STEPS TO APPLY FOR A NOVEL CPT CODE

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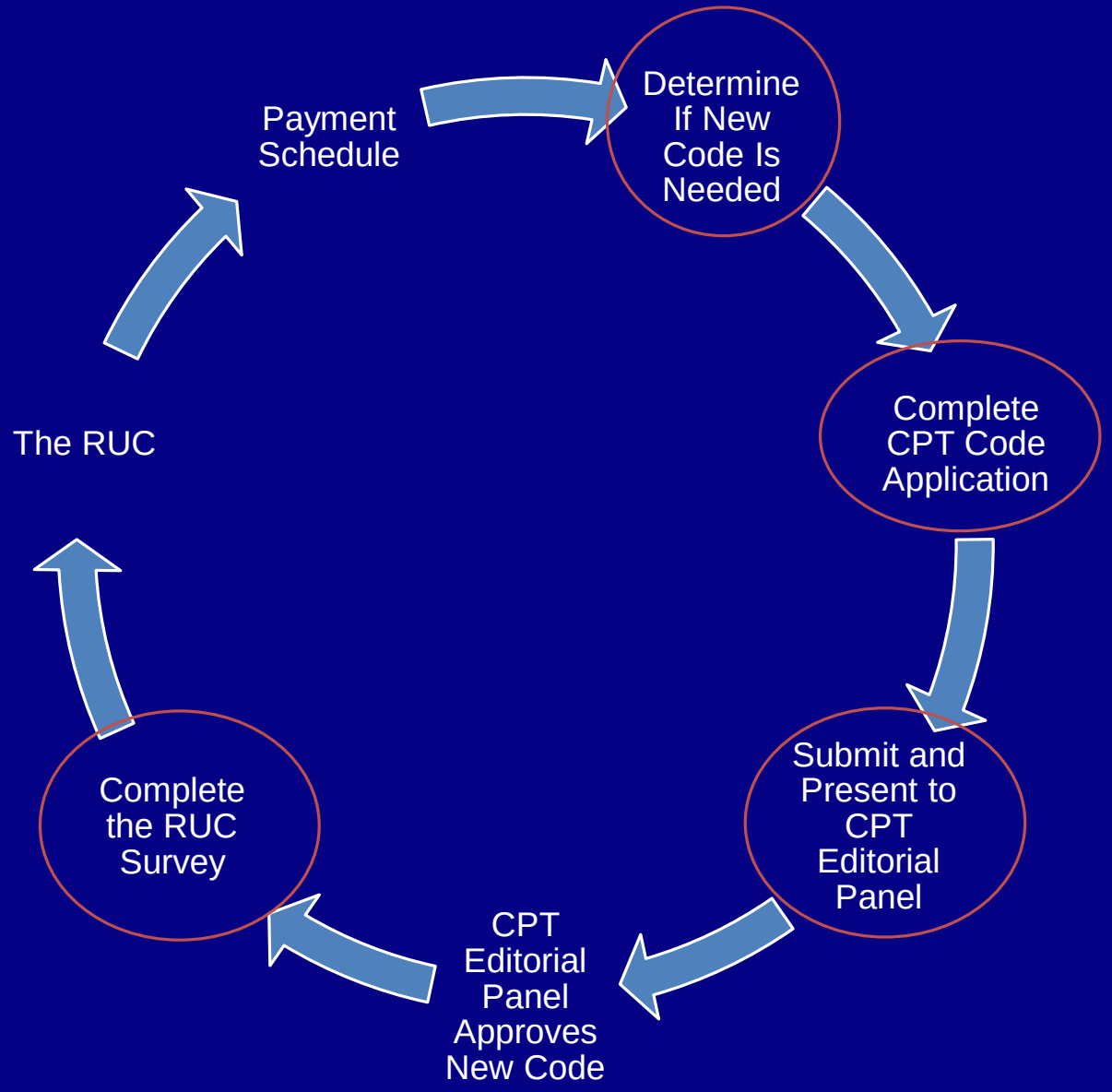
NO DISCLOSURES

THE PROCESS


Determine If New Code Is Needed
Complete CPT Code Application
Submit and Present to CPT Editorial Panel
CPT Editorial Panel Approves New Code
Complete the RUC Survey
The RUC
Payment Schedule

IS THERE AN EXISTING CODE(S) THAT REFLECTS THE SERVICE?

YES - USE EXISTING CODE

- The service or procedure performed has been altered by some specific circumstance or added complexity, but its definition is not changed
  - Append modifier to code

NO – CREATE NEW CODE

- Determine if multiple procedures are required to treat a 1 problem.
- Define the physician work involved in the procedure/service.
- Determine if the procedure/service represent additional “intraoperative” work that is not already accounted for in an existing code.

ENSURE THE NEW PROCEDURE/SERVICE MEETS THE CRITERIA

- General Criteria
- Category I Criteria
- Category III Criteria
- Literature Requirements

GENERAL CRITERIA

- Ensure the descriptor is unique, well-defined, and clearly identifies the procedure/service
- The descriptor structure, guidelines and instructions are consistent with current CPT conventions
- Descriptor is not a fragmentation of an existing code and is not currently reportable with one or more existing codes. Procedures frequently performed together may require new/revised code
- The descriptor reflects the procedure as typically performed and reflects the typical combination or complete procedure/service
- The descriptor does not represent extraordinary circumstances of an existing procedure/service
- The specific Category I or Category III code criteria are met

CATEGORY I CRITERIA

- FDA approval or clearance for all necessary devices and drugs required for the procedure/service
- Procedure/service is performed by many physicians across the United States.
- Procedure/service is performed with frequency consistent with its intended clinical use
- Procedure/service is consistent with current medical practice.
- Documented clinical efficacy in literature that meets CPT requirements

Category I Literature Requirements	Utilization	Typical	Typical	Limited, Specialized or Humanitarian	Limited, Specialized or Humanitarian
	Technology	New	Existing or Non-Contributory	New	Existing or Non-Contributory
Maximum # of Peer-Reviewed Publications Per Distinct Service(s)/Technique(s):		5	5	5	3-5
For each Additional Distinct Service(s)/Technique(s) within Multi-code Family(ies)		2-5	2-5	2-5	2-5
Minimum # with Exclusively U.S. Patient Populations OR Majority U.S. Population (provide specific number/percentage of patients from U.S. population to be considered within PDA Grid Column 7 titled "US or Foreign Population Studied):		1	1	1	1
Minimum # with No Overlapping Patient Populations and No Overlapping Authors:		2	2	1	1
Minimum Level of Evidence for at least One Article		IIa	IIIa/IIIb	IIIb	IV
Make an "X" in the box for the type of utilization and technology that best fits the procedure/literature being requested.					

LITERATURE CRITERIA DEFINITIONS

- **New Technology:**

  Individuals or organizations putting forth code change applications will be required to specifically indicate the pathway for FDA approval or clearance.

  Services or procedures requiring devices or other technology necessitating the following Food and Drug Administration (FDA) pathways are defined for CPT literature requirements as those involving “new” technology:

  1) Premarket Approval (PMA) or Investigational Device Exemption (IDE);
  2) Panel Track Submission
  3) DeNovo 510(k)

LITERATURE CRITERIA DEFINITIONS

- **Existing or Non-Contributory Technology:**

  Services or procedures which are approved or cleared via other FDA requirements (e.g., traditional 510(k)) or those which do not involve technology are defined for CPT literature requirements as those where technology is “existing or non-contributory.”

  Most CPT code change applications currently fall within this category.

Level of Evidence Table – LOE

Level	Short Description (based on Oxford Centre 2009)
Ia	Evidence obtained from systematic review of randomized controlled trials
Ib	Evidence obtained from an individual randomized controlled trial
	Randomized Controlled Trial(s): *An epidemiological experiment in which subjects in a population are randomly allocated into groups, usually called study and control groups, to receive or not receive an experimental preventive or therapeutic procedure, maneuver, or intervention. The results are assessed by rigorous comparison of rates of disease, death, recovery, or other appropriate outcome in the study and control groups.*
IIa	Evidence obtained from systematic review of cohort studies
IIb	Evidence obtained from an individual cohort study
	Cohort study(ies): *The analytic method of epidemiologic study in which subsets of a defined population can be identified who are, have been, or in the future may be exposed or not exposed, or exposed in different degrees, to a factor or factors hypothesized to influence the probability of occurrence of a given disease or other outcome. The main feature of cohort study is observation of large numbers over a long period (commonly years) with comparison of incidence rates in groups that differ in exposure levels.*
IIIa	Evidence obtained from systematic review of case control studies
IIIb	Evidence obtained from a case control study
	Case-control study(ies): *The observational epidemiologic study of persons with the disease (or other outcome variable) of interest and a suitable contro (comparison, reference) group of persons without the disease. The relationship of an attribute to the disease is examined by comparing the diseased and non-diseased with regard to how frequently the attribute is present or, if quantitative, the levels of the attribute, in each of the groups.*
IV	Evidence obtained from case series
	Case-series: *A group or series of case reports involving patients who were given similar treatment. Reports of case series usually contain detailed information about the individual patients. This includes demographic information (for example, age, gender, ethnic origin) and information on diagnosis, treatment, response to treatment, and follow-up after treatment.*
V	Evidence obtained from expert opinion without explicit critical appraisal

CATEGORY III CRITERIA

- Procedure/service is currently or recently performed in humans; **AND**

At least one of the following additional criteria has been met:

- Supported by at least one CPT/HCPAC advisor representing practitioners who would use this procedure or service supports; **OR**
- Actual or potential clinical efficacy is supported by peer reviewed literature available in English; **OR**
- There is a) at least one Institutional Review Board approved protocol of a study being performed, b) a description of a current and ongoing United States trial outlining the efficacy, or c) other evidence of evolving clinical utilization.

DEVELOPING A NEW CODE

- Information for code
  - Guidelines (if applicable)
  - Code Descriptor
  - Parenthetical notes (if applicable)
  - Typical patient vignette
  - Description of work
  - Use data (prevalence of disease, frequency of use, % will replace another procedure)
  - Global period (0, 10, 90, XXX, ZZZ)

CPT CONVENTIONS

Code Descriptor Formatting Instructions

When entering code information on this application, please use the formatting shown below. When **ADDING** codes, this will require specifying the recommended terminology (code descriptor) for the proposed CPT code and the placement of the proposed code in the current text of CPT (list section, subsection as illustrated below). When requesting a code **REVISION** you should use strike-pouts for deletions and underlining for additions/revisions (example: 33420 Valvotomy, mitral valve (~~commissurotomy);~~ closed heart). You may copy and paste the following symbols as appropriate:

●	This symbol precedes a **new** code (example: ● 1234X)
▲	This symbol precedes a **revised** code (example: ▲12345)
✚	This symbol indicates an **add-on code** to be reported with another code (example: ✚12345)
⃠	This symbol indicates codes that are **exemptions to modifier 51**, but have not been designated as CPT add-on procedures or services (example: ⃠12345)
⚡	This symbol indicates codes that are **product pending FDA approval** (example: ⚡12345)
#	This symbol indicates codes that are **out-of-numerical sequence** (example: #12345)
★	This symbol indicates codes that are **telemedicine** (example: ★12345)

Example:

Surgery
Digestive System
Stomach
Incision

D12345 ~~Old procedure~~

(Code 12345 has been deleted. To report, see 1234X1-1234X2)

⊙●1234X1 New procedure first

✚⊙●1234X2 each additional (list separately in addition to primary procedure)

(Report code 1234X2 in conjunction with code 1234X1)

CPT CONVENTIONS (ZZZ GLOBAL)

- Add-on codes Place the following phrase at the end of the add-on code descriptor (List separately in addition to code for primary procedure)”;
  - Add a parenthetical instruction for the code/list of codes with which this/these add-on code/codes can ONLY be reported [(Use [new code 1X1X0] in conjunction with [1X1X1, 1X1X2, 1X1X1])]

TYPICAL PATIENT EXAMPLE

- 19281 - Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

  A 70-year-old female has recently had invasive ductal carcinoma in the upper outer quadrant of the right breast diagnosed using stereotactic core biopsy and is a candidate for breast conservation surgery. Trailing microcalcifications are seen in two directions from the original biopsy site. A dual-wire/needle localization is performed under mammographic guidance to bracket the lesion for surgical planning.

EXAMPLES OF INTRAOPERATIVE IMAGING CODES

- **19281** Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, **including mammographic guidance (000 Global)**
- **+19282** each additional lesion, **including mammographic guidance** (List separately in addition to code for primary procedure) **(ZZZ Global)**

  (Use 19282 in conjunction with 19281)
- **19285** Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds),percutaneous; first lesion, **including ultrasound guidance (000 Global)**
- **19287** Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, **including magnetic resonance guidance (000 Global)**
- **+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) **(ZZZ Global)**

  (Use 38900 in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38531, 38542, 38562, 38564, 38570, 38571, 38572, 38740, 38745, 38760, 38765, 38770, 38780, 56630, 56631, 56632, 56633, 56634, 56637, 56640)
- **76998** Ultrasonic guidance, intraoperative **(XXX Global)**

CPT INSTRUCTIONS / APPLICATIONS

- General Information – CPT

  https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology

- CPT Applications:

  https://www.ama-assn.org/practice-management/applying-cpt-codes

Jump to:
CPT Code Criteria

CPT Code Criteria

Code Change Application Submission

Frequently Asked Questions

Submit an Online PLA Application

Code Change Application Submission

Paper applications will continue to be required for the February 2019 Panel meeting for all code change requests except PLA requests. Download the appropriate paper form below and submit the completed form to ccpsubmit@ama-assn.org. Deadline for application submission is Nov. 7, 2018.

DOWNLOADS

Category I & Category III CPT® Code(s) Application DOCX, 174.76 KB

Category I "Short Form" Codes Application DOCX, 109.15 KB

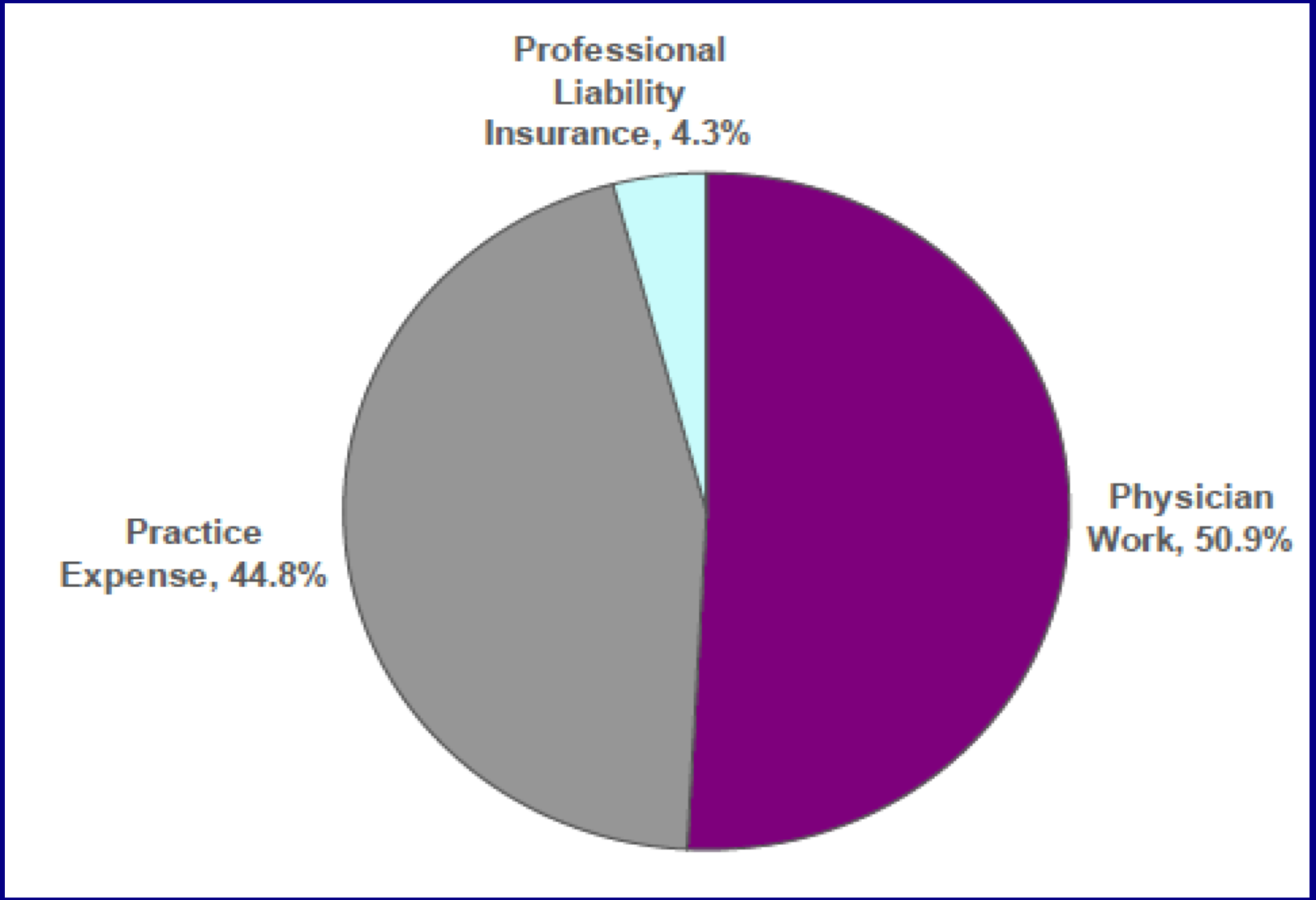
Molecular Pathology Multianalyte Assays with Algorithmic Analyses-Genomic Sequencing Procedures Codes Application DOCX, 118.25 KB

Pathology and Laboratory Application DOCX, 138.83 KB

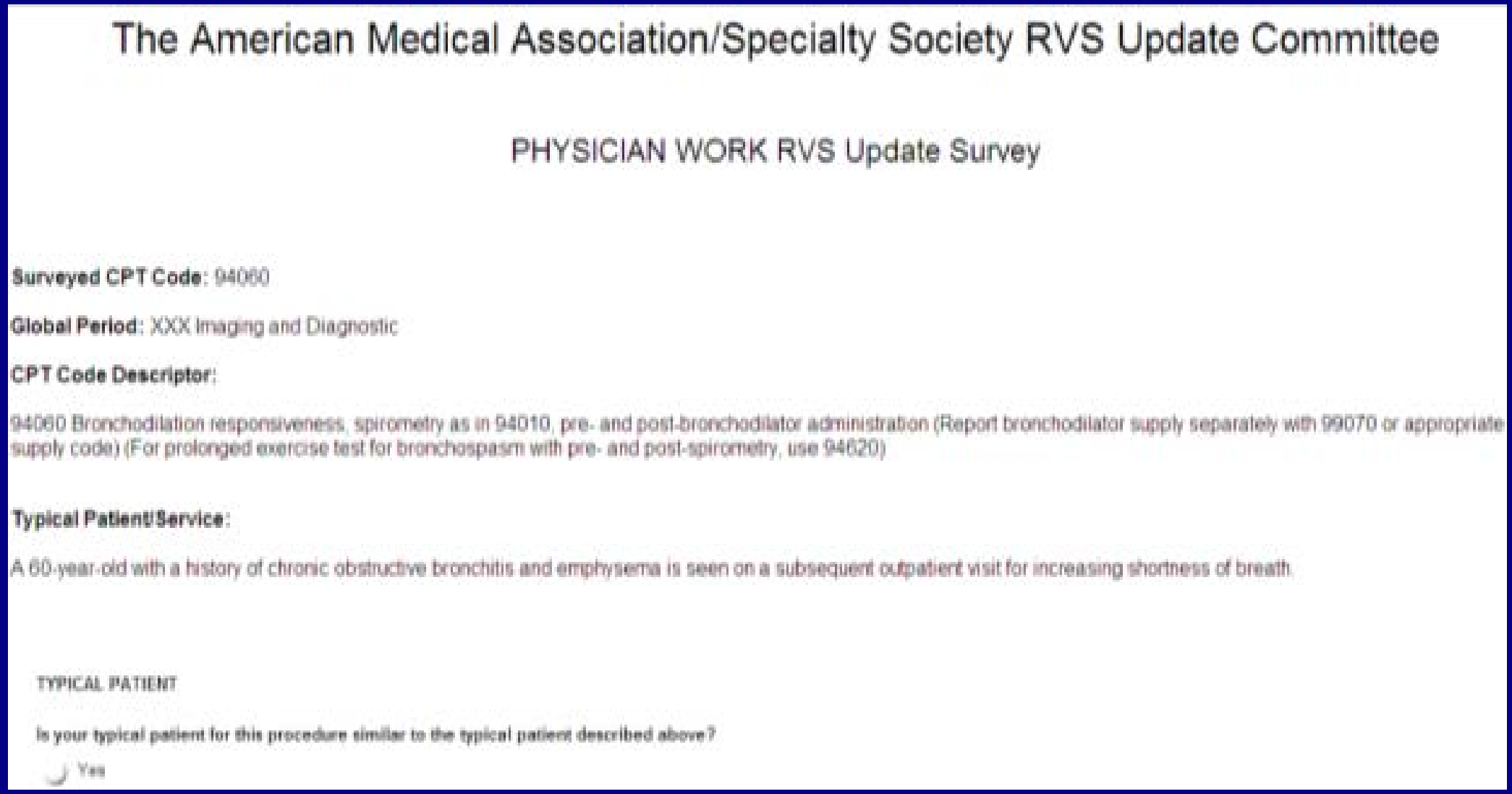
IF CPT APPLICATION IS APPROVED

NEXT STEP IS TO COMPLETE THE RUC SURVEY FOR THE CODE(S)

WHY ARE THE SURVEYS IMPORTANT?



COMPLETING THE SURVEY - TYPICAL PATIENT



The American Medical Association/Specialty Society RVS Update Committee

PHYSICIAN WORK RVS Update Survey

Surveyed CPT Code: 94060

Global Period: XXX Imaging and Diagnostic

CPT Code Descriptor:

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

Typical Patient/Service:

A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

TYPICAL PATIENT

Is your typical patient for this procedure similar to the typical patient described above?

Yes

COMPLETING THE SURVEY - REFERENCE SERVICE LIST

Typical Patient/Service:

A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

Select reference code

94060 Selected Reference Service

Reference Service List for Bronchodilator Spirometry 94060

Code	Descriptor	2011 RVW	Global
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	0.17	XXX
99406	Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes	0.24	XXX
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	0.26	XXX
G0424	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day	0.28	XXX
94375	Respiratory flow volume loop	0.31	XXX
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.48	XXX
94620	Pulmonary stress testing, simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre and post spirometry and oximetry)	0.64	XXX
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management	0.76	XXX
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	0.90	XXX
	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key		

WHAT IS PHYSICIAN WORK

“Physician work” includes the following elements:

- Physician time it takes to perform the service
- Physician mental effort and judgment
- Physician technical skill and physical effort, and
- Physician psychological stress that occurs when an adverse outcome has serious consequences

TIME-

How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure

90 Day Global

a) Day preceding procedure **Survey Code**

Pre-service evaluation time: _____ minutes

b) Day of procedure

Pre-service evaluation: _____ minutes
Pre-service positioning time: _____ minutes
Pre-service scrub, dress, wait time: _____ minutes
Intra-service time: _____ minutes
Immediate post-service time* _____ minutes

c) Post-Operative Work – Please respond to the following questions based on your *typical* experience for each survey code. *Typical* for purpose of this survey means more than 50% of the time.

ZZZ Global

Day of procedure **Survey code**
Intra-service time: _____ minutes

INTENSITY AND COMPLEXITY

Compare INTENSITY COMPONENTS of the survey code(s) relative to the corresponding reference code(s) you selected

Mental effort and judgment

	Survey Code 94060  **Relative to** **Selected Reference Code [94660]** 
• The range of possible diagnoses and/or management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed • Urgency of medical decision making	❑Much Less ❑Somewhat Less ❑Identical ❑Somewhat More ❑Much More

HOW MANY RVUS DO YOU THINK IT'S WORTH?

VERY IMPORTANT

Based on your review of all previous questions, please provide your estimate work RVU (to the 2nd decimal place) for the survey code:

For example, if the survey code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the survey code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the survey service "relative" to the work RVU of comparable and established reference services. Please keep in mind the range of work RVUs in the reference service list when providing your estimate.

PRACTICE EXPENSE

Indirect (overhead: admin, office, all other) vs. direct PE pools

Direct inputs (clinical staff time, disposable supplies, equipment):

- Must be allocable to a single CPT code for a single patient; otherwise indirect
- 3 categories only -clinical labor, disposable supplies, equipment (>$500)

Clinical Labor Inputs

1	hcpcs	source	labor_code	description	rate_per_m	nf_pre_svc	nf_svc	nf_post_svc	f_pre_svc	f_svc	f_post_svc	global_	reference_cc
7048	94015	Feb05	L047C	RN/Respiratory Therapis	0.47	0	35	0				XXX	f
7049	94060	Feb01	L047C	RN/Respiratory Therapis	0.47	5	51	5				XXX	
7050	94070	Mar04 G	L047C	RN/Respiratory Therapis	0.47	0	45	0				XXX	3
7051	94150		L037D	RN/LPN/MTA	0.37	0	26	0				XXX	
7052	94200	CMS	L047C	RN/Respiratory Therapis	0.47	0	26	0				XXX	94200
7053	94250	CMS	L047C	RN/Respiratory Therapis	0.47	0	31	0				XXX	94250

QUESTIONS