce the initial dilator through the skin incision and advance to the inferomedial edge of the rostral lamina at the operative level. Use sequential dilators to create a working portal within the soft tissues. Center the final working tube over the lateral aspect of the lamina and medial facet joint of the appropriate operative level. Secure the working tube to a sterile arm that is attached to the bed. Perform the laminoforaminotomy with the use of a high-speed drill and a Kerrison rongeur to create a working

window into the foramen. Once the high-speed burr has been used to thin the lamina and the epidural space is accessible, a Kerrison punch is used to continue the osseous resection from medial to lateral. Address epidural bleeding. Use a nerve hook or Penfield 4 to dissect and retract the nerve root. Secure the traversing nerve root with a nerve root retractor. Perform a discectomy and decompression. Remove any evident free fragments of disc. Incise annulus of disc, remove any visible, loose disc fragments with a micro-pituitary rongeur. Contained disc fragments require incision of the posterior longitudinal ligament. Control bleeding with powdered Gelfoam and bipolar cautery. Copiously irrigate the wound with normal saline solution. Obtain hemostasis with electrocautery or hemostatic foam. Close the wound in layers.

Description of Post-Service Work:
Immediate postoperative care [through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with nursing staff.

Later same day hospital care visit after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Examine patient, check wound(s) and patient progress, and monitor for abnormal neurological findings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Next day subsequent hospital care and discharge management Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Examine patient, check wound(s) and patient progress, and monitor for abnormal neurological findings. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. When it is safe to discharge the patient, review postdischarge wound care and activity limitations, including planned physical therapy. Answer questions from patient and/or family, nursing, and other provider(s). Write orders for post-discharge films, medications, and therapy. Chart patient discharge notes.

Office: Examine patient and perform periodic neurological exams. Write orders for medications. Order and review follow-up films. Monitor wounds and remove staples, when appropriate. Assess pain scores and adequacy of analgesia. Check PMP registry and discuss decreasing or discontinuing opioid medications, muscle relaxants, and other analgesic management. Discuss advancing activities, including return to work/school, provide appropriate documentation when needed for return to work/school; discuss safe return to driving when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for medical chart. Answer questions from patient and/or family, and insurance staff. Discuss (oral and written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63030					
Sample Size:	2489	**Resp N:**	82			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**40.00**	65.00	220.00
Survey RVW:	10.92	15.31	**15.46**	16.95	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	66.00	**90.00**	90.00	180.00

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):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 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:	63030	**Recommended Physician Work RVU: 13.18**		
		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:		**15.00**	**3.00**	**12.00**
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:	**40.00**	**33.00**	**7.00**

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):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 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
63047	090	15.37	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22867	090	15.00	**RUC Time**

CPT Descriptor Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

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
52601	090	13.16	**RUC Time**	44,942

CPT Descriptor 1 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
53440	090	13.36	**RUC Time**	1,020

CPT Descriptor 2 Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)

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: 61 **% of respondents:** 74.3 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 8.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 63030	**Top Key Reference CPT Code:** 63047	**2nd Key Reference CPT Code:** **22867**
Median Pre-Service Time	70.00	75.00	68.00
Median Intra-Service Time	90.00	90.00	90.00
Median Immediate Post-service Time	40.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	60.00	0.00
Median Discharge Day Management Time	19.0	38.00	19.00
Median Office Visit Time	86.0	69.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**305.00**	**362.00**	**276.00**
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.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	62%	26%	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	15%	69%	16%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	66%	31%

Physical effort required	10%	67%	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	2%	69%	20%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	0%	71%	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	14%	0%	86%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	14%	0%	86%
Physical effort required	0%	43%	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%	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.

Background

In October 2018, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. Code 63030 was identified with Medicare data from 2014-2017e indicated that it was performed less than 50% of the time with inpatient status, yet included inpatient hospital Evaluation and Management services within the global period. In January 2019, the RUC reviewed an action plan and recommended that code 63030 be reviewed in two years (January 2021) to determine if the CPT 2017 changes were effective to ensure correct reporting of this service. In December 2020, the RAW noted that 63030 continued to have outpatient status more than 50% of the time. The specialty society indicated that there was still coding confusion and the RUC recommended that CPT code 63030 be referred to CPT to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The CPT code change application to differentiate inpatient (63030) versus outpatient (630X0) was rejected by the CPT Panel. In rejection the application, the Panel noted that the proposed descriptor changes "were not unique, well-defined, and described a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT." This resulted in code 63030 (lumbar) reverting back to the RUC for survey. The societies added code 63020 (cervical) and +63035 (additional level) as family codes for review.

Important additional discussion about postoperative facility work

Many years ago, the RUC developed a policy for work and time inputs for codes where a patient went home the same day after a procedure and there was overlap in immediate post-work/time and later same day discharge work/time. The resolution by the RUC, with concurrence by CMS when proposed, was to indicate one-half discharge code (0.5 x99238) as a proxy for overlapping work on the same date. In fact, to accurately determine this, the RUC developed a new survey question to differentiate between same day discharge and next day discharge. The 0.5 x 99238 proxy initially was only applied to same day services. This reduction in discharge work was similar to E/M codes established for same day admit and discharge, where discharge did not get full value. On the other hand, a full discharge service code was allowed in global codes if the patient stayed one or more midnights, similar to E/M codes established for a facility visit on day 1 and a full discharge code on a subsequent date.

The facility status (observation versus inpatient) for patients who are placed in a hospital bed on a surgical floor postoperatively and stay overnight has been extensively discussed for more than 10 years. The early years of this discussion led to the "two-midnight rule." Unfortunately, CMS mixed facility status with physician work in developing a 23-hour outpatient stay policy about what E/M codes can and cannot be associated with a global code by assuming all claims with an outpatient facility status should be treated the same in terms of physician work independent of whether the work was performed on the same day as a procedure or the next day.

Surgical societies responded to the 23-hour outpatient stay policy when proposed by indicating that a patient can be admitted as inpatient and discharged the next day and maintain inpatient status if all the requirements for assignment of status were met in newly developed programs such as InterQual which are based on criteria of facility resource utilization. For example, if a patient came into the hospital with a diagnosis of acute renal failure with a creatinine of 6, used a vein light for IV access and was placed on IV fluids at 75cc/hour, the patient would not qualify for inpatient status. However, if the fluids ran at 100cc/hour or greater, the same patient would qualify for inpatient status. The physician work to order 75cc/hr versus 100cc/hr of fluids may not be different, but the resources used by the facility would be different and result in different payments to the facility. All of this is to say that physician work is judged by MDM or time and not by facility resources used.

In 2023, the inpatient versus observation (outpatient) reporting paradigm will change since there will be a single code to report on the date of admission and a single code to report on the subsequent discharge day that is independent of whether the patient's facility status is inpatient or observation. The establishment of a single combined inpatient/observation E/M code for each level of physician work is consistent with what surgeons have been saying since 2007 – an E/M visit for a patient in a hospital bed on the surgical floor is not dependent on the final facility status for the patient, but instead on the MDM (or total time) required. Any difference in patient acuity would result in more or less medical decision making and/or time and be reported appropriately.

In fact, at the October 2021 RUC meeting, the Research Subcommittee and the RUC agreed that postoperative physician E/M work should accurately be accounted for in global codes:

The Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to change its policy for discharge day visits in the surgical global period, where the ½ day discharge proxy would only be applicable to services that typically involve a same-day discharge. Similarly, the Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to eliminate its 23-hour stay policy of allocating the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of an outpatient

procedure. The Research Subcommittee also recommends for an update on this meeting to be provided to the RUC after it takes place.**[Approved]**

All of the discussion above is meant to emphasize that reason needs to prevail in the discussion about accounting for "perceived" changes in physician work for patients who are not ambulatory and do not leave a hospital on the day of a procedure, but instead are admitted to the surgical ward, and—if medically able and appropriate—leave the next day. Although we will follow the 23-hour policy for code 63030 in this agenda tab, we emphasize that in 2023, there will no longer be different codes for hospital inpatient or observation care services and that movement of time and reduction of claims to "0.5" is counter to the RUC recommendation made at the October 2021 meeting .

Recommendation - 63030

We recommend maintaining the current work RVU of 13.18. Using magnitude estimation, a value of 13.18 accounts for both the decrease in postoperative facility work and increase in postoperative office work. As presented in the "Important additional discussion about postoperative facility work" above, we believe (and the RUC agrees) that full work should be accounted for in global codes. An E/M facility visit should not be decreased for surgical postop work in global codes and discharge day management work on the day after surgery. This is not less work than for medical patient on the day of and after admission for observation (ie, surgeons should not get credit for 0.5 x 99238 while physicians caring for medical patients are allowed to report 1.0 x 99238 for the same work). If the arbitrary discounting of global code E/M work was not implemented, the total time per the survey would be the same as current time, with only a shift of work from facility to office. Fundamentally, the total work for 63030 has not changed.

Pre-time Package 4

Evaluation time: Standard package time of 40 minutes which is less than the survey median.

Positioning time: The survey median time of 15 minutes is recommended. This is less than the time allowed for supine positioning followed by prone positioning for posterior thoracic/lumbar surgery package SS3.

Scrub, dress, wait time: The survey median time of 15 minutes is recommended which is less than package 4 time.

Post-time

A total of 40 minutes is shown which includes the survey median time of 30 minutes plus the intra-time of 10 minutes for current code 99231 per the CMS 23-hour outpatient policy—keeping in mind that in 2023, code 99231 will be revised to reflect both inpatient and observation (outpatient) E/M work. Additionally, 99238 has been shown as 0.5 x 99238 even though this patient will not typically be discharge on the same day and complete discharge day management work will be performed on the day after surgery.

Postop Office Visits

The first visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed, the wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology, and reassure the patient with that information. Medication management is performed including a PDMP check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants, and discussing how the medication use might impact the patient's ability to work, drive, study, provide child care safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or OTC) and/or other analgesics to switch to as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals, including order therapy. Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent HNP; and whether a UA and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with PM&R for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their HR specified work needs.

The second and third visit will typically be level 99213 and include interval update of H&P, medication management, PT/OT progress review and order revision, interval imaging order as needed, and continued assessment of patient progress watching for recurrent HNP.

Key Reference Codes

KRS1 code 63047 is similar to 63020, but appropriately has a higher RVW to account for additional postop work. KRS2 code 22867 is more intense and complex than 63030 due to bilateral decompression as well as placement of an interlaminar/interspinous process stabilization/distraction device and therefore is appropriately valued higher.

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	090	13.18	0.076	305	70	90	140
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	090	15.00	0.106	276	68	90	118
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	090	15.37	0.077	362	75	90	197

MPC Codes

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	090	13.16	0.114	236	61	75	100
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	090	13.18	0.076	305	70	90	140
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	090	13.36	0.098	248	55	90	103

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) 63030

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization 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? 27,404
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 neurosurgery Frequency 15500 Percentage 56.56 %

Specialty orthopaedic surgery Frequency 11250 Percentage 41.05 %

Specialty Frequency 0 Percentage %

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:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 63030

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:63035 Tracking Number Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: ZZZ Current Work RVU: **3.15** RUC Recommended RVU: **4.00**

CPT Descriptor: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: After performing a L5-S1 discectomy (separately reported) on a 50-year-old male with a 6-week history of progressive right leg pain unresponsive to conservative therapy and imaging studies that identified right-sided disc herniations at two levels, an additional level right L4-5 discectomy is performed. Note: This is an add-on service which only includes the work of the additional level discectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The incision is extended as necessary to facilitate exposure of the spinous process on the side of the abnormality over the next operative level. Use lateral fluoroscopy to confirm the level. Release the deep lumbar fascia with a knife or Bovie electrocautery Reflect muscular attachments off of the vertebral lamina and medial facet complex. Secure retractors and achieve hemostasis. If using tubular dilators, complete a second cycle of introducing and docking the tubular dilator over the involved disc space. Instead of releasing the deep fascia through an open incision, introduce the initial dilator through the skin incision and advance to the inferomedial edge of the rostral lamina at the operative level. Use sequential dilators to create a working portal within the soft tissues. Center the final working tube over the lateral aspect of the lamina and medial facet joint of the appropriate operative level. Secure the working tube to a sterile arm that is attached to the bed. Use lateral fluoroscopy to confirm the new level. Perform the laminoforaminotomy with the use of a high-speed drill and a Kerrison rongeur to create a working window into the foramen. Once the high-speed burr has been used to thin the lamina and the epidural space is accessible, a Kerrison punch is used to continue the osseous resection from medial to lateral. Address epidural bleeding. Use a nerve hook or Penfield 4 to dissect and retract the nerve root. Secure the traversing nerve root with a nerve root retractor. Perform a discectomy and decompression. Remove any evident free fragments of disc. Incise annulus of disc, remove any visible, loose disc fragments with a micro-pituitary rongeur. Contained disc fragments require incision of the posterior longitudinal ligament. Control bleeding with powdered Gelfoam and bipolar cautery. Copiously irrigate the wound with normal saline solution. Obtain hemostasis with electrocautery or hemostatic foam. The wound extension is closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2022					
Presenter(s):	John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63035					
Sample Size:	2489	**Resp N:**	81			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	20.00	100.00
Survey RVW:	3.00	3.50	**4.00**	5.25	18.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	40.00	**60.00**	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:	63035	**Recommended Physician Work RVU: 4.00**		
		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:		**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)

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
63048	ZZZ	3.47	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

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**	9013

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
		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: 59 **% of respondents:** 72.8 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 8.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 63035	Top Key Reference CPT Code: 63048	2nd Key Reference CPT Code: 22552
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	60.00	45.00	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	**60.00**	**45.00**	**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.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	69%	24%	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%	64%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	66%	31%
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	3%	69%	27%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	29%	71%	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%	100%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	71%	29%
Physical effort required	0%	57%	43%

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%	71%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2018, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. Code 63030 was identified with Medicare data from 2014-2017e indicated that it was performed less than 50% of the time with inpatient status, yet included inpatient hospital Evaluation and Management services within the global period. In January 2019, the RUC reviewed an action plan and recommended that code 63030 be reviewed in two years (January 2021) to determine if the CPT 2017 changes were effective to ensure correct reporting of this service. In December 2020, the RAW noted that 63030 continued to have outpatient status more than 50% of the time. The specialty society indicated that there was still coding confusion and the RUC recommended that CPT code 63030 be referred to CPT to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The CPT code change application to differentiate inpatient (63030) versus outpatient (630X0) was rejected by the CPT Panel. In rejection the application, the Panel noted that the proposed descriptor changes "were not unique, well-defined, and described a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT." This resulted in code 63030 (lumbar) reverting back to the RUC for survey. The societies added code 63020 (cervical) and +63035 (additional level) as family codes for review.

Compelling Evidence - flawed mechanism or methodology used in the previous valuation

1. Code 63035 is a Harvard-based code. The Harvard study method for reviewing "secondary codes" (ie, add-on codes) was to survey the primary code as a global code and the add-on code as a multiple of the primary code and then subtract one from the other to determine the additional work related to the secondary code.[1] So, for example, the data for code 63030 surveyed as a 90-day global code was compared with the data for code 63035 surveyed as a 90-day global code for 2 levels. Although this sounds like a good idea, the Harvard study used two different panels of neurosurgeons to survey each code resulting in data that did not make sense; some elements of work were lower for 63035even though a hemilaminectomy of 2 levels was performed. Further, the difference in total time between the two surveys was 51 minutes, but the final Harvard dataset indicated 49 minutes of intra-time for 63035. We believe this was a flaw methodology to determine both an absolute and relative value for 63035, resulting in an underestimation of time and work required, which meets compelling evidence.

2. The Harvard study solicited responses only from neurosurgeons (n=17) even though an almost equal number of orthopaedic surgeons perform this service. This also meets compelling evidence.

Recommendation - 63035

We recommend the survey median work RVU of 4.00.

Key Reference Codes

Code 63035 requires more time than KRS1 63048, supporting a higher value for 63035 and justifying the median survey value for this code. Code 63048 describes the work of extending a laminectomy to an additional level. In 63048, the skin incision is extended either higher or lower, followed by additional fascial incision and dissection of paraspinal muscles to expose the next level of the spine. Radiographic localization is not necessary, since the work is routinely performed at an adjacent level. Hence the exposure in 63048 builds off of the exposure used for the base code. For 63035, especially when using a tubular retractor system, the exposure is completed de novo. A new, unique fascial incision is made remotely from the base code fascial incision, followed by new dissection of paraspinal musculature and new placement of a retractor. For a tubular retractor, new radiographs are required for docking the retractor safely upon the lamina and ensuring appropriate retractor position. The exposure of 63035 is unique and does not directly build of the exposure of the base code and therefore requires more time and work when compared to 63048.

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	ZZZ	3.47	0.77	45	0	45	0
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	ZZZ	4.00	0.067	60	0	60	0

[1] Appendix D4.1 of the the Harvard Phase III Final Report)

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)	ZZZ	6.50	0.144	45	0	45	0

MPC Codes

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	ZZZ	3.47	0.77	45	0	45	0
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	ZZZ	4.00	0.067	60	0	60	0
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	ZZZ	4.13	0.103	40	0	40	0

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. (Use 63035 in conjunction with 63020-63030)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63035

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization 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? 6,873
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 neurosurgery Frequency 3750 Percentage 54.56 %

Specialty orthopaedic surgery Frequency 3090 Percentage 44.95 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 63035

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: Lumbar Laminotomy with Decompression
TAB: 17

SOURCE	Review Year	CPT	DESC	global	Resp	IWPUT	WPUT	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	POST P-SD	POST 32	POST 31	POST 38	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11	12 Month Svy Experience MIN	12 Month Svy Experience 25th	12 Month Svy Experience MED	12 Month Svy Experience 75th	12 Month Svy Experience MAX	TYP?
REF1	2013	63047	Laminectomy, facetectomy and foraminotor	90	32	0.077	0.042			15.37			362	40	15	20			90			30	1	1	1.0			3									
REF2	2005	63075	Discectomy, anterior, with decompression o	90	24	0.132	0.055			19.60			355	60	20	15			90			30	1		1.0			2	1							
current	1995	63020	Laminotomy (hemilaminectomy), with decor	90		0.059	0.039			16.20			412	90					120			35	1	1	1.0			3							
SVY	2022	63020	Laminotomy (hemilaminectomy), with decor	90	79	0.093	0.046	10.92	15.95	17.50	19.65	30.00	384	45	20	15	60	80	90	120	180	30	1	1	1.0		1	2			0	1	5	10	100	92%
REC		63020	'Laminotomy (hemilaminectomy), with deco	90	79	0.077	0.042			15.95			379	40	20	15			90			30	1	1	1.0		1	2				0	1	5	10	100	92%
REF1	2013	63047	Laminectomy, facetectomy and foraminotor	90	61	0.077	0.042			15.37			362	40	15	20			90			30	1	1	1.0			3								
REF2	2016	22867	Insertion of interlaminar/interspinous proces	90	7	0.106	0.055			15.00			271	33	15	15			90			30			0.5			3							
current	1995	63030	Laminotomy (hemilaminectomy), with decor	90		0.057	0.039			13.18			342	75					90			30		2	1.0			3							
SVY	2022	63030	Laminotomy (hemilaminectomy), with decor	90	82	0.087	0.046	10.92	15.31	15.46	16.95	30.00	339	45	15	15	45	66	90	90	180	30		1	1.0		1	2			0	20	40	65	220	98%
REC		63030	Laminotomy (hemilaminectomy), with decor	90		0.076	0.043			13.18			305	40	15	15			90			40			0.5		1	2			0	20	40	65	220	98%
REF1	2013	63048	Laminectomy, facetectomy and foraminotor	ZZZ	59	0.077	0.077			3.47			45						45																	
REF2	2010	22552	Arthrodesis, anterior interbody, including dis	ZZZ	7	0.144	0.144			6.50			45						45																	
current	HVD	63035	Laminotomy (hemilaminectomy), with decor	ZZZ		0.064	0.064			3.15			49						49																	
SVY	2022	63035	Laminotomy (hemilaminectomy), with decor	ZZZ	81	0.067	0.067	3.00	3.50	4.00	5.25	18.00	60	0			20	40	60	60	120	0								0	5	10	30	100	93%
REC		63035	'Laminotomy (hemilaminectomy), with deco	ZZZ		0.067	0.067			4.00			60	0					60			0													

FACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01/2022

CPT Code	Long Descriptor	Global Period
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	90
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	90
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
63020	A 45-year-old female presents with intractable left arm pain unresponsive to conservative therapy. Imaging identified a left C5-6 foraminal disc herniation. She undergoes a left C5-6 laminoforaminotomy.
63030	A 50-year-old male presents with a 6-week history of progressive right leg pain unresponsive to conservative therapy. Imaging identified a right L5-S1 paracentral disc herniation resulting in right lateral recess stenosis. He undergoes a right L5-S1 discectomy.
63035	After performing a L5-S1 discectomy (separately reported) on a 50-year-old male with a 6-week history of progressive right leg pain unresponsive to conservative therapy and imaging studies that identified right-sided disc herniations at two levels, an additional level right L4-5 discectomy is performed. Note: This is an add-on service which only includes the work of the additional level discectomy.

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 society advisors reviewed the current PE inputs for these facility only 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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   current codes

3. Is this code(s) typically reported with an E/M service?

   no

FACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

4. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

Increase in cost is due to increases in clinical labor rate, increased postop visit level; and addition of exam light for postop visits. The exam light is needed to assess the wound and remove staples and is a standard piece of equipment in a neurosurgeon and orthopaedic exam room.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

no

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

na

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:

na

8. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Activity	Clinical Staff Work	TIME
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.	5
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.	20
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.	8
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.	20

FACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, preop diet restrictions, reviews patient medical status and answers final pre-admission questions.	7

b. Service period (includes pre, intra and post):

Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as: Responding to patient/family questions about home activity restrictions. Confirmation of discharge antibiotics if needed, and pain medication. Coordination with other physicians and QHPs involved in the care of the patient for transfer of records. Transitioning discharge information to the surgeon's office medical record, including medication list, correspondence and imaging or lab results pending at discharge.

c. Post-service period:

The clinical staff work includes the standard activities involved in any E/M visit including ensuring the appropriate supplies are available in the room, ensuring imaging and lab reports are available, rooming the patient, gowning, reviewing current medications/allergies in EHR, obtaining vital signs, assisting with positioning, wound care, coordination of care, and cleaning of the room.

9. 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*):

na

10. 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

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

na

14. Are you recommending a PE supply pack for this recommendation? Yes
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

pack, post-op incision care (staple) SA052

15. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

FACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
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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, post-op incision care (staple)	SA052	pack	
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

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

na

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

na

18. 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

19. 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	Office Visits
EQ168	light, exam	Office Visits

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

na

ADDITIONAL INFORMATION

FACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD (AANS); Karin Swartz, MD (NASS); Clemens Schirmer, MD (CNS); Hussein Elkousy, MD (AAOS): William Creevy, MD (AAOS)

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 requires greater detail/explanation, please include here:

na

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. 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): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD, AANS; Karin Swartz, MD, NASS; Clemens Schirmer, MD, CNS; Hussein Elkousy, MD, AAOS: William Creevy, MD, AAOS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01/2022

CPT Code	Long Descriptor	Global Period
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	90
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	90
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
63020	A 45-year-old female presents with intractable left arm pain unresponsive to conservative therapy. Imaging identified a left C5-6 foraminal disc herniation. She undergoes a left C5-6 laminoforaminotomy.
63030	A 50-year-old male presents with a 6-week history of progressive right leg pain unresponsive to conservative therapy. Imaging identified a right L5-S1 paracentral disc herniation resulting in right lateral recess stenosis. He undergoes a right L5-S1 discectomy.
63035	After performing a L5-S1 discectomy (separately reported) on a 50-year-old male with a 6-week history of progressive right leg pain unresponsive to conservative therapy and imaging studies that identified right-sided disc herniations at two levels, an additional level right L4-5 discectomy is performed. Note: This is an add-on service which only includes the work of the additional level discectomy.

FACILITY-ONLY CODES. NO PE INPUTS RECOMMENDED

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:

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 (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

3. Is this code(s) typically reported with an E/M service?

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD, AANS; Karin Swartz, MD, NASS; Clemens Schirmer, MD, CNS; Hussein Elkousy, MD, AAOS: William Creevy, MD, AAOS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Is this code(s) typically reported with the E/M service in the nonfacility?
(Please see the *Billed Together* tab in the RUC Database)

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 the *Billed Together* tab in the RUC Database)

5. If you are requesting an increase over the aggregate current cost for clinical activities, supplies and equipment, please provide compelling evidence. (Please see *PE compelling evidence guidelines* on Collaboration). Please explain if the increase can be entirely accounted for because of an increase in physician time:

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

8. 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:

9. 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:

10. Please provide a brief description of the clinical staff work for the following:

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
SPECIALTY SOCIETY(IES): AANS, CNS, NASS, AAOS, ISASS
PRESENTER(S): John Ratliff, MD, AANS; Karin Swartz, MD, NASS; Clemens Schirmer, MD, CNS; Hussein Elkousy, MD, AAOS: William Creevy, MD, AAOS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

a. Pre-Service period:

b. Service period (includes pre, intra and post):

c. Post-service period:

11. 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:*

12. 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.

13. 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*):

14. 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.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

19. 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.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

22. 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)?

23. 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:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 63020,63030,63035
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

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
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**63020**		**63020**		**63030**		**63030**		**63035**		**63035**	
3	**Clinical Activity Code**	**Meeting Date: 01/2022 Tab: 17 Specialty: AANS, CNS, NASS, AAOS, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Laminotomy (hemilaminectomy), with decompression of nerve root(s),		Laminotomy (hemilaminectomy), with decompression of nerve root(s),		Laminotomy (hemilaminectomy), with decompression of nerve root(s),		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including		Laminotomy (hemilaminectomy), with decompression of nerve root(s),		Laminotomy (hemilaminectomy), with decompression of nerve root(s),	
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7		**TOTAL CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**197**	**0**	**180**	**0**	**191**	**0**	**0**	**0**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**60**	**0**	**60**	**0**	**60**	**0**	**0**	**0**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**12**	**0**	**12**	**0**	**6**	**0**	**0**	**0**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**125**	**0**	**108**	**0**	**125**	**0**	**0**	**0**	**0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12		**PRE-SERVICE PERIOD**															
13		**Start: Following visit when decision for surgery/procedure made**															
14	CA001		L037D				5		5		5		5				
15	CA002		L037D				20		20		20		20				
16	CA003		L037D				8		8		8		8				
17	CA004		L037D				20		20		20		20				
18	CA005		L037D				7		7		7		7				
21		**End: When patient enters office/facility for surgery/procedure**															
22		**SERVICE PERIOD**															
23		**Start: When patient enters office/facility for surgery/procedure:**															
59	CA036		L037D			**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**6**	**n/a**		**n/a**	
66		**End: Patient leaves office/facility**															
67		**POST-SERVICE PERIOD**															
68		**Start: Patient leaves office/facility**															
71		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
72		99211 16 minutes	16														
73		99212 27 minutes	27														
74		99213 36 minutes	36				3		2		3		2				
75		99214 53 minutes	53						1				1				
76		99215 63 minutes	63														
77	CA039		L037D			**0.0**	**108.0**	**0.0**	**125.0**	**0.0**	**108.0**	**0.0**	**125.0**	**0.0**	**0.0**	**0.0**	**0.0**
84		**End: with last office visit before end of global period**															
85	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**													
86		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
87	SA048						3		3		3		3				
88	SA052						1		1		1		1				
93	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**												
94		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
95	EF031			Office Visits			108		125		108		125				
96	EQ168			Office Visits					125				125				