AMA/Specialty Society RVS Update Committee
Pointe Hilton Squaw Peak Resort
January 15-18, 2020

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Friday, January 17, 2020 at 8:00 a.m. The following RUC Members were in attendance:

Peter K. Smith, MD
Jennifer Aloff, MD
Allan Anderson, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Jimmy Clark, MD
Scott Collins, MD
Gregory DeMeo, MD
Verdi J. DiSesa, MD
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
David F. Hitzeman, DO
Omar S. Hussain, DO
Thomas Kintanar, MD*
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
Scott Manaker, MD, PhD
Bradley Marple, MD
Daniel McQuillen, MD
Dee Adams Nikjeh, PhD
Jordan Pritzker, MD
John H. Proctor, MD, MBA
Marc Raphaelson, MD
Christopher K. Senkowski, MD, FACS
Ezequiel Silva III, MD
Norman Smith, MD
Stanley W. Stead, MD, MBA
G. Edward Vates, MD
James C. Waldorf, MD

Gregory L. Barkley, MD*
Eileen Brewer, MD*
Audrey Chun, MD*
Joseph Cleveland, MD*
William D. Donovan, MD, MPH*
William F. Gee, MD*
Gregory Harris, MD*
John Heiner, MD*
Peter Hollmann, MD*
Gwenn V. Jackson, MD*
John Lanza, MD*
Mollie MacCormack, MD*
Scott D. Oates, MD*
Joseph Schlecht, DO*
M. Eugene Sherman, MD*
James Shoemaker Jr, MD*
Clarice Sinn, DO*
Donna Sweet, MD*
Timothy H. Tillo, DPM*
David Wilkinson, MD, PhD*

*Alternate

II. Chair's Report

- Doctor Peter Smith welcomed everyone to the RUC Meeting.

- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and deferred introducing the CMS representatives to Doctor Hambrick during her report.

- Doctor Smith welcomed the following Contractor Medical Directors:
  - Janet Lawrence, MD
  - Richard W. Whitten, MD, MBA

- Doctor Smith welcomed the following Member of the CPT Editorial Panel:
  - Jordan Pritzker, MD – CPT Editorial Panel RUC Member

- Doctor Smith welcomed the following representatives from the Ontario Medical Association:
  - Michael Adamson, MA - Senior Director of Tariff - Economics, Policy and Research
  - Joanna Nadolski, MA, MHSc - Manager, Economics
  - Jennifer Wilock, MHSc - Manager, Tariff

- Doctor Smith congratulated the following new RUC Alternate Member for this meeting:
  - Thomas Kintanar, MD – American Academy of Family Physicians

  Please note after January 2020, Doctor Kintanar will serve as Advisory Committee Alternate member for the American Academy of Family Physicians.

- Doctor Smith wished a fond farewell to the following departing RUC Members:
  - Jennifer Aloff, MD – Primary Care Rotating Seat
  - Allan Anderson, MD – American Psychiatric Association
  - Daniel McQuillen, MD – Infectious Diseases Society of America

  Please note after January 2020, Doctor Aloff will continue to participate in the RUC as the RUC Alternate member for the American Academy of Family Physicians and Doctor McQuillen will serve as the RUC Advisor for IDSA.

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with ≥1 million Medicare claims = 75 respondents
  - Codes with Medicare claims between 100,000-999,999 = 50 respondents
  - Codes with <100,000 Medicare claims = 30 respondents
  - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith conveyed the following guidelines related to Confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting).
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
  - To protect privacy of individuals, do not photograph, audio or video record without advanced permission.

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  - Full confidentiality agreement found on Collaboration site (Structure and Functions) and the RUC App.

- Doctor Smith conveyed the Lobbying Policy:
  - "Lobbying" means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
  - Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
  - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
  - Full lobbying policy found on Collaboration site (Structure and Functions) and the RUC App.

- Doctor Smith informed attendees about the AMA meeting code of conduct policy:
  - Updated in early 2019, the policy for members and guests at AMA-sponsored events is included in registration materials, onsite, and on the RUC App.
  - Contact Dan Lantry, AMA Associate General Counsel, onsite if necessary.

- Doctor Smith conveyed the following procedural rules for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
  - RUC members or alternates sitting at the table may not present or debate for their society.
  - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
  - RUC members should address the Chair directly throughout the meeting.

- Doctor Smith shared the following procedural guidelines to the Facilitation Committee process:
  - Ideal Composition:
    - Knowledgeable regarding the issues at hand
      - Primary and Secondary Reviewers
      - Alternates who serve in the seat during presentation
    - Representative of the RUC as a whole
    - Without conflict of interest
  - RUC alternate members may participate in substitution of a RUC member during facilitations but should not serve in addition to the RUC member.
  - RUC members should attend facilitations for tabs in which he/she is the primary reviewer and serve as a vice-chair of that facilitation.
  - RUC members or alternates should not serve on facilitation for an issue in which their specialty society has a primary interest (surveyed). If assigned to that facilitation, speak with RUC staff.

- Doctor Smith conveyed the following procedural guidelines related to RUC Ballots:
  - If a tab fails, all RUC Members/Alternates must complete a ballot to aid the facilitation committee.
  - Alternates should identify themselves on the ballots and may be asked to serve on the facilitation committee.
  - Ballot results will be de-identified before release to the facilitation committee to maintain confidentiality.

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- The RUC will suspend deliberation to allow sufficient time to ensure that all 28 ballots are completed. The function of the facilitation committee will be enhanced greatly by the small amount of time and work as each member carefully considers their estimation of appropriate work value(s).

- Doctor Smith laid out the following procedural guidelines related to specialty society staff/consultants:
  - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification.

- Doctor Smith conveyed the following procedural guidelines related to commenting specialty societies:
  - In October 2013, the RUC determined which members may be "conflicted" to speak to an issue before the RUC:
    1. a specialty surveyed (LOI=1) or
    2. a specialty submitted written comments (LOI=2).

    RUC members from these specialties are not assigned to review those tabs.

  - The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.

- Doctor Smith relayed the following procedural guideline related to presentations:
  - If RUC Advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC Chair.

- Doctor Smith shared the following procedural guidelines related to voting:
  - Work RVUs require a 2/3 vote. Motions require a majority vote.
  - RUC votes are published annually on the AMA website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.
  - If members are going to abstain from voting because of a conflict or otherwise, please notify AMA staff so we may account for all 28 votes.
  - Please share voting remote with your alternate if you step away from the table to ensure 28 votes.

- Doctor Smith announced that all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.

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III. Director's Report

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA, provided the following points of information:

- Ms. Smith announced the *new* RUC Collaboration site that includes all the meeting materials, handouts, and the updated RUC database. Staff is available to assist with accessing the site if needed. Please note, RUC materials are typically posted to this site not emailed out.

IV. Approval of Minutes from October 2019 RUC Meeting

The RUC approved the October 2019 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update (Informational)

Doctor Jordan Pritzker provided the CPT Editorial Panel update. The CPT Panel last met in September 2019, prior to the RUC's October 2019 meeting. There are 16 tabs being addressed at this RUC meeting from the September CPT meeting.

- **February 2020** – The next Panel meeting is February 7-8, 2020 in San Francisco at the Hyatt Regency. This meeting starts the next cycle for the 2022 Code Set.
- The Panel's Annual Meeting is on Thursday, February 6, with six presentations on the schedule as listed in the agenda on the CPT Collaboration website. There are 37 code change applications (CCAs) on the February CPT Editorial Panel meeting agenda. Doctor Dee Nikjeh is the RUC member attending the CPT Editorial Panel meeting as the RUC representative. This is the first Panel meeting that code change applicants did not have the choice to submit a paper application. All applicants were required to submit the SmartApp electronic code change application.
- There is one RUC-referred issue on the February agenda, Tab 9 (Ultrasound Study Follow Up-Delete 76970) which is a request to delete the ultrasound study follow up code 76970. In October 2018, the Relativity Assessment Workgroup (RAW) discussed future screens and recommended lowering the threshold and examined the list of CMS/Other source codes with Medicare utilization over 20,000. In April 2019, the RAW lowered the threshold of CMS/Other source codes to 20,000. Code 76970 was identified in this screen, and the RUC recommended referral to the CPT Editorial Panel for deletion.
- Other issues being reviewed at the February Panel meeting include:
  - Tab 37 is a review of Appendix C clinical examples for Evaluation and Management (E/M) Office or Other Outpatient Services codes 99202-99215 to determine if modifications are needed due to the revisions made to codes 99202-99215 for the CPT 2021 code set.
  - Tab 38 is Code Set Maintenance review of 85 codes with low utilization for possible deletion at the May 2020 Panel meeting.
  - Tab 39 – (CPT Literature Standards-Outside US Data) - is a request to review the Category I literature requirement that necessitates submitting a US patient.
- The next CCA submission deadline is February 12, 2020 for the May 2020 Panel meeting, which will be held in Chicago, IL.

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

Doctor Edith Hambrick, MD, JD, MPH, CMS Medical Officer, provided the report of the Centers for Medicare & Medicaid Services (CMS):

- Doctor Hambrick introduced staff from CMS attending this meeting:
  - Christiane LaBonte, MS - Health Insurance Specialist
  - Karen Nakano, MD - Medical Officer
  - Michael Soracoe, PhD - Analyst
  - Gift Tee, MPH - Director, Division of Practitioner Services
  - Pamela Villanyi, MD – Medical Officer

- CMS is working on the NPRM for the Medicare Physicians' Payment Schedule for CY2021. Please make an appointment to discuss any issues regarding codes or policy proposals as soon as possible.

VII. Contractor Medical Director Update (Informational)

Doctor Richard W. Whitten and Doctor Janet Lawrence, Medicare Administrative Contractor (MAC) Medical Directors, provided the Contractor Medical Director (CMD) update:

- Upcoming MAC Re-Procurements: Jurisdiction E – Posted with targeted award date in Fall 2020 (States of California, Hawaii, Nevada, American Samoa, Guam, & Northern Mariana Islands)
- MACs are developing new workgroups in the interest of having more consistency across regions. The latest addition is an Interventional Pain Management Workgroup. Also, the Self-Administered Drug Workgroup is back and active so look for more information/updates.
- Look at the CMS website for changes in CMDs.

VIII. Washington Update (Informational)

Jennifer McLaughlin, JD, Assistant Director of Federal Affairs, AMA, provided the Washington Report:

- CY 2020 Physician Payment Schedule/Quality Payment Program Proposed Rule

  - The CY 2020 Medicare Physician Payment Schedule conversion factor is $36.09. CY 2019 conversion factor was $36.04.
  - Evaluation and Management (E/M)
    - Aligns E/M office visit coding changes with framework adopted by CPT Editorial Panel
    - Accepts RUC valuations for stand-alone office visits
    - Creates add-on code for E/M office visits for ongoing care related to complex chronic conditions
    - Does not apply the office visit increases to visits bundled into the global surgery packages
    - E/M changes not effective until January 2021
  - Care management services
    - Transitional care management – CMS changed documentation requirements and payment as recommended by the RUC to increase utilization
    - Chronic care management – Created one add-on code for additional time spent in certain cases and recognized ongoing CPT work in this area

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        - Principal care management – Created two codes to reimburse for providing care management to patients with one serious, high-risk condition
    - Opioid treatment services
        - Office-based monthly bundled payments for the treatment of opioid use disorder
        - Opioid Treatment Programs

- CMS' Patients Over Paperwork Initiative

    - For every hour of face-to-face time with patients, physicians spend nearly two additional hours on administrative tasks throughout the day
    - CMS continues to prioritize reducing provider burdens by eliminating unnecessary regulations in the healthcare system
    - Administrator Verma plans to open a new office dedicated to burden reduction and is particularly interested in addressing rural health issues and tackling prior authorization
    - AMA continues to work with the Federation to recommend opportunities to reduce burdens in Medicare program, including reduce quality reporting requirements and rescinding the 2-Midnight Rule

- HHS' Regulatory Sprint to Coordinated Care #RS2CC

    - AMA commented on Stark and Anti-kickback *proposed rules* that would modernize fraud and abuse laws and reduce barriers to value-based payment arrangements
    - AMA emphasized changes should allow physicians to receive payment for the value of care provided and promote competition and choice by allowing physicians the same opportunities hospitals have in delivering care
    - Timeline for final rules is TBD. We will keep you updated.

- Quality Payment Program (QPP): Trends and What's Ahead

    - 98% of eligible clinicians successfully participated in the Merit Based Incentive Payments System (MIPS) in 2018.
    - They will receive either a positive or neutral payment adjustment in 2020 as a result of their 2018 MIPS results.
    - The payment adjustments are largely budget neutral. Because nearly all physicians – 98% avoided a MIPS penalty, the bonuses were small in 2020.
    - The exception to budget neutrality is the exceptional payment adjustment, which is divided up among all the clinicians who score above a certain benchmark. In 2018, it was set at 70 points. Those clinicians get a bonus from a $500 million/year pool.
    - Key data points from the first two years of MIPS and APMs shows most physicians were able to successfully participate and earn a bonus.
    - What's driving the improvement from 2017 to 2018? There were several factors; two are highlighted below:
        - First, in response to strong advocacy from the AMA and the Federation, CMS significantly increased the exclusion criteria for small practices or those that don't have a large book of Medicare business starting with the 2018 performance year. The 2018 QPP final rule exempted physician practices with less than $90,000 in Medicare revenue (up from $30k in the 2017 QPP rule) or fewer than 200 unique Medicare patients per year (up from 100 in the 2017 QPP rule). Smaller practices (or those with fewer Medicare beneficiaries) are less likely to participate in MIPS due to the compliance costs. Therefore, pulling small practices out of the denominator will improve the participation percentage.

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        - Second, 2018 was a second transition year. The performance requirements continued to gradually ramp up. For instance, cost measures only counted toward 10% the MIPS final score in 2018.

    - Alternative Payment Models (APMs) – Claim your 5% incentive payment
        - CMS is trying to verify banking information for about 3,000 physicians who are eligible to receive an APM incentive payment
        - Even physicians who are no longer with the practice that participates in an APM may be entitled to payments based on their 2017 participation
        - Go to qpp.cms.gov/about/resource-library for the list of physicians and instructions for providing contact and banking information to CMS to claim these payments. Deadline is February 28, 2020.
    - Looking Ahead: APMs
        - CMS estimates that 210,000 to 270,000 clinicians will be eligible APM Participants in 2020 and exempt from MIPS reporting requirements. It also estimates that APM incentive payments will total between $535 million and $685 million.
        - Primary Care First and Kidney Care First models are accepting applications until January 22, 2020.
        - AMA partnered with AAFP and ACP to host CMMI staff in a 60-minute webinar and Q&A on January 6 to help physicians decide if PCF is right for them.

    - Key Merit Based Incentive Payments System (MIPS) policies:
        - Maintain low volume threshold, bonuses for small practices
        - Eliminate 21% of existing quality measures and remove measures that do not meet benchmarking criteria for two consecutive years
        - Keep cost category at 15% of final score and add 10 episode-based cost measures
        - CMS continues to increase the threshold for participating in MIPS.
    - MIPS Value Pathways (MVPs)
        - New MIPS participation framework that would focus on episodes of care
        - One area that is ripe for improvement: more timely data (e.g., comparative analytics from Medicare claims data) from CMS
        - AMA continues to have concerns, such as including administrative claims measures
        - Next steps include working with interested specialties to develop and submit MVPs
        - MVPs would start in 2021 at the earliest

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Improvements

    - Continuing focus on improvement to these programs both through the regulatory process and legislation
    - Having conversations with Congress and CMS on several priorities, including:
        - Replacing zero percent updates in 2020-2025 with positive updates
        - Extending Advanced APM bonuses for an additional time period
        - Making technical fixes to current program, including: allowing multi-category credit in MIPS to reduce reporting burden; giving CMS authority to score small practices against small practices to level playing field; and removing flawed total cost measure.
    - Positive Medicare Physician Payment Schedule updates
        - Congressional action is needed to address a six-year freeze in Medicare PPS service updates from 2020-2025 under MACRA.
        - Potential window for action: Appropriations bill passed at end of 2019 included extenders through May 22, 2020.

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- AMA has had several meetings with Congress to discuss increasing the Medicare conversion factor update and providing Members of Congress with the information that physicians need a margin to continue to transition to value-based care and ensure access to care.
- Physician pay has not kept up with other health care payment updates or with inflation, increasing just 7 percent from 2001 to 2019. In comparison, the cost of running a medical practice increased 34 percent between 2001 and 2019, or 1.6 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, as measured by the Medicare Economic Index. Economy-wide inflation, as measured the Consumer Price Index, increased 45 percent over this time period.
- As a result, Medicare physician pay doesn't go nearly as far as it used to. Adjusted for inflation in practice costs, Medicare physician pay declined 20 percent from 2001 to 2019, or by 1.3 percent per year on average.

- Physician-Focused Payment Models
  - Many of the stakeholder organizations and physician leaders who had submitted physician-focused payment models to PTAC, who then recommended those models, have grown frustrated because HHS has not implemented any of them (out of more than 16 recommended for implementation or testing). Several PTAC members, including Len Nichols and Harold Miller, resigned out of the same frustrations.
  - AMA leadership is interested in getting some improvements to the process so it works better and so models are more likely to get implemented. The AMA has begun talking to the PTAC members who resigned and specialty societies who have submitted a physician-focused payment model to PTAC and been following the process closely. Although nothing is set in stone, we've discussed a few ideas, such as allowing PTAC to obtain input from the Centers for Medicare & Medicaid Innovation (CMMI) and the CMS actuary as its critical to know whether a proposal is likely to reduce Medicare spending and allowing PTAC to provide technical assistance to stakeholders who are submitting models earlier in the process.

Ms. McLaughlin answered questions following her presentation. A RUC member asked about the QPP positive results and, as it relates to practice expense, whether the AMA has looked at the cost per practice to get to the 1.68% increase. Also, regarding projections for APM providers, has the AMA looked at how many of those providers are in Medicare Advantage and moving out of traditional Medicare practice. Ms. McLaughlin responded with further information on our future projections for APMs and fee for service.

IX. Relative Value Recommendations for *CPT 2021*

Tissue Expander, Other Than Breast (Tab 4)
Jeff Kozlow, MD (ASPS)

In February 2019, the CPT Editorial Panel approved the deletion of two codes and revisions to seventeen codes to provide descriptor clarification of any overlap in physician work for breast reconstruction services. In the CPT coding changes application, the specialty stated that this change is editorial and does not involve a change in work. At the April 2019 RUC meeting, the RUC agreed that the seventeen breast reconstruction services should be surveyed for the October 2019 RUC meeting. Codes 11960, 19316, 19350, 19355, and 19396 were also included as being part of the same code family. Based on the change in the typical patient for CPT code 11971 and multiple Harvard valued codes, the RUC agreed that all twenty-two of these services be surveyed, contrary to the specialty initial recommendation that these

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changes are editorial only and do not require surveying. At that time, the RUC had recommended surveying all twenty-two codes for the October 2019 RUC meeting.

At the October 2019 RUC meeting, the specialty elected to survey two of the codes and send a third code to CPT for revision. The specialty noted that the designation of a single 22 code family was too expansive, and that the family categorization should be more granular than surgical procedures for the repair and/or reconstruction of the same anatomic region. The specialties proposed 8 families of services to the RUC noting that this categorization assigns similar procedures together and ensures that the survey process is effective. The RUC concurred with the more granular classification of families that group analogous procedures together. Furthermore, the specialty indicated, and the RUC agreed, that three of the code families, autologous reconstruction, nipple procedures and moulage formation were not identified by any RAW screens, had no change to their work from CPT revisions and had no obvious flaws to their valuation (i.e., a site of service valuation issue), and therefore would not need to be reviewed at this time. The RUC agreed that, although the specialty societies had conducted surveys of code 11970 and 11971 for October 2019, these services should be resurveyed with their newly identified respective code families. The *Tissue Expander, Other Than Breast* code family was one of the code families identified by the RUC for review for the January 2020 RUC meeting.

Compelling Evidence
The RUC reviewed and accepted compelling evidence that the original valuation of CPT code 11960 was based on flawed methodology when it was reviewed in 1995 which resulted in the service having a negative IWPUT. The value of the service did not appropriately take into context the times assigned to the service in 1995. In addition, the RUC reviewed and accepted compelling evidence based on a change in patient population. The specialty society noted that much of the orthopedic surgery and hand surgery utilization for this service is potentially miscoding and the most common diagnoses in the claims data is now neuropathy. The specialty believed that this was due to miscoding for a carpal tunnel procedure using a balloon that is completely different than the intended placement of a tissue expander with post-operative expansion for recruitment of soft tissue. A code change application was presented at the September 2019 CPT Editorial Panel meeting to add parentheticals directing appropriate usage and to prevent the usage of the code for a carpal tunnel procedure, which was supported both by hand surgery and orthopedic surgery. The same parenthetical also limited the coding of 11960 *Insertion of tissue expander(s) for other than breast, including subsequent expansion* with 11971 *Removal of tissue expander(s) without insertion of prosthesis* since placement of a new expander would inherently include the work of removal of a prior expander if present.

11960 *Insertion of tissue expander(s) for other than breast, including subsequent expansion*
The RUC reviewed the survey results from 31 plastic surgeons and recommends: 33 minutes of pre-service evaluation time, 3 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 90 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 7 99213 post-operative office visit and 2 99212 post-operative office visits. The first post-operative visit is to change dressings, remove the drain, evaluate the patient and review pain control. Visits two through eight of the post-operative visits are related to the incremental filling of the tissue expander typically starting at 3-4 weeks post-operative and occurring on a weekly basis. The specialty noted and the RUC agreed that the typical patient for this service (a scalp expansion) takes a particularly long time to expand as the skin is relatively inelastic. The specialty noted that the 7 visits for expansion are procedural visits which involve taking vital signs, talking about pain control, evaluating the soft tissues for further suitability for expansion. The procedure needs to be a sterile procedure, involving prepping, draping, scrub/dress/wait time for each of the 7 post-operative procedural visits which supports these visits being approximately the same amount of work as 99213 office visits.

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The RUC reviewed the survey 25th percentile work RVU of 12.40 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 12.40, the RUC compared the survey code to CPT code 28046 *Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm* (work RVU= 12.38, intra-service time of 90 minutes, total time of 334 minutes) and noted that both services have an identical amount of intra-service time and the survey code involves somewhat more total time. The RUC also compared the survey code to CPT code 25575 *Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna* (work RVU= 12.29, intra-service time of 90 minutes, total time of 342 minutes) and noted that both services have an identical amount of intra-service time and the survey code involves somewhat more total time. **The RUC recommends a work RVU of 12.40 for CPT code 11960.**

Practice Expense
The Practice Expense Subcommittee changed the exam table to a power table, which is typical for this specialty. The Subcommittee also removed a redundant suture removal kit. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Breast Implant/Expander Placement (Tab 5)
Jeff Kozlow, MD (ASPS)
Facilitation: Facilitation Committee #1

In February 2019, the CPT Editorial Panel approved the deletion of two codes and revisions to seventeen codes to provide descriptor clarification of any overlap in physician work for breast reconstruction services. In the CPT coding changes application, the specialty stated that this change is editorial and does not involve a change in work. At the April 2019 RUC meeting, the RUC agreed that the seventeen breast reconstruction services should be surveyed for the October 2019 RUC meeting. Codes 11960, 19316, 19350, 19355, and 19396 were also included as being part of the same code family. Based on the change in the typical patient for CPT code 11971 and multiple Harvard valued codes, the RUC agreed that all twenty-two of these services be surveyed, contrary to the specialty initial recommendation that these changes are editorial only and do not require surveying. At that time, the RUC had recommended surveying all twenty-two codes for the October 2019 RUC meeting.

At the October 2019 RUC meeting, the specialty elected to survey two of the codes and send a third code to CPT for revision. The specialty noted that the designation of a single 22 code family was too broad, and that the family categorization should be more granular than surgical procedures for the repair and/or reconstruction of the same anatomic region. The specialties proposed 8 families of services to the RUC noting that this categorization assign similar procedures together and ensures that the survey process is effective. The RUC concurred with the more granular classification of families that group analogous procedures together. Furthermore, the specialty indicated, and the RUC agreed, that three of the code families, autologous reconstruction, nipple procedures and moulage formation were not identified by any RAW screens, had no change to their work from CPT revisions and had no obvious flaws to their valuation (i.e., a site of service valuation issue), and therefore would not need to be reviewed at this time. The RUC agreed that, although the specialty societies had conducted surveys of code 11970 and 11971 for October 2019, these services should be resurveyed with their newly identified respective code families. In October 2019, the RUC reviewed these family of services with the specialty societies and agreed that these services would be surveyed for physician work and practice expense in January 2020. The *Breast Implant/Expander Placement* code family was one of the code families identified by the RUC for review for the January 2020 RUC meeting.

In addition, codes 19340 and 19357 were identified via the Site of Service Anomaly screen. Services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. Code 19357

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was also identified via the 090-Day Global Codes with >6 office visits based on 2018 estimated Medicare utilization > 1,000 screen.

11970 ***Replacement of tissue expander with permanent implant***
The RUC reviewed the survey results from 43 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 12 minutes for pre-service scrub/dress/wait, 60 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 1 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT 0.041 for the current times is inappropriately low for this relatively intense major surgical procedure, which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times.

The RUC reviewed the survey 25th percentile work RVU of 10.26 and agreed that this value overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC compared the survey code to CPT code 26262 *Radical resection of tumor, distal phalanx of finger* (work RVU= 8.29, intra-service time of 60 minutes, total time of 212 minutes) and noted that both services involve identical intra-service times and similar total times and the survey code was slightly less intense. The RUC also compared the survey code to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU of 9.77, intra-service time of 60 minutes, total time of 207 minutes) and noted that both services have identical intra-service times and similar total times, however the reference code is a more intense service to perform. Following the review of these and other reference codes, the RUC agreed that it would be appropriate to maintain the current value of 8.01 for the survey code. **The RUC recommends a work RVU of 8.01 for CPT code 11970.**

19325 ***Breast augmentation with implant***
The RUC reviewed the survey results from 45 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 12 minutes for pre-service scrub/dress/wait, 60 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit and 4 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively. The RUC noted that the drop in intra-service time and total time does not necessarily warrant a change in value for the survey code. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT 0.052 for the current times is low for this relatively intense major surgical procedure, which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times.

The RUC reviewed the survey 25th percentile work RVU of 10.00 and agreed that this value overstates the amount of physician work involved. Therefore, the RUC compared the survey code to CPT code 37761 *Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg* (work RVU= 9.13, intra-service time of 60 minutes, total time of 224) and noted that both services have an identical amount of intra-service time and similar total time. The RUC also compared the survey code to MPC code 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU= 7.80, intra-service time of 60 minutes, total time of 233.5 minutes) and noted that although both services have identical intra-service time, the survey code is a more intense

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service to perform. Following the review of these and other reference codes, the RUC agreed that it would be appropriate to maintain the current value of 8.64 for the survey code. The RUC also noted that although 19325 has the same intra-service time as 11970, it also includes the additional work of creating a pocket versus 11970 where there already is an expander and the pocket has already been created prior to this procedure. CPT code 19325 also includes more total time and it is appropriate to value this as somewhat higher. **The RUC recommends a work RVU of 8.64 for CPT code 19325.**

19340 ***Insertion of breast implant on same day of mastectomy (ie, immediate)***
The RUC reviewed the survey results from 44 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 14 minutes for pre-service scrub/dress/wait, 80 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 2 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC reviewed the survey 25th percentile work RVU of 14.25 and agreed that this value overstates the amount of physician work involved. The RUC agreed that a direct crosswalk to CPT code 36831 *Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU= 11.00, intra-service time of 85 minutes, total time of 248, RUC reviewed in 2013) would be appropriate, noting that both services involve an identical amount of physician work and similar times and therefore should be valued the same. The RUC agreed with the specialty that the work for 19342 to 19340 are similar and should be valued the same. CPT code 19342 is a more intense service as it also involves the additional work to recreate the mastectomy defect; this is appropriately reflected in the higher IWPUT relative to 19340 (0.079 vs. 0.072). The RUC also reviewed reference codes 64910 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU= 10.52, intra-service time of 75 minutes, total time of 257 minutes) and code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU= 11.90, intra-service time of 75 minutes, total time of 233 minutes) and agreed that they appropriately bracketed the recommended times and value for survey code 19340. **The RUC recommends a work RVU of 11.00 for CPT code 19340.**

19342 ***Insertion or replacement of implant on separate day from mastectomy***
The RUC reviewed the survey results from 43 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 12 minutes for pre-service scrub/dress/wait, 80 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 1 99213 post-operative office visit and 3 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC reviewed the survey 25th percentile work RVU of 14.39 and agreed that this value overstates the amount of physician work involved. The RUC agreed that a direct crosswalk to CPT code 36831 *Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU= 11.00, intra-service time of 85 minutes, total time of 248, RUC reviewed in 2013) would be appropriate, noting that both services involve an identical amount of physician work and similar times and therefore should be valued the same. The RUC agreed with the specialty that the work for 19342 to 19340 are similar and should be valued the same. CPT code 19342 is a more intense service as it also involves the additional work to recreate the mastectomy defect; this is

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appropriately reflected in the higher IWPUT relative to 19340 (0.079 vs. 0.072). The RUC also reviewed reference codes 64910 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU= 10.52, intra-service time of 75 minutes, total time of 257 minutes) and code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU= 11.90, intra-service time of 75 minutes, total time of 233 minutes) and agreed that they appropriately bracket the recommended times and value for survey code 19340. **The RUC recommends a work RVU of 11.00 for CPT code 19342.**

19357 ***Tissue expander placement in breast reconstruction, including subsequent expansion(s)***
The RUC reviewed the survey results from 44 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 90 minutes for intra-service time, 23 minutes for immediate post-time, 0.5 99238 discharge visit, 5 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively. The first post-operative visit is to change dressings, remove the drain and evaluate the patient. Visits two through six of the post-operative visits are related to the incremental filling of the tissue expander typically starting at 3-4 weeks post-operative and occurring on a weekly basis. The seventh visit would typically occur one month following the completion of the expansion.

The RUC reviewed the survey 25th percentile work RVU of 17.95 and agreed that this value overstates the amount of physician work involved. The RUC agreed that a direct crosswalk to CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* (work RVU= 15.36, intra-service time of 90 minutes, total time of 353 minutes, last reviewed in 2011). The RUC noted that both services have identical intra-service times, similar total times and involve the same amount of physician work. The RUC also compared this code to MPC code 19303 *Mastectomy, simple, complete* (work RVU= 15.00, intra-service time of 90 minutes, total time of 283) and noted that both services involve identical intra-service time, though the survey code involves much more total time. The RUC also compared this code to non-breast tissue expander code 11960 reviewed at this meeting and noted that 19357 is more intense and complex to perform due to the additional more intense work of going beneath the muscle which is not required for the typical patient for 11960. **The RUC recommends a work RVU of 15.36 for CPT code 19357.**

Practice Expense
The Practice Expense Subcommittee made a revision to account for the reduction in discharge time to a half-day discharge. The Practice Expense Subcommittee changed the exam table to a power table for each code which is typical for this specialty. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

<u>Breast Implant/Expander Removal (Tab 6)</u>
Jeff Kozlow, MD (ASPS)

In February 2019, the CPT Editorial Panel approved the deletion of two codes and revisions to seventeen codes to provide descriptor clarification of any overlap in physician work for breast reconstruction services. In the CPT coding changes application, the specialty stated that this change is editorial and does not involve a change in work. At the April 2019 RUC meeting, the RUC agreed that the seventeen breast

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reconstruction services should be surveyed for the October 2019 RUC meeting. Codes 11960, 19316, 19350, 19355, and 19396 were also included as being part of the same code family. Based on the change in the typical patient for CPT code 11971 and multiple Harvard valued codes, the RUC agreed that all twenty-two of these services be surveyed, contrary to the specialty initial recommendation that these changes are editorial only and do not require surveying. At that time, the RUC had recommended surveying all twenty-two codes for the October 2019 RUC meeting.

At the October 2019 RUC meeting, the specialty elected to survey two of the codes and send a third code to CPT for revision. The specialty noted that the designation of a single 22 code family was too broad, and that the family categorization should be more granular than surgical procedures for the repair and/or reconstruction of the same anatomic region. The specialties proposed 8 families of services to the RUC noting that this categorization assign similar procedures together and ensures that the survey process is effective. The RUC concurred with the more granular classification of families that group analogous procedures together. Furthermore, the specialty indicated, and the RUC agreed, that three of the code families, autologous reconstruction, nipple procedures and moulage formation were not identified by any RAW screens, had no change to their work from CPT revisions and had no obvious flaws to their valuation (i.e., a site of service valuation issue), and therefore would not need to be reviewed at this time. The RUC agreed that, although the specialty societies had conducted surveys of code 11970 and 11971 for October 2019, these services should be resurveyed with their newly identified respective code families. In October 2019, the RUC reviewed these family of services with the specialty societies and agreed that these services should be surveyed for physician work and practice expense in January 2020. The *Breast Implant/Expander Removal* code family was one of the code families identified by the RUC for review for the January 2020 RUC meeting.

Compelling Evidence
The RUC reviewed and accepted compelling evidence that the original valuation of CPT code 11971 was based on flawed methodology when it was reviewed in 1995 which resulted in the service having a negative IWPUT. The value of the service was not changed to appropriately account for the times newly assigned to the service in 1995. This code was last reviewed with hundreds of other services during the first Five-Year Review prior to the creation of the IWPUT metric, so it may not have been as apparent at the time that the assigned value was lower than the sum of the post-operative visits that were bundled into the service.

The RUC also reviewed and accepted compelling evidence based on change in patient population for all three services in this family, 11971, 19328 and 19330 based on a change in patient population. The number of patients that are eligible for breast reconstruction has changed. Twenty or thirty years ago, the patient did not have a BMI under 30 and nor major comorbidities. Now, breast reconstruction is appropriately provided to a much broader patient population, including many more oncology patients, due to advancements in care and surgical technique over the past few decades. With the increased access to breast reconstruction, patients with more comorbidities require management of the infected or otherwise complicated breast implant. The change in patient expectations has significantly increased the work intensity of the procedure not only intra-operatively, but also in the pre- and post- periods due to the elevated complexity of discussions with the patient. In addition, the patient population for code 11971 changed since this service was reviewed in 1995 for this service from scalp expansion for a pediatric patient to a breast procedure for an adult.

Furthermore, the old descriptor for CPT code 19330 was inappropriately vague, “Removal of mammary implant material”, which the specialty noted some providers may have interpreted that under the old coding structure they may report separately for removal of ruptured contents (i.e., silicone gel).

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11971 ***Removal of tissue expander without insertion of implant***
The RUC reviewed the survey results from 56 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 10 minutes for pre-service scrub/dress/wait, 45 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 1 99213 post-operative office visit and 3 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively. The RUC noted that the existing times and values for 11971 created a negative IWPUT of -0.041, which strongly indicates either the current times are highly inflated relative to the current work RVU and not valid for comparison to the new times and value. In addition, the physician work for the modern typical patient for 11971, an adult female patient with a history of breast cancer who is having breast tissue expanders removed, is also greater than the removal of a scalp expander from a pediatric patient. Removing a breast tissue expander also involves the more intense work of going beneath the muscle, which is was not required for the historic typical patient.

The RUC reviewed the survey 25th percentile work RVU of 7.02 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 7.02, the RUC compared the survey code to MPC code 26615 *Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone* (work RVU= 7.07, intra-service time of 45 minutes, total time 217 minutes) and note that both services involve identical intra-service times and similar total times. The RUC also compared the survey code to CPT code 28645 *Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed* (work RVU= 7.44, intra-service time of 45 minutes, total time of 217 minutes) and noted that both services have identical intra-service time and very similar total times. **The RUC recommends a work RVU of 7.02 for CPT code 11971.**

19328 ***Removal of intact-breast implant***
The RUC reviewed the survey results from 56 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 10 minutes for pre-service scrub/dress/wait, 45 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 1 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively. Code 19328 is more intense intraoperatively relative to family code 11971 since it is typically a more chronic infection that requires additional work in removing the chronic inflammatory tissue as well as additional effort is required to score what is now a well formed scar capsule in order to promote healing. Therefore, the intraoperative work is greater and more intense. This is supported by the survey data where the respondents indicated a higher work RVU for 19328 compared to 11971.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. During the initial Harvard study, only overall post-operative time data was surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC has had the opportunity to review the hospital and office visits for code 19328 and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

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The RUC reviewed the survey 25th percentile work RVU of 7.44 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 7.44, the RUC compared the survey code to CPT code 28291 *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant* (work RVU= 8.01, intra-service time of 50 minutes, total time of 215 minutes) and noted that the reference code involves more intra-service and total time, supporting a somewhat lower valuation for the survey code. The RUC also compared the survey code to MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU= 7.97, intra-service time of 45 minutes, total time of 185 minutes) and noted that both services have identical intra-service times and similar total times, whereas the reference code is slightly more intense intra-operatively. **The RUC recommends a work RVU of 7.44 for CPT code 19328.**

19330 ***Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)***
The RUC reviewed the survey results from 56 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 10 minutes for pre-service scrub/dress/wait, 75 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 1 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. During the initial Harvard study, only overall post-operative time data was surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC has had the opportunity to review the hospital and office visits for code 19328 and also the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

The RUC reviewed the survey 25th percentile work RVU of 9.00 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 9.00, the RUC compared the survey code to CPT code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU= 11.90, intra-service time of 75 minutes, total time of 233) and noted that both services have identical intra-service time and very similar total times, though the reference code is somewhat more intense for the surgeon intra-operatively. The RUC also compared the survey code to MPC code 21015 *Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm* (work RVU= 9.89, intra-service time of 75 minutes, total time of 277 minutes) and noted that both services have identical intra-service time, whereas the reference code involves more total time — the lower value for the survey code has appropriate rank order with the reference code. **The RUC recommends a work RVU of 9.00 for CPT code 19330.**

Practice Expense
The Practice Expense Subcommittee changed the exam table to a power table for each code which is typical for this specialty. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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RUC Recommendation for New CPT Parenthetical
The RUC noted that the CPT introductory materials state that 19330 and 19371 should not be reported together as 19371 includes the removal of the breast implant and all intracapsular contents:

> "Removal of a ruptured breast implant, including the implant contents, is reported with 19330. A complete capsulectomy (19371) includes removal of the breast implant and all intracapsular contents."

The RUC recommends for this also to be clearly stated in a parenthetical under the codes to further emphasize that these services should never be reported together.

Secondary Breast Mound Procedure (Tab 7)
Jeff Kozlow, MD (ASPS)

In February 2019, the CPT Editorial Panel approved the deletion of two codes and revisions to seventeen codes to provide descriptor clarification of any overlap in physician work for breast reconstruction services. In the CPT coding changes application, the specialty stated that this change is editorial and does not involve a change in work. At the April 2019 RUC meeting, the RUC agreed that the seventeen breast reconstruction services should be surveyed for the October 2019 RUC meeting. Codes 11960, 19316, 19350, 19355, and 19396 were also included as being part of the same code family. Based on the change in the typical patient for CPT code 11971 and multiple Harvard valued codes, the RUC agreed that all twenty-two of these services be surveyed, contrary to the specialty initial recommendation that these changes are editorial only and do not require surveying. At that time, the RUC had recommended surveying all twenty-two codes for the October 2019 RUC meeting.

At the October 2019 RUC meeting, the specialty elected to survey two of the codes and send a third code to CPT for revision. The specialty noted that the designation of a single 22 code family was too broad, and that the family categorization should be more granular than surgical procedures for the repair and/or reconstruction of the same anatomic region. The specialties proposed 8 families of services to the RUC noting that this categorization assign similar procedures together and ensures that the survey process is effective. The RUC concurred with the more granular classification of families that group analogous procedures together. Furthermore, the specialty indicated, and the RUC agreed, that three of the code families, autologous reconstruction, nipple procedures and moulage formation were not identified by any RAW screens, had no change to their work from CPT revisions and had no obvious flaws to their valuation (i.e., a site of service valuation issue), and therefore would not need to be reviewed at this time. The RUC agreed that, although the specialty societies had conducted surveys of code 11970 and 11971 for October 2019, these services should be resurveyed with their newly identified respective code families. In October 2019, the RUC reviewed these family of services with the specialty societies and agreed that these services should be surveyed for physician work and practice expense in January 2020. The *Breast Implant/Expander Placement* code family was one of the code families identified by the RUC for review for the January 2020 RUC meeting.

Compelling Evidence
The RUC reviewed and accepted compelling evidence based on change in procedure technique for all three services in this family. Code 19370 was revised by CPT where it now includes multiple different elements of work on the capsule that previously were not part of the code including partial capsulectomy and capsulorrhaphy. The work of suturing the capsule, tightening the capsule and/or removing a section of it is additional work that was not previously described by the old code descriptor. When this code was originally valued, there were fewer maneuvers performed relative to the modern typical patient and procedure. The inclusion of these maneuvers adds work that is now inclusive in the code descriptor. Code 19371 was revised by CPT where it now includes additional elements of work, the removal of all capsule contents, that was not previously part of the descriptor. Code 19380 was previously extremely vague,

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"revision of reconstructed breast" — now this service has been formally defined in detail. The descriptor revisions describe separate maneuvers were previously vague.

The RUC also reviewed and accepted compelling evidence based on change in patient population for all three services in this family, 19370, 19371 and 19380 based on a change in patient population. The number of patients that are eligible for breast reconstruction has changed. Twenty or thirty years ago, patients would only be typically undergoing this procedure if the patient did not have a BMI under 30 and nor major comorbidities. Now, breast reconstruction is appropriately provided to a much broader patient population, including many more oncology patients, due to advancements in care and surgical technique over the past few decades. With the increased access to breast reconstruction, patients with more comorbidities require management of the infected or otherwise complicated breast implant. The change in patient expectations has significantly increased the work intensity of the procedure not only intra-operatively, but also in the pre- and post- periods due to the elevated complexity of discussions with the patient.

19370 ***Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy***
The RUC reviewed the survey results from 42 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 78 minutes for intra-service time, 24 minutes for immediate post-time, 0.5 99238 discharge visit and 3 99213 post-operative office visits. The evaluation is spent in part in setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and work RVU (0.046) is inappropriately low for this intense major surgical procedure, which strongly implies the current total times are inflated relative to the current work RVU and not valid for comparison to the new times. During the initial Harvard study, only overall post-operative time was surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC reviewed the hospital and office visits for code 19370 and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

The RUC reviewed the survey 25th percentile work RVU of 10.00 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 10.00, the RUC compared the survey code to CPT code 36831 *Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU= 11.00, intra-service time of 85 minutes, total time of 248, RUC reviewed in 2013) and noted that the reference code involves somewhat more intra-service time and similar total time, and a value of 10.00 for the survey code would value it appropriately relative to this reference service. The RUC also reviewed reference codes 64910 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU= 10.52, intra-service time of 75 minutes, total time of 257 minutes) and code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU= 11.90, intra-service time of 75 minutes, total time of 233 minutes) and agreed that although these services both have 3 minutes less intra-service time relative to the survey code, both of them are somewhat more intense to perform. **The RUC recommends a work RVU of 10.00 for CPT code 19370.**

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19371 ***Peri-implant capsulectomy, breast, complete, including removal of all intra-capsular contents***
The RUC reviewed the survey results from 42 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 90 minutes for intra-service time, 25 minutes for immediate post-time, 0.5 99238 discharge visit, 2 99213 post-operative office visits and 1 99212 post-operative office visit. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The specialty noted that the work of removal of intra-capsular contents, which was newly added to the code descriptor was formerly reported by many providers separately with either code 19328 or 19330. In the 2017 Medicare reported together data, CPT code 19371 was reported with these services 14.5 percent of the time and 15 percent of the time, respectively.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and work RVU (0.039) is inappropriately low for this intense major surgical procedure, which strongly implies the current total times are inflated relative to the current work RVU and not valid for comparison to the new times. During the initial Harvard study, only overall post-operative time were surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC has had the opportunity to review the hospital and office visits for code 19371 and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

The RUC reviewed the survey 25th percentile work RVU of 10.81 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify work a work RVU of 10.81, the RUC compared the survey code to MPC code 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU= 11.19, intra-service time of 90 minutes, total time of 267 minutes) and noted that both services have identical intra-service times and very similar total times, whereas the reference code is slightly more intense intra-operatively. The RUC also compared the survey code to CPT code 36831 *Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU= 11.00, intra-service time of 85 minutes, total time of 248, RUC reviewed in 2013), noting that both services involve a similar amount of physician work and similar times and therefore should be valued similarly. The RUC also reviewed reference codes 64910 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU= 10.52, intra-service time of 75 minutes, total time of 257 minutes) and 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU= 11.90, intra-service time of 75 minutes, total time of 233 minutes) and agreed that they appropriately bracket the recommended value for survey code 19371. **The RUC recommends a work RVU of 10.81 for CPT code 19371.**

19380 ***Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)***
The RUC reviewed the survey results from 41 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 25 minutes for immediate post-time, 0.5 99238 discharge visit, 2 99213 post-operative office visits and 2 99212 post-operative office visits. The

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evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and work RVU (0.049) is inappropriately low for this intense major surgical procedure, which strongly implies the current total times are inflated relative to the current work RVU and not valid for comparison to the new times. During the initial Harvard study, only overall post-operative time were surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC has had the opportunity to review the hospital and office visits for code 19380 and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

The RUC reviewed the survey 25th percentile work RVU of 12.00 and agreed that this value appropriately accounts for physician work involved when performing this service. To justify a work RVU of 12.00, the RUC compared the survey code to CPT code 64569 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* (work RVU=11.00, intra-service time of 120 minutes, total time of 312 minutes) and noted that both services have identical intra-service times, similar total times, though the survey code is a more intense intraoperative service for the physician. The RUC also compared the survey code to MPC code 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, intra-service time of 120 minutes, total time of 279 minutes) and noted that both services have identical intra-service time, whereas the reference code is a somewhat more intense service to perform. Following the review of these and other reference codes, the RUC agreed that the survey 25th percentile work RVU of 12.00 is appropriate. **The RUC recommends a work RVU of 12.00 for CPT code 19380.**

Practice Expense
The Practice Expense Subcommittee had changed the exam table to a power table for each code which is typical for this specialty. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Breast Lift/Reduction (Tab 8)
Jeff Kozlow, MD (ASPS)

In February 2019, the CPT Editorial Panel approved the deletion of two codes and revisions to seventeen codes to provide descriptor clarification of any overlap in physician work for breast reconstruction services. In the CPT coding changes application, the specialty stated that this change is editorial and does not involve a change in work. At the April 2019 RUC meeting, the RUC agreed that the seventeen breast reconstruction services should be surveyed for the October 2019 RUC meeting. Codes 11960, 19316, 19350, 19355, and 19396 were also included as being part of the same code family. Based on the change in the typical patient for CPT code 11971 and multiple Harvard valued codes, the RUC agreed that all twenty-two of these services be surveyed, contrary to the specialty initial recommendation that these changes are editorial only and do not require surveying. At that time, the RUC had recommended surveying all twenty-two codes for the October 2019 RUC meeting.

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At the October 2019 RUC meeting, the specialty elected to survey two of the codes and send a third code to CPT for revision. The specialty noted that the designation of a single 22 code family was too broad, and that the family categorization should be more granular than surgical procedures for the repair and/or reconstruction of the same anatomic region. The specialties proposed 8 families of services to the RUC noting that this categorization assign similar procedures together and ensures that the survey process is effective. The RUC concurred with the more granular classification of families that group analogous procedures together. Furthermore, the specialty indicated, and the RUC agreed, that three of the code families, autologous reconstruction, nipple procedures and moulage formation were not identified by any RAW screens, had no change to their work from CPT revisions and had no obvious flaws to their valuation (i.e., a site of service valuation issue), and therefore would not need to be reviewed at this time. In October 2019, the RUC reviewed these family of services with the specialty societies and agreed that these services should be surveyed for physician work and practice expense in January 2020. The *Breast Lift/Reduction* code family was one of the code families identified by the RUC for review for the January 2020 RUC meeting.

19316 *Mastopexy*
The RUC reviewed the survey results from 97 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 14 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 20 minutes for immediate post-time, 0.5 99238 discharge visit, 2 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-operatively.

The RUC reviewed the survey 25th percentile work RVU of 15.15 and agreed that this value overstates the amount of physician work involved. The RUC compared the survey code to CPT code 64569 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* (work RVU=11.00, intra-service time of 120 minutes, total time of 312 minutes) and noted that both services have identical intra-service times, similar total times and the survey code is a slightly more intense intraoperative service for the physician. The RUC also compared the survey code to MPC code 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, intra-service time of 120 minutes, total time of 279 minutes) and noted that both services have identical intra-service time, whereas the reference code is a more intense service to perform. Following the review of these and other reference codes, the RUC agreed that it would be appropriate to maintain the current value of 11.09 for the survey code. **The RUC recommends a work RVU of 11.09 for CPT code 19316.**

19318 *Breast reduction*
The RUC reviewed the survey results from 180 plastic surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 180 minutes for intra-service time, 25 minutes for immediate post-time, 0.5 99238 discharge visit, 2 99213 post-operative office visit and 2 99212 post-operative office visits. The evaluation is spent setting and marking the patient in an upright position to evaluate breast shape and measure base dimensions. Additional time is also required to review choice of implants with the patient. Ten minutes of positioning time are necessary to account for the time involved in securing arms and assessing the position of the head and neck and making any adjustments to allow for sitting upright intra-

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operatively. This service is typically performed bilaterally in the Medicare population, though the multiple procedure reduction applies.

The RUC reviewed the survey 25th percentile work RVU of 17.60 and agreed that this value overstates the amount of physician work involved. The RUC compared the survey code to top key reference code 15736 *Muscle, myocutaneous, or fasciocutaneous flap; upper extremity* (work RVU=17.04, intra-service time of 150 minutes, total time of 396 minutes) and noted that the survey code involves more intra-service time and both services involve similar intensity (72 percent of survey respondents that selected the reference code said the survey code had either identical or somewhat more intensity than the reference code). However, the reference code involves 29 more minutes of total time than the survey code, making it warranted to value the survey code somewhat less. The RUC also compared the survey code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180, total time of 383) and noted that although both services have identical intra-service times, the reference code involves more intraoperative intensity and also more total time. Following the review of these and other reference codes, the RUC agreed that it would be appropriate to maintain the current value of 16.03 for the survey code. When comparing 19318 *Breast reduction* to 19316 *Mastopexy*, breast reduction is more intense physician work because of the additional time and intensity involved in removing tissue and having to shape the breast that was reduced in size. **The RUC recommends a work RVU of 16.03 for CPT code 19318.**

Practice Expense
The Practice Expense Subcommittee had changed the exam table to a power table for each code which is typical for this specialty. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Femur Lengthening Device Procedures (Tab 9)
William Creevy, MD (AAOS) and Hussein Elkousy, MD (AAOS)

In September 2019, the CPT Editorial Panel approved the addition of a code to report osteotomy, femur, and insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging. The American Academy of Orthopaedic Surgeons expressed an interest in surveying the new CPT code 27X00 along with existing CPT codes 27465, 27466, and 27468 as part of the family. In January 2020, however, the specialty society indicated that the descriptors for both the new and existing codes needed to be further revised to better describe and distinguish the physician work involved in the procedures. The society requested referral to CPT and intends to submit a new code change application for the May 2020 CPT Editorial Panel meeting. A new coding proposal will be developed, and the full array of coding options will be determined including revising additional existing codes in the family as well as potentially requesting new codes. The specialty society will then survey the entire family for the October 2020 RUC meeting.

CMS questioned why the codes needed revision. The specialty society stated that there has been significant change in repair technique since the Harvard valuation of these codes and they would like to take this into account for the survey. For example, it would currently be difficult for a survey respondent to determine for a femur lengthening or shortening procedure, if a plate is used, if external fixation is used, or if an intramedullary nail is used; and there are different amounts of work involved for each technique. Referral would allow the society to create better descriptors that more clearly differentiate work. In addition, CPT codes 27466 and 27468 are Harvard-valued and do not have vignettes. The specialty society is requesting that CPT rescind new code 27X00 for CPT 2021 and they will develop a new coding proposal to incorporate all the revisions related to this family for CPT 2022. **The RUC concurred and recommends that CPT codes 27X00, 27465, 27466, and 27468 be referred to the May 2020 CPT Editorial Panel.**

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Tibia Lengthening Device Procedures (Tab 10)
William Creevy, MD (AAOS) and Hussein Elkousy, MD (AAOS)

In September 2019, the CPT Editorial Panel approved the addition of a code to report osteotomy, tibia and fibula, and insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging. The American Academy of Orthopaedic Surgeons expressed an interest in surveying the new CPT code 27X16 and existing CPT code 27715 as part of the family. In January 2020, however, the specialty society requested referral to CPT with the intent to submit a new code change application for the May 2020 CPT Editorial Panel meeting. The society indicated that the descriptors for both the new and existing code needed to be further revised to better describe and distinguish the physician work involved in the procedures. In particular, the society believed that clarification is needed for CPT code 27715 which entails shortening, lengthening, or combination, stating that it would be difficult to perform a survey until it is better defined.

It is the RUC's understanding that the specialty society will request that CPT rescind the new code for CPT 2021 and that the society will develop a new coding proposal to incorporate all the revisions related to this family, and the femur, for CPT 2022. The specialty society will then survey the entire family for the October 2020 RUC meeting. **The RUC concurred and recommends that CPT codes 27X16 and 27715 be referred to the May 2020 CPT Editorial Panel.**

Shoulder Debridement (Tab 11)
William Creevy, MD (AAOS) and Hussein Elkousy, MD (AAOS)

In October 2018, CPT code 29823 was identified as a Harvard valued service with 2017 Medicare utilization over 30,000 and an action plan was requested for January 2019. In January 2019, the RUC recommended to refer CPT code 29823 and family code 29822 for revision. The code descriptors for 29822 and 29823 were not clear (eg, limited versus extensive) and there were no guidelines to assist providers and coders with selecting the correct code. In September 2019, the CPT Editorial Panel approved revision of the two codes to clarify limited and extensive debridement by specifying the number of discrete structures debrided and providing examples of the structures.

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])***
The RUC reviewed the survey results from 54 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 7.03 accurately reflects the physician work necessary to perform this service and is a reduction from the current Harvard-based work value. The RUC recommends 30 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 30 minutes intra-service time and 20 minutes immediate post-service time, 0.5 99238 discharge visit, 2-99213 office visits and 1-99212 office visit. The RUC noted that the additional 12 minutes of pre-service positioning time is necessary because the patient is initially placed supine, then rolled into the lateral decubitus position. Pads are placed to protect bony prominences. A shoulder boom is used to support the arm and allow the appropriate amount and angle of traction. Monitors and arthroscopic video equipment are also positioned with the assistance of the surgeon. The areas of trochar insertion need to be determined and marked and areas of prepping and draping identified. More sophisticated pumps for surgery require more set up time for the surgeon with more tubing to manage and more sophisticated monitors have more options for set up and positioning. With respect to office visits, the Harvard study did not survey for the level and number of post-operative visits but instead only for time. The Harvard survey data indicated that CPT code 29822 had 40 minutes of office visit time. This time was converted to E/M codes in 1997 by a CMS contractor to 3.5 x 99212 for code 29822. These visits underestimate the work

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(intensity/complexity) and time required for these patients postoperatively. *See attached additional rationale explaining how the different components of work (pre, intra, post) were developed during the Harvard study.*

The RUC discussed the significant reduction in intra-service time from 69 to 30 minutes. The RUC reiterated that the survey code had never been RUC-valued denoting that the current times are over 25 years old from the Harvard study and not valid for comparison. The specialty society stated that the reduction in intra-service time is a reflection that the surgeons are much more adept and have better equipment than when the procedure was first initiated in the 1980s. The RUC also noted that the total time for the entire 90-day global period was only 13 minutes less (204 versus 191).

The RUC compared CPT code 29822 to the top key reference code 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* (work RVU = 7.03 and 58 minutes pre-service time, 40 minutes intra-service time and 15 minutes immediate post-service time) and noted the similar amount of total time and physician work. The RUC further noted that the higher intra-service time for the key reference service is offset by the intensity of the survey code. CPT code 29822 is considered more intense, with over half of survey respondents that selected the reference code indicating that the survey code had more intensity/complexity overall relative to the key reference code. Most of the difference in intensity between the codes is due to the three-dimensional difficulties in operating on the shoulder versus the knee including a difference in the number of portals and use of a cannula in the shoulder scope. The survey procedure is greater in intensity due intrinsically to the differences between the shoulder arthroscopy versus the knee arthroscopy and the scoping involved.

For additional support, the RUC referenced the second key reference code 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* (work RVU = 7.39 and 58 minutes pre-service time, 45 minutes intra-service time and 15 minutes immediate post-service time) and noted that the reference code has more intra-service and total time than the survey code and is therefore appropriately valued higher. The RUC further noted that 70% of survey respondents that selected the second key reference code rated the survey code as more intense and complex, again justifying the higher IWPUT for the survey code (0.08) relative to the key reference service (.065). The RUC concluded that CPT code 29822 should be valued at the 25th percentile work RVU of 7.03 as supported by the survey and well-aligned with the key reference service codes. **The RUC recommends a work RVU of 7.03 for CPT code 29822.**

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])***

The RUC reviewed the survey results from 54 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 7.98 accurately reflects the physician work necessary to perform this service and is a reduction from the current Harvard-based work value. The RUC recommends 30 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 50 minutes intra-service time and 20 minutes immediate post-service time, 0.5 99238 discharge visit, 2-99213 office visits and 1-99212 office visit. The RUC noted that the additional 12 minutes of pre-service positioning time is necessary because the patient is initially placed supine, then rolled into the lateral decubitus position. Pads are placed to protect bony prominences. A shoulder boom is used to support the arm and allow the appropriate amount and angle of traction. Monitors and arthroscopic video equipment are also positioned with the assistance of the surgeon. The areas of trochar insertion need to be determined and marked and areas of prepping and draping identified. More sophisticated pumps for

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surgery require more set up time for the surgeon with more tubing to manage and more sophisticated monitors have more options for set up and positioning. The RUC also noted that the survey code is a more extensive procedure with 20 minutes more intra-service time than CPT code 29822. With respect to office visits, the Harvard study did not survey for the level and number of post-operative visits but instead only for time. The Harvard survey data indicate CPT code 29823 had 47 minutes of office visit time. This time was converted to E/M codes in 1997 by a CMS contractor to 4 x 99212 for 29823. These visits underestimate the work (intensity/complexity) and time required for these patients postoperatively. *See attached additional rationale explaining how the different components of work (pre, intra, post) were developed during the Harvard study.*

The RUC compared CPT code 29823 to the top key reference code 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* (work RVU = 7.39 and 58 minutes pre-service time, 45 minutes intra-service time and 15 minutes immediate post-service time) and noted that the survey code has 5 minutes more intra-service time yet similar intensity as the reference code (0.067 and 0.065 respectively). The RUC questioned the nearly identical intensity of the survey code and the key reference code. The specialty society acknowledged that the survey procedure is greater in intensity due intrinsically to the differences between the shoulder arthroscopy versus the knee arthroscopy and the scoping involved. MPC codes 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97) and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77) also reflect higher values, and the society chose to honor the survey and be consistent with its companion code 29822 in selecting the 25th percentile RVU recommendation. The RUC concurred and concluded that CPT code 29823 should be valued at the 25th percentile work RVU of 7.98 as supported by the survey. **The RUC recommends a work RVU of 7.98 for CPT code 29823.**

Work per Unit Time (WPUT)
The RUC notes that it is important to understand that intra-service work is only one component of the total work for a global code. CMS has recently accepted the RUC's rationale for E/M services that the intensity of the pre, intra, and post-service work is the same, and the same whether the work is face-to-face or non-face-to-face. This has resulted in a computation of work per unit time (WPUT) which was in fact a method that CMS (then HCFA) used for code comparison in the early years of the fee schedule.

The WPUT for CPT code 29822 is not different (0.037) for 204 minutes of work at the current 7.60 work RVUs compared to the Harvard manipulated data of 191 minutes at the proposed 7.03 work RVUs. Regarding CPT code 29823, the prior WPUT was lower than code 29822 which intuitively is incorrect but is explained by the fact that times (evaluation and immediate postop) were set lower by the Harvard algorithm. The newly proposed WPUT of 0.038 for 211 minutes at 7.98 work RVUs correctly aligns the WPUT for CPT code 29823 as slightly more intense/complex than 29822. Thus, contending that there really is no change in value for these two procedures - just a rearrangement of time.

The work per unit time for CPT codes 29822 (0.037) and 29823 (0.038) is lower than any of the recently reviewed office visit E/M codes which range from 0.039 to 0.043 WPUT except for 99211 for a nursing visit. Further, a review of the WPUT for RUC reviewed codes with similar total time indicates that the work per unit time for the two survey codes is not different (or less where appropriate) than other global codes with similar total times. *See attached additional rationale.*

Practice Expense
The PE Subcommittee reviewed the standard 90-day global inputs and replaced the staple removal kit with a suture removal kit (SA054 *pack, post-op incision care (suture)*). **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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Absorbable Nasal Implant Repair (Tab 12)
R. Peter Manes, MD (AAO-HNS) and Lance Manning, MD (AAO-HNS)

In September 2019, the CPT Editorial Panel approved the addition of a code to report repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s).

30468 ***Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)***
The RUC reviewed the survey results from 168 otolaryngologists and determined that the survey 25th percentile work RVU of 2.80 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 38 minutes of pre-service time, 20 minutes of intra-service time, and 15 minutes of immediate post-service time. Pre-time package 3 and post-time package 9A were selected due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia. It is anticipated that over time this service may shift to primarily office-based and will be captured by the appropriate site of service screen as that transition occurs and requires revaluation.

The RUC compared the surveyed code to CPT code 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)* (work RVU= 2.81 and intra-service time of 20 minutes) and noted that both codes have identical intra-service time and should be valued similarly. Although reference code 45346 has less total time than the survey code, it is a more intense service. CPT code 30468 is more intense than CPT code 45346 due to the risk of cosmetic deformity. The placement of the nasal implant occurs in an area with exceedingly thin skin, where it is easy to puncture the skin during placement. If this occurs, the defect is very difficult to repair and often leads to lifelong scarring. The survey code requires more physician time and work than code 45346 and thus valued appropriately. Additionally, the RUC compared the survey code to the top key reference code 30140 *Submucous resection inferior turbinate, partial or complete, any method* (work RVU= 3.00 and intra-service time of 20 minutes), and noted that both codes have identical intra-service time and should be valued similarly. The majority of survey respondents rated the survey code somewhat more to much more intense/complex than top key reference code 30140, warranting the work value for the survey code. **The RUC recommends a work RVU of 2.80 for CPT code 30468.**

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the specialty's recommendation to add a new supply "absorbable nasal implant and delivery device" kit needed for the procedure. The kit can be used bilaterally or unilaterally. The specialty society clarified that in the very unusual event of unilateral implantation, the second device would be discarded and not be used in another patient. **The RUC recommends the direct PE inputs as submitted by the specialty societies**.

Atrial Septostomy (Tab 13)
Sergio Bartakian, MD (SCAI); Edward Toggart, MD (SCAI); Edward Tuohy, MD (ACC); Thad Waites, MD (ACC) and Richard Wright, MD (ACC)
Pre-Facilitation: Facilitation Committee #2

Two transvenous septostomy codes, CPT code 92992 *Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)* and CPT code 92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)* were nominated by the Society for Cardiovascular Angiography and Interventions as potentially misvalued in comments on the CY 2019 PFS Final Rule. These services are typically performed on pediatric patients, a non-Medicare population, and are contractor priced. The specialty society requested that these services be surveyed through the RUC process. In January 2019, the RUC identified the possibility that related imaging guidance may not be correctly bundled into CPT code 92992. Therefore, the RUC recommended

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that CPT code 92992 be referred to the CPT Editorial Panel for revision to bundle in all forms of imaging guidance typically used during the procedure. Additionally, the specialty societies indicated that CPT code 92993 is antiquated and rarely performed. The RUC recommended that CPT code 92993 be referred to the CPT Editorial Panel for revision or possible deletion. The RUC recommended that the codes be surveyed as 000-day global periods because these procedures do not provide definitive therapy; the patients requiring these procedures often remain critically ill after the lifesaving/temporizing procedures. In September 2019, the CPT Editorial Panel deleted two codes describing atrial septostomy and replaced them including a new section in CPT with extensive guidelines and new descriptors to better describe bundled services for transcatheter atrial septostomy (TAS) and transcatheter intracardiac shunt creation by stent placement (TIS).

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)***

Septostomy is a rare, lifesaving, emergent procedure performed by pediatric interventional cardiologists for infants with a severe form of congenital heart disease. The level of difficulty has increased due in part to its performance on extremely small newborns and neonates. With the increasing numbers of successful premature infants surviving to delivery, the average gestational age and size of the patient who receives the intervention has progressively decreased (smallest 1200 grams). This progression of increasingly more premature infants has complicated the procedure further due to the numerous other comorbidities that accompany extreme prematurity, namely, immature pulmonary development and an increased incidence of acute kidney injury and hepatic dysfunction. However, the available equipment for performance of an atrial septostomy has not changed in the roughly five decades since this procedure was first performed. The result is a transition of the procedure being performed at the bedside, to one that most often now requires performance in the cardiac catheterization lab.

The RUC reviewed the survey results from 56 interventional cardiologists and pediatric/congenital interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 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* (work RVU = 14.00, 90 minutes intra-service time and 183.0 minutes total time) would accurately reflect the physician work necessary for this service and falls appropriately between the median and survey 25th percentile. The crosswalk was selected for the RVU only, not the service period times, because the value has been recently RUC-reviewed (2016) and CMS-accepted and is an understandable intracardiac procedure that crosses from the right to the left side of the heart.

The RUC recommends 20 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 55 minutes intra-service time and 45 minutes immediate post-service time. The RUC discussed the difference in intensity between the survey code (IWPUT = 0.220) and the proposed crosswalk (IWPUT = 0.136). The specialties explained that the crosswalk code is an elective/scheduled adult procedure while the survey code is an emergent life-saving procedure on a newborn resulting in significantly higher intensity for the survey code. The specialties further explained that there is an issue for pediatric intensivists who cannot report for critical care due to another provider from the same specialty also reporting critical care on same day. The RUC recommended revising the pre-service package in order to capture the intensity involved in the pre-service time; thus, the RUC recommended the pre-service times as indicated by the survey respondents.

The RUC compared CPT code 33741 to the top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU = 17.97, 30 minutes pre-service time, 120 minutes intra-service time and 60 minutes

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immediate post-service time) and noted the intra-service time is more than double that of the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the intensity of the survey code. CPT code 33741 is considered more intense, with 75% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code. As with the crosswalk code, the difference in intensity is attributed to the precarious size of the patient and the urgent nature of the survey procedure. Per the vignette for 93580, patients range from infants to adults whereas the typical patient for the survey code is a 1-day old premature infant.

The RUC also referenced the second key reference code 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU = 9.85, 29 minutes pre-service time, 68 minutes intra-service time and 30 minutes immediate post-service time) noting that these are high intensity codes, so it is difficult to rely only on intra-service time. However, the typical patient for 92920 is an adult in contrast to the survey code's vignette for a 1-day-old premature infant. Thus, the total time and intensity of the reference code is much less than the survey code. It was noted that 43% of survey respondents that selected the second key reference code (12.5%) rated the survey code as more intense and complex, justifying a higher work value for the survey code. The key reference codes appropriately bracket the survey code and demonstrate that the crosswalk value will maintain relativity within the family.

For additional support, the RUC compared the survey code to CPT code 31601 *Tracheostomy, planned (separate procedure); younger than 2 years* (work RVU = 8.00, 60 minutes pre-service time, 45 minutes intra-service time and 30 minutes immediate post-service time) noting that septostomy is similar to a tracheostomy of the heart. For both procedures, the potential outcome is the same, in the absence of a hole successfully being made, the patient will die. However, whereas the physician typically has full visualization of an immobile operative field, the neck area, when performing a tracheostomy, for septostomy the physician must rely on imaging guidance to perform the procedure in the heart, which remains constantly moving. Moreover, the comparator code is a planned procedure on a typical 18-month-old patient while the survey code is an emergency procedure on a premature infant, thus the value and intensity are appropriately higher for the survey code.

The RUC concluded that CPT code 33741 should be valued based on a direct work RVU crosswalk to CPT code 33340 which falls between the median and 25th percentile as supported by the survey. **The RUC recommends a work RVU of 14.00 for CPT code 33741.**

33745 ***Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, all imaging guidance by the proceduralist when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt***
Transcatheter intracardiac shunt creation by stent implant is a procedure performed predominantly by pediatric interventional cardiologists for infants and children with severe forms of congenital heart disease. It is a rare procedure performed roughly half as often as a septostomy. The new code provides treatment for a variety of congenital heart defects ranging from a premature infant with hypoplastic left heart syndrome with a restrictive atrial communication, to an older child/adult with late post-surgical complications of prior repair of congenital heart defects (Fontan, Mustard, Senning, Warden procedures, to name a few).

There is no similarity in the work captured with CPT code 33745 and that for CPT code 33741. The latter is a replacement of the original 2 atrial septostomy codes (balloon and blade methods). The two old septostomy codes were felt to be similar and could be captured with a single code. CPT code 33745 is a

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new code created with the initial thought having been to capture the work performed in premature infants who underwent atrial decompression of hypoplastic left heart syndrome, with placement of a stent in a very restrictive atrial communication. As the code was developed, the specialty had at least six different diagnoses/scenarios for which a stent was placed in various positions within the heart. Rather than create six different codes, the specialties broadened the description to capture all of them rather than have six different codes of similar work. The physician work described in 33745 was not captured in the previous codes.

The RUC reviewed the survey results from 54 interventional cardiologists and pediatric/congenital interventional cardiologists and determined that the survey 25th percentile work RVU of 20.00 accurately reflects the physician work necessary for this service. The RUC recommends 25 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 92 minutes intra-service time and 60 minutes immediate post-service time. The RUC recommended revising the pre-service time package to reflect the survey results.

The RUC questioned the high intensity of the survey code given that it is not an emergent procedure. The specialties explained that the primary issue of increased complexity/stress/risk is surrounding the fact that these are stents implanted inside the beating heart itself and not within a blood vessel as all other stent CPT codes. Unlike those other interventions, any error in the precise placement of the stent in these procedures results in a delivered stent loose within the heart and requires emergency surgery to retrieve.

The RUC compared CPT code 33745 to the top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU = 24.39, 30 minutes pre-service time, 180 minutes intra-service time and 60 minutes immediate post-service time) and noted the intra-service time is nearly twice that of the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the intensity of the survey code. CPT code 33745 is considered more intense for the reasons, with 89% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also referenced the second key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU = 17.97 and 30 minutes pre-service time, 120 minutes intra-service time and 60 minutes immediate post-service time) and again noted that the higher intra-service time for the key reference service is offset by the intensity of the survey code. All the survey respondents that selected the second key reference code (26%) rated the survey code as more intense and complex, justifying the higher work value for the survey code. The RUC concluded that CPT code 33745 should be valued at the 25th percentile work RVU of 20.00 as supported by the survey and appropriately bracketed by the key reference service codes. **The RUC recommends a work RVU of 20.00 for CPT code 33745.**

33746 ***Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, all imaging guidance by the proceduralist when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 53 interventional cardiologists and pediatric/congenital interventional cardiologists and determined that the survey median work RVU of 10.50 accurately reflects the physician work necessary for this add-on service, which is needed under emergency circumstances. The RUC recommends 60 minutes intra-service time. As with the base code (33745), the primary issue of increased intensity/complexity surrounds the fact that these are stents implanted inside the beating heart itself and not within a blood vessel as all other stent CPT codes. Unlike those other interventions, any error

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in the precise placement of the stent in these procedures results in a delivered stent loose within the heart and requires emergency surgery to retrieve. CMS inquired whether, when it is determined that the second stent is needed, is it typically straddling a vessel. The specialties confirmed that the stent typically overhangs the heart, most commonly in a different site within the heart.

The RUC compared CPT code 33746 to the top key reference code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU = 8.00 and 60 minutes intra-service time) and noted that the ZZZ codes have the same intra-service time but the survey code is valued higher due to the higher intensity of the code. For the reasons, the survey code is considered more intense with 74% of survey respondents that selected this reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced the second key reference code 92998 *Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 5.99 and 58 minutes intra-service time) and noted the lesser intra-service time and physician work for the key reference service. The reference code is also much less intense than the survey code with 77% of survey respondents that selected the second key reference code (25%) rating the survey code as more intense and complex, again justifying the higher work value for the survey code. The RUC concluded that CPT code 33746 should be valued at the median work RVU of 10.50 as supported by the survey. **The RUC recommends a work RVU of 10.50 for CPT code 33746.**

Practice Expense
These services are facility-only and have no direct practice inputs. **The RUC recommends no direct practice inputs for CPT codes 33741, 33745, and 33746.**

Computer-Aided Mapping of Cervix Uteri (Tab 14)
Jon Hathaway, MD (ACOG) and Mitch Schuster, MD (ACOG)

In September 2019, the CPT Editorial Panel approved the addition of a code to report computer-aided mapping of cervix uteri during colposcopy.

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)***
The RUC reviewed the survey results from 47 gynecologists/obstetricians and determined that the survey median work RVU of 0.81 accurately reflects the typical physician work necessary for this service. The RUC recommends 15 minutes of intra-service time. During the procedure, the computer-aided spectral imaging system dynamically captures images of the cervix to record the intensity and spatial distribution of acetowhitening as it changes over time. The physician is continuously monitoring and evaluating changes and any morphological features, under full view and magnification with filters, and records his/her impression of the cervix. The physician reviews the areas that appear abnormal based on standard criteria in combination with the color map and points out these areas to the patient.

The RUC initially compared the survey code to both top key reference codes 58110 *Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)* (work RVU= 0.77 and intra-service time of 12 minutes) and 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU= 0.83 and intra-service time of 10 minutes) and noted that the survey code requires more physician time and work than both key reference services and thus valued

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appropriately. Most survey respondents also rated the survey code identical or somewhat more intense/complex than both key reference services. The RUC also compared the survey code to CPT code 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)* (work RVU= 0.80 and intra-service time of 15 minutes) and noted that both codes have identical intra-service time and should be valued similarly. Additionally, the RUC compared the survey code to CPT code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU= 0.85 and intra-service time of 15 minutes) and noted that both codes have identical intra-service time. The survey code is appropriately bracketed relative to the physician work of reference codes 95984 and 76979.

To further support a work RVU of 0.81 for the survey code, the RUC compared code 57465 to MPC comparison code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU= 0.80 and intra-service time of 15 minutes)**. The RUC recommends a work RVU of 0.81 for CPT code 57465.**

New Technology/New Services
The RUC recommends that CPT code 57465 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 RUC recommends the direct practice expense inputs as submitted by the specialty societies.

<u>Dilation of Eustachian Tube (Tab 15)</u>
R. Peter Manes, MD (AAO-HNS) and Lance Manning, MD (AAO-HNS)
Facilitation: Facilitation Committee #3

In September 2019, the CPT Editorial Panel created two new codes to describe the dilation of the eustachian tube via surgical nasopharyngoscopy, unilateral and bilateral.

69705 ***Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral***
The RUC reviewed the survey results from 192 otolaryngologists and determined that the survey median work RVU of 3.00 appropriately accounts for the work required to perform this procedure. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub, dress, wait time, 20 minutes intra-service time and 15 minutes immediate post-service time. This service utilizes a rigid endoscope to guide a balloon dilation system through the nose, put the balloon into the eustachian tube orifice, inflate the balloon and dilate the eustachian tube. This service is typically not going to be performed with other services. This eustachian tube procedure is distinct and not typically associated with other procedures either balloon or non-balloon. The specialty society confirmed the pre-service evaluation time requires 30 minutes, which includes many tasks such as meeting with patients and family to describe and discuss in detail the planned procedure, reviewing and updating the medical history, performing a current physical exam, reconciling medications and allergies, addressing nothing by mouth (NPO) status and timing, discussing the patient's expected convalescence and educating the patient and caregivers regarding the signs and symptoms of the most common complications, reviewing and obtaining informed consent, providing a detailed description of the postoperative changes in eustachian tube function and the expected dynamic changes in nasal and eustachian tube function changes as the wound matures, verifying

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the availability of all required instruments and supplies, ensuring that the endoscopes, suction, source for insufflation, and video recording equipment are available and functioning properly and reviewing radiographic images. The pre-service positioning decreased to 3 minutes in accordance with the package and other similar services. The 10 minutes of scrub, dress and wait time includes spraying topical anesthesia and decongestant first and waiting for that to take effect, then allowing the physician to put pledgets with topical anesthesia and decongestant in the nose to sit and take effect as well. The physician will then start the procedure using the endoscope to remove the initial pledgets and place more pledgets further in the posterior nasal cavity and nasopharynx which was inaccessible at first because the physician had to decongest the anterior part of the nasal cavity. The physician will also inject anesthesia in the middle turbinate all for decongestant and to eliminate bleeding.

The RUC compared CPT code 69705 to the top key reference service 31297 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium* (work RVU = 2.44, 20 minutes intra-service time and 56 minutes total time) and noted that 679XX requires more physician work and total time. The survey respondents also noted that 69705 is somewhat more intense than 31297. The specialty society indicated that the sphenoid sinus is located straight on, the physician uses one zero-degree rigid endoscope. However, with 69705, the physician starts with a zero-degree rigid endoscope and then switches to a 30-degree rigid endoscope. Manipulation of the hands is more complicated because what the physician is seeing is not straight ahead. Regarding dilation, when the physician dilates a sphenoid sinus, he/she places the balloon in the sphenoid ostium and the physician can see the edge of the proximal part of the balloon. However, in the eustachian tube, the physician cannot visually see the dilation, the balloon opening, thus 69705 appropriately has a higher RVU then 31297. The number of dilations vary for both procedures, the eustachian tube is typically 2 dilations and the sphenoid are 1-2 dilations, but it varies.

The RUC compared code 69705 to the second top key reference service 31296 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium* (work RVU = 3.10, 25 minutes intra-service time and 61 minutes total time), which requires 5 more minutes of intra-service time but less total time. However, the survey respondents noted that 69705 is identical or somewhat more intense than CPT code 31296. For CPT code 69705, the area of the eustachian tube orifice opens into the nasopharynx which is only 4mm away from the carotid artery. The physician must always be cognizant of the proximity to the carotid artery, which reinforces the intensity of this procedure. The RUC also noted that codes 31296 and 31297 are office-based procedures that require less tasks to complete. CPT code 69705, performed in the hospital setting, will require a variety of additional pre-service tasks such as nothing by mouth (NPO) status and timing, updating current physician exam, etc. The RUC notes that 69705 maintains the relativity of physician work, time and intensity to the recently valued nasal sinus endoscopy with balloon dilation codes 31296-31298.

The RUC compared 69705 to similar service 30140 *Submucous resection inferior turbinate, partial or complete, any method* (work RVU = 3.00, 20 minutes intra-service time and 78 minutes total time), which requires the same physician work and exact same time elements, thus supporting the relativity of this service. Lastly, the RUC referenced MPC code 31500 *Intubation, endotracheal, emergency procedure* (work RVU = 3.00 and 10 minutes intra-service time and 32 minutes total time), which requires the same amount of physician work as 69705, but much less total time and is a much more intense procedure. **The RUC recommends a work RVU of 3.00 for CPT code 69705.**

69706 Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral
The RUC reviewed the survey results from 192 otolaryngologists and determined that the survey median work RVU of 4.27 appropriately accounts for the work required to perform this procedure. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub, dress, wait time, 30 minutes intra-service time and 15 minutes immediate post-service time. The RUC agreed with the pre-service time and activities as discussed in code 69705. The specialty societies clarified that

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the pre-service time is replicated from 69705 because the physician is completely removing the scope and inserting it into the other nostril. The RUC noted that the survey respondents may have underestimated the intra-service time for this bilateral service compared to the unilateral code, they indicated 20 minutes intra-service time for 69705 but only 10 additional minutes when performed bilaterally in code 69706. The RUC noted that if this service was described by one code but performed bilaterally and reported with the bilateral procedure modifier-50, the work RVUs would be 4.50. However, due to practice expense issues to ensure the correct inputs for the balloon were captured, two codes were created.

The RUC compared 69706 to key reference service 31298 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia* (work RVU = 4.50, 40 minutes intra-service time and 76 minutes total time) and determined that 31298 requires slightly more physician intra-service time, but both require the same total time. Additionally, 69706 is more intense to perform because the physician must always be cognizant of the proximity to the carotid artery only 4mm away and the manipulation of the scopes to access the eustachian tube is also much more intense than that of the straight on access to the frontal and sphenoid sinuses.
The RUC referenced similar service 31254 *Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)* (work RVU = 4.27, 30 minutes intra-service time and 83 minutes total time), which requires similar time and the same physician work. For additional support, the RUC referenced code 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU = 4.27, 30 minutes intra-service time and 81 minutes total time). **The RUC recommends a work RVU of 4.27 for CPT code 69706.**

RUC Database Flag
The Committee recommends that the RUC flag CPT code 69706 as "do not use to validate work" since the survey respondents may have underestimated the intra-service time.

Practice Expense
The PE Subcommittee recommends two new supply items, the *kit, eustachian tube procedure* and *eustachian tube balloon*. The specialty societies confirmed that one eustachian balloon and one kit, which includes an insufflator, is used for both the unilateral and bilateral procedure, codes 69705 and 69706, a second separate eustachian balloon is not used for the bilateral procedure. The PE Subcommittee modified the clinical staff time to increase to reflect the standard inputs. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Service
The RUC recommends that CPT codes 69705 and 69706 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Medical Physics Dose Evaluation (PE Only) (Tab 16)
Curtis Anderson, MD (SIR); Lauren Golding, MD (ACR); Andrew Moriarity, MD (ACR); Kurt Schoppe, MD (ACR); Gerald White, MS (ACR) and Richard Wright, MD (ACC)

In May 2019, the CPT Editorial Panel created a new practice expense only code to describe medical physics dose evaluation for radiation exposure that exceeds the institutional review threshold. The service describes the work of clinical staff performing an evaluation following the procedure where the threshold of exposure was met. The service recreates the procedure to accurately determine organ specific doses resulting from radiation exposure during the procedure. If the site, state or equipment requirements determines that the threshold was met, the physician or office staff contact the physicist and request the service.

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At the October 2019 RUC meeting, the Practice Expense (PE) Subcommittee reviewed the PE recommendations for new CPT code 7615X. The clinical activities associated with the service involve high amounts of clinical staff time, and the Subcommittee had concerns that there may be overlap between some of the categories. The PE Subcommittee considered the time elements of the *Medical Physicist* (L152A) clinical staff and was unable to make a recommendation to the RUC based on the specialty society expert panel proposal. The PE Subcommittee instead requested that the specialty societies conduct a PE survey to obtain data that would drive the Subcommittee's decisions. The PE Subcommittee cited two primary reasons that a PE survey is necessary to appropriately review and determine accurate direct practice expense inputs for this service. First, this is a new service with a high amount of clinical staff time and, because there are no other similar services, there are no appropriate reference codes to compare the clinical staff activities and times. Second, the service is stand-alone, meaning that the medical physicist works independently from a physician and there are no elements of the practice expense that are informed by time from a physician work survey. Following the meeting the specialty societies developed a PE survey which was reviewed and approved by the Research Subcommittee.

At the January 2020 RUC meeting the PE Subcommittee reviewed the results of the practice expense survey. The PE Subcommittee noted that the specialty societies included facility-based providers in addition to non-facility based providers in their survey sample, as recommended by the PE Subcommittee and approved by the RUC Research Subcommittee in October 2019. The PE spreadsheet includes the original consensus panel October 2019 recommendations, the median survey results and the January 2020 consensus panel recommendations. The recommended times are consistent with the survey median times. No reference code is included as there are no similar services in radiology or cardiology. There was a total of 41 responses to the PE survey. A PE Subcommittee member inquired about the expected use of the service and the specialty societies explained that, although it is not a common service, the specialty estimates that it is done 16,000 times per year. This is based on interventional, long-duration procedures, including both in the facility and non-facility settings. It is expected to be utilized for exposure during fluoroscopic-guided interventions only and not for any other imaging modality. The evaluation is on a per procedure basis and is not a lifetime cumulative dose. The Subcommittee also inquired about how the equipment time and the specialties explained that the time was calculated based on the component times of the survey, crosschecked with survey responses. Equipment items, *computer, desktop, w-monitor* (ED021) and *Technologist PACS workstation* (ED050) are used at the same time and unavailable for other use during the times indicated on the PE spreadsheet. The PACS workstation generally cannot have software such as spreadsheets and word processing, so both machines are required during the service. Some PE Subcommittee members were concerned about the granularity of the practice expense survey as well as concerned about overlap in the physicist work, especially in clinical activities, CA012 *Review requisition, assess for special needs*, CA014 *Confirm order, protocol exam* and CA021 *Perform procedure/service---NOT directly related to physician work time*. The expert panel explained that some of the descriptions of work are similar not because of overlap but rather because certain similar tasks must be done multiple times. The presenters explained that the PE Survey was intentionally explicit to avoid overlap. For example, the for clinical activity CA012, the medical physicist reviews information in PACS multiple times over several days. The specialty also clarified that it is critical to do a detailed review of the case, protocol the exam and confirm the order for each individual case because the reference radiation dose level is different for each patient and each institution. The specialty also clarified that the reference levels are intentionally broad so the medical physicist might be contacted to do an initial investigation and may determine that the service does not need to be performed, in fact, in roughly 95% of inquiries the medical physicist determines that the service is not necessary and the code is not utilized. For clinical activity CA014, the physicists looks at the images in the medical record and determines if there is enough information, whereas the clinical activity CA021 only occurs after CA014, likely on a different day and that is when the calculations are done and the medical physicist physically goes to the angiography lab and determines in retrospect the positioning of the patient. This step is critical in calculating the dose to the skin. The physicist will also spend time during

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CA021 talking to the technicians and doing measurement in the angiography room to determine dose indices. Clinical activity CA034 is distinct from other clinical activities as it is the final documentation of the different calculations across the days. This is when the medical physicist formalizes and describes the dose as well as determines assumptions about overlap of imaging fields to find the maximum dose for the patient. So that the physician can be confident about the safety of future treatment options for the patient, the report includes dose effect metrics regarding what the dosage means for the patient. Each patient is unique just by the fact of getting to the stage were this service is needed, so there is no possibility for a template report.

The PE Subcommittee asked for additional clarification about the context in which this service would be provided. The specialties explained that the code is used in cases where the dose of radiation was delivered in a complex procedure and there was not an option for the interventional radiologist to do something different or terminate the procedure. Often the patients have a high body mass index, and this amplifies the dose. The code is not performed because of an error on the physician's part— rather typically the procedure had to be completed knowing there could be adverse consequences and complications to the patient. The valuable information obtained through this evaluation is important to the physician, patient and family for continuity of care and future treatment decisions. The radiation safety committee for the state and the hospital are all interested in this information. Also, the Joint Commission needs to know that the provider has a policy in place to do this evaluation if necessary. Finally, the PE Subcommittee questioned if equipment item, ER050 *phantom, solid water calibration check* is essential to this procedure. The presenters explained that the equipment is used for a crucial step in the procedure in the angiography room to double check calculations and validate the work that has been done. The presenters added that a full hour in the angiography room, also indicated by the survey respondents, using ER050 *phantom, solid water calibration check* to validate the work, is reasonable and expected. The presenters also confirmed that this is not routine quality improvement work. The PE Subcommittee ultimately decided that however the time is apportioned, the aggregate median time of the survey is accurate for an evaluation of this complexity. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Ophthalmic Ultrasound Anterior Segment (Tab 17)
David Glasser, MD (AAO); Parag Parekh, MD (ASCRS); Gayatri Reilly, MD (ASRS) and Ankoor Shah, MD (AAO)

CPT code 76513 was initially identified for review based on volume growth. Volume has remained flat at approximately 27,000 since 2014. The increased volume prior to 2014 was attributed to improved equipment. In October 2018, a list of RUC referrals for CPT Assistant articles from 2013-2016 were reviewed and seventeen codes were identified. Action plans were requested for January 2019 and the RUC subsequently recommended that code 76513 be surveyed for April 2019. At the April 2019 RUC meeting, the specialty societies requested to refer this service to the CPT Editorial Panel for revision. In preparing to survey, it was found that the procedure was typically performed bilaterally. The specialties noted their intent to submit a code change application with a change to the descriptor to include "unilateral or bilateral" for the September 2019 CPT Editorial Panel meeting, thus the RUC recommended referral. In September 2019, the CPT Editorial Panel approved revision of the code for anterior segment ophthalmic ultrasound to clarify that it is reported for either unilateral or bilateral.

CPT codes 76510, 76511, 76512 and 76514 were initially included as part of the family with CPT code 76513 to be surveyed for the January 2020 RUC meeting. However, the specialty societies asserted that CPT code 76513 is not part of a family with any of the other codes in the Diagnostic Ultrasound, Head and Neck section of CPT. The other ophthalmic ultrasound codes in that section (CPT 76510-76512, 76514-76529) are used to image other anatomic sites in the eye (cornea, retina, axial length) for other diagnoses (corneal thickness, retinal pathology, pre-cataract surgery lens implant calculations, foreign body localization). In contrast, CPT code 76513 is used to image the anterior segment (anterior chamber,

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angle, iris, and posterior chamber). The societies affirmed that current values should be maintained for those codes which were suggested as potentially being part of the same family, CPT codes 76510, 76511, 76512 and 76514. These codes have all been surveyed within the last three years. All have also been converted from unilateral to bilateral and reduced in their payments to eliminate any duplication with a provided office visit whether they are performed together or not. The RUC agreed with the specialty societies' assessment of the code family and the surveying of only CPT code 76513.

76513 ***Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral***
The RUC reviewed the survey results from 33 ophthalmologists and retina specialists and determined that the survey 25th percentile work RVU of 0.60 accurately reflects the physician work necessary for this service. CPT code 76513 is typically used to identify the etiology of a persistent narrow angle in the face of a patent peripheral iridotomy. It differentiates between normal and abnormal anatomic variability and pathologic posterior iris and ciliary body lesions including detachments, inflammatory conditions, and tumors. It is typically performed on the same day as an Evaluation and Management (E/M) office visit. The RUC recommends 3 minutes pre-service time, 10 minutes intra-service time and 2 minutes immediate post-service time. The 10-minute median intra-service time is consistent with the physician acquiring the image as well as performing the interpretation. Physicians typically acquire the image to ensure that all quadrants are completely visualized to rule out any pathology that is unknown and invisible prior to imaging. The survey pre-service time was reduced from 6 to 3 minutes and the survey post-service time from 6 to 2 minutes because the service is typically performed with an office or eye visit code. In addition to reviewing prior test results and the referring physician notes, the physician typically adjusts the ultrasound machine settings after the technician has turned it on, positions the patient, anesthetizes the cornea and applies ultrasonic gel as part of the pre-service work. Two minutes is required for post-service work which includes irrigating the cornea, instructing the patient on lubricants and symptoms suggestive of corneal injury, reviewing the results with the patient, and dictating a report for the EHR and referring physician.

The RUC noted that CPT code 76513 has never been RUC surveyed, thus the current times are CMS/Other and not valid for comparison. In this case, the code was crosswalked to one of the other ultrasound codes when it was first created and valued. The CMS/Other time source makes it impossible to compare the current numbers to the times and values derived from the survey results. The RUC further noted the significant reduction in utilization that is expected from the revised code (a 26 percent reduction in utilization) because it now includes both unilateral and bilateral. The current code was typically reported twice but now will only be reported once whether performed unilaterally or bilaterally. Based on the current frequency of billing two units, AMA analysis suggests that the code descriptor change along with the recommended new work value will result in an approximate 33% reduction in payment.

The RUC compared CPT code 76513 to the top key reference code 76512 *Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)* (work RVU = 0.56, 3 minutes pre-service time, 11 minutes intra-service time and 2 minutes immediate post-service time) and noted that the survey code has one minute less intra-service time and slightly higher intensity. Sixty percent of respondents that selected the reference code ranked the survey code as more intense and complex relative to the key reference service. The reason this procedure is more intense than other retinal ultrasounds is because the potential diagnoses are more diverse, including the possibility of a tumor hidden behind the iris, and the entire 360 degrees of the ciliary body must be imaged. Imaging the anterior segment is more challenging than imaging the retina more posteriorly, requiring greater technical skill and patient cooperation.

For additional support, the RUC referenced CPT code 74210 *Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast*

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(eg, barium) study (work RVU = 0.59, 3 minutes pre-service time, 10 minutes intra-service time and 2 minutes immediate post-service time) noting that the codes have identical times and nearly identical work values. The RUC concluded that CPT code 76513 should be valued at the 25th percentile work RVU of 0.60 as supported by the survey. **The RUC recommends a work RVU of 0.60 for CPT code 76513.**

Affirmations
The RUC affirms the October 2016 RUC recommendations for CPT codes 76510, 76511 and 76512, and affirms the current 2020 work RVU of 0.14 for CPT code 76514.

Practice Expense
The Practice Expense Subcommittee had an extensive discussion about the potential for duplication or overlap between different clinical staff and the physician as well as discussing the need for the new supply item, ClearScan ultrasound probe cover (water-filled condom covers). Ultimately, the Subcommittee accepted the original spreadsheet for CPT code 76513 and made no changes. The Subcommittee reviewed and affirmed the inputs from October 2016 for the other four codes without modification. **The RUC recommends the direct practice expense inputs for CPT code 76513 as submitted by the specialty society and recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee for CPT codes 76510, 76511, 76512 and 76514.**

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

External Extended ECG Monitoring (Tab 18)
Mark Schoenfeld, MD (HRS); David Slotwiner, MD (HRS) and Richard Wright, MD (ACC)

In September 2019, the CPT Editorial Panel replaced four Category III codes with eight new Category I codes to report external electrocardiographic (ECG) recording by continuous rhythm recording and storage for periods longer than 48 hours. The existing Holter monitor codes (93224-93227) that include up to 48 hours of continuous recording were also reviewed as part of this family of services.

Holter Monitors – Up to 48 Hours

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***
The RUC reviewed the survey results from 72 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 0.39 for CPT code 93227, the professional interpretation component only code. The RUC recommends 2 minutes pre-service evaluation time, 8 minutes intra-service time and 5 minutes immediate post-service time.

The discussion of this code started with a broader discussion of the entire family of codes. The work for external electrocardiographic recording begins when the technician sets up the patient with the monitor, explains how to use the monitor and educates the patient on how to use the accompanying diary. The patient is instructed to return to the office 24-48 hours later to remove the device. At that time, the technician scans the data, tabulates the frequencies of arrythmias, noting any abnormalities, and creates a preliminary report for the physician to review. The technician work is not included in this professional component only code, CPT code 93227. The work captured in CPT code 93227 includes the physician reviewing the logged diaries, preliminary report and providing the final interpretation and report.

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The RUC discussed what has changed for this service since its last RUC review in 2010. The specialty societies indicated that no significant change in the work of interpreting the results of 24-48-hour Holter monitoring has occurred, but that the monitoring technology has improved and the data somewhat easier to review. Therefore, the explanation for the decrease in survey physician time is unclear. The specialty did point out that data received for the 24-48 hour codes compared to the up to 7 days or 14 days is not linear. The data from these different reporting periods reflects different indications, tabulating heart rates and ventricular beats. The data for the shorter up to 48 hour monitoring may have similar data as with the 7-14 day monitors but the frequency of events is generally higher. The extended monitors are normally used for patients with less frequent symptoms, therefore the physician must extend the duration to capture these events.

The RUC compared 93227 to the top two key reference services and determined that 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU = 0.30, 5 minutes intra-service time and 11 minutes total time) requires less physician work and time to complete and 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.52, 7 minutes intra-service time and 17 minutes total time) requires the same physician time and intensity to perform. For additional support, the RUC referenced MPC codes 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32) and 92250 *Fundus photography with interpretation and report* (work RVU = 0.40) and comparable code 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)* (work RVU = 0.40). **The RUC recommends a work RVU of 0.39 for CPT code 93227.**

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***

The specialty society indicated, and the RUC agreed, that the physician work for this composite code (the sum of 93225, 93226 and 93227) should be the same as the professional interpretation component only code 93227. The RUC recommends 2 minutes pre-service evaluation time, 8 minutes intra-service time and 5 minutes immediate post-service time. **The RUC recommends a work RVU of 0.39 for CPT code 93224.**

93225 ***External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)***
93226 ***External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report***

CPT codes 93225 and 93226 are practice expense only services performed by an electrodiagnostic technologist (L037A) to obtain the recording or provide the scanning analysis with report. CPT code 93225 is typically performed in a physician's office and 93226 is typically performed in an independent diagnostic testing facility (IDTF). After extensive discussion the PE Subcommittee determined that it is appropriate to remove supply item SA002 *kit, ambulatory Holter* from CPT code 93225 and add this supply to CPT code 93226. Although SA002 is utilized by the technologist in the office, it is typically supplied by the IDTF to the practice rather than separately assembled/purchased by the practice itself. For rhythm clinics that report these services globally, the ambulatory Holter kit and Holter monitor would be included in CPT code 93224. Similarly, the equipment time of 1,474 minutes for equipment item, EQ127 *Holter monitor* is appropriately allocated to CPT code 93226 because the IDTF owns the Holter monitor. The equipment time is calculated by summing the default formula for clinical staff time allocated to CPT

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code 93225 plus the time the monitor is in use by the patient. This includes the clinical staff activities to connect and disconnect the Holter (34 minutes) and adding 1,440 minutes to reflect a typical 24-hours of time the device is worn by the patient for recording. Although both codes indicate that recording can be up to 48 hours and the specialty recommended an average of 1.5 days, the PE Subcommittee determined that it is not appropriate to use an average, but rather the typical. For example, if a patient did return with the Holter monitor after 1.5 days, it would be the in middle of the night. Ultimately it was determined that 24 hours is the typical amount of time that the device is worn by the patient.

Long-Term Continuous Recorders
48 Hours – Up to 7 Days

93244 ***External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation***
The RUC reviewed the survey results from 72 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 0.50 for CPT code 93244, the professional interpretation component only code. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time and 5 minutes immediate post-service time.

The technology for this external electrocardiographic recording is quite different than the Holter monitor. For these longer recording devices, the patient wears one small patch with two electrodes. The device is placed by the technician in the physician office and the patient is educated on the use of the device and the log diary. However, the patient does not return to the physician office to have the device removed. Rather, the device is returned directly to the device manufacturer who then scans the device. The IDTF has technicians who scan the data and create a preliminary report that is sent to the physician. The technician clinical staff work is not included in this professional component only code, CPT code 93244. The physician work captured in CPT code 93244 includes the physician reviewing the preliminary report and interpreting a final report.

The RUC compared 93244 to the top two key reference services and determined that 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.52, 7 minutes intra-service time and 17 minutes total time) requires similar physician work and time to complete and 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/ or pharmacological stress; supervision only, without interpretation and report* (work RVU = 0.45, 15 minutes intra-service time and 19 minutes total time) requires similar physician time and intensity to perform. For additional support, the RUC referenced MPC code 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU = 0.54, 10 minutes intra-service time and 22 minutes total time). **The RUC recommends a work RVU of 0.50 for CPT code 93244.**

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***
The specialty society indicated, and the RUC agreed, that the physician work for this composite code (the sum of 93242, 93243 and 93244) should be the same as the professional interpretation component only code 93244. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time and 5 minutes immediate post-service time. **The RUC recommends a work RVU of 0.50 for CPT code 93241.**

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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)***
93243 ***External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report***
CPT codes 93242 and 93243 are practice expense only services utilizing new technology supply item, *extended external ECG patch, medical magnetic tape recorder (ECG patch)*. CPT code 93242 is performed by an electrodiagnostic technologist (L037A) to obtain the recording and is typically provided in a physician's office and CPT code 93243 is performed by both an electrodiagnostic technologist (L037A) and a cardiovascular technician (L038B) to provide the scanning analysis with report and is typically performed in an IDTF. Although the new supply, *ECG patch,* is applied by clinical staff in the office, it is typically provided by the IDTF to the practice rather than purchased by the practice itself. For rhythm clinics that report globally, the patch would be included in CPT code 93241. The clinical staff work involved in applying the patch in 93242 includes the following: the patch is registered in the system and synced. Staff attach the device by applying adhesive patches after skin preparation that includes abrading the skin and cleaning of adhesive patch sites with alcohol pads and waiting for those areas to thoroughly dry. The device is activated and validated.

The RUC recommends 12 minutes allocated to CA021, *perform procedure/service---NOT directly related to physician work time* for this work. Typically, the patch is removed by the patient themselves and delivered to the IDTF. The clinical staff work involved with scanning analysis with report in 93243 in the IDTF includes the following: An electrodiagnostic tech (L037A) completes initial steps for scanning analysis. Incoming patch deliveries are sorted and distributed to work queues. The return box is opened, diary book removed, top housing is removed using a custom tool to expose USB connection, and device is plugged in to extract serial number and diagnostic logs. Device serial number is compared to the online patient registration; similarly, patient initials are validated against registration data (to ensure both serial number and patient ID). Discrepancies are entered into system for resolution. Diary content/entries are data entered into the patient record, creating a log of noted events and patient identified symptoms. Confirmation is made of readiness of patch recording for uploading. Transfer is initiated of extracted data to upload server and transfer same data to the cloud and initiate algorithm processing. Diagnostic logs and device recording are reviewed. Device circuit board is physically extracted to inspect for physical damage. Circuit board is allocated and logged for recycling of components. Other recycled and waste materials are separated into appropriate receptacles. The workspace is cleaned. The RUC recommends 24 minutes allocated to CA021, *perform procedure/service---NOT directly related to physician work time* for this work. A second clinical staff type, cardiovascular technician (L038B), completes the scanning analysis. Clinical staff review data, rhythms, and beats to identify the various types of abnormalities (blocks, ectopics, AF, tachycardias, etc.) to include in the multiple page reports. These are custom generated by the cardiovascular technician for every case. After data analysis, the staff generates a report and completes a quality verification before report release. The specialty society consulted with IDTFs that provide the service. The IDTFs informally queried technicians deemed to be efficient by managers and the typical time for scanning analysis and report generation was 76 minutes. The RUC recommends 76 minutes allocated to CA021, *perform procedure/service---NOT directly related to physician work time* for this work.

The RUC is steadfast in its policy that all information and invoices regarding pricing are only informational and provided with the RUC practice expense recommendations when appropriate for CMS use in determining appropriate pricing. The RUC does not make recommendations about the purchase price of supplies and equipment. Generally, the RUC would not provide information about the cost of supplies and equipment in the RUC recommendations document. However, the RUC is providing clarifying information for this new technology. Because the scanning analysis code (93243) is currently reported by IDTFs directly to Medicare and the patch is provided and not purchased by the physician practice for the recording code (93242), the specialty society was not able to provide a traditional invoice for the *extended external ECG patch, medical magnetic tape recorder*. However, the society did present a method whereby the

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company/IDTF that is the dominant provider of extended ECG services up-to-15 days summarized a weighted median of services provided 1/1/17-10/31/19. That table is presented below and can also be found in the PE SOR for these codes. The specialty society presents this as a reasonable proxy for the various patch technologies that are typically used for 7-day services. In addition, CMS and its contractors have been paying for these services under Category III codes 0297T since 2013. The Agency should have the necessary information to parse out appropriate average pricing for the patch used in both the 7-day and the 15-day service based on contractor pricing.

	# Claims	Weighted Median
Contracted/Commercial	336,281	$525
Contracted/Medicare	37,410	$350
Contracted/Medicaid	2,107	$400
Non-contracted	2,862	$375
Client bill	15,002	$300
Self-pay	18,218	$200
Total	**411,880**	**$497**
Minus 93247 Rec. Inputs		-$58.06
Patch Price		**$438.94**

The PE Subcommittee also clarified that supply item SA002 *kit, ambulatory Holter* is included in the services that include the *ECG patch*, not because the ECG patch is a Holter, but because services utilizing the patch also require the supplies included in the kit such as gloves, swabs and razors to apply the patch. Finally, equipment item ED021 *computer, desktop, w-monitor* is included for all codes that include scanning analysis with report (93243 and 93241) using the default formula because clinical staff use the computer to perform the data download, analysis, and report generation.

Long-Term Continuous Recorders
Greater than 7 Days – Up to 15 Days

93248 ***External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation***
The RUC reviewed the survey results from 71 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 0.55 for CPT code 93248, the professional interpretation component only code. The RUC recommends 5 minutes pre-service evaluation time, 12 minutes intra-service time and 5 minutes immediate post-service time.

The technology for this service is quite different than the Holter monitor. For these longer recording devices, the patient wears one small patch with two electrodes. The device is placed by the technician in the physician office and the patient is educated on the use of the device and the log diary. However, the patient does not return to the physician office to have the device removed. Rather, the device is returned directly to the device manufacturer who then scans the device. The independent diagnostic testing facility (IDTF) has technicians who scan the data and create a preliminary report that is sent to the physician. The physician reviews the preliminary report and interprets a final report. This service requires slightly more physician time and work than 93244, as more data is collected than with the up to 7 days recordings. The physician work captured in CPT code 93248 includes the physician reviewing the preliminary report and interpreting a final report.

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The RUC compared 93248 to the top two key reference services and determined that 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.52, 7 minutes intra-service time and 17 minutes total time) and 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* (work RVU = 0.52, 6 minutes intra-service time and 16 minutes total time) require similar physician work and intensity to perform. For additional support, the RUC referenced MPC codes 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU = 0.54, 10 minutes intra-service time and 22 minutes total time) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69, 10 minutes intra-service time and 23 minutes total time). **The RUC recommends a work RVU of 0.55 for CPT code 93248.**

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***

The specialty society indicated, and the RUC agreed that the physician work for this composite code (the sum of 93246, 93247 and 93248) should be the same as the professional interpretation component only code 93248. The RUC recommends 5 minutes pre-service evaluation time, 12 minutes intra-service time and 5 minutes immediate post-service time. **The RUC recommends a work RVU of 0.55 for CPT code 93245.**

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)***
93247 ***External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report***

CPT codes 93246 and 93247 are practice expense only services utilizing new technology supply item, *extended external ECG patch, medical magnetic tape recorder (ECG patch)*. CPT code 93246 is performed by a electrodiagnostic technologist (L037A) to obtain the recording and is typically provided in a physician's office and 93247 is performed by both a electrodiagnostic technologist (L037A) and a cardiovascular technician (L038B) to provide the scanning analysis with report and is typically performed in an IDTF. Although the new supply, *ECG patch,* is applied by clinical staff in the office, it is typically provided by the IDTF to the practice rather than purchased by the practice. For rhythm clinics that report globally, the patch would be included in CPT code 93245. The clinical staff work involved in applying the patch in 93246 includes the following: The patch is registered in the system and synced. Staff attach the device by applying adhesive patches after skin preparation that includes abrading the skin and cleaning of adhesive patch sites with alcohol pads and waiting for those areas to thoroughly dry. The device is activated and validated. The RUC recommends 12 minutes allocated to CA021, *perform procedure/ service---NOT directly related to physician work time* for this work. Typically, the patch is removed by the patient themselves and delivered to the IDTF. The clinical staff work involved with scanning analysis with report in 93247 in the IDTF includes the following: An electrodiagnostic tech (L037A) completes initial steps for scanning analysis. Incoming patch deliveries are sorted and distributed to work queues. The return box is opened, diary book removed, top housing is removed using a custom tool to expose USB connection, and device is plugged in to extract serial number and diagnostic logs. Device serial number is compared to the online patient registration; similarly, patient initials are validated against registration data (to ensure both serial number and patient ID). Discrepancies are entered into system for resolution. Diary content/entries are data entered into the patient record, creating a log of noted events and patient identified symptoms. Confirmation is made of readiness of patch recording for uploading. Transfer is initiated of the extracted data to upload server and transfer same data to the cloud and initiate algorithm processing. Diagnostic logs and device recording are reviewed. Device circuit board is physically extracted to inspect for physical

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damage. Circuit board is allocated and logged for recycling of components. Other recycled and waste materials are separated into appropriate receptacles. The workspace is cleaned.

The RUC recommends 24 minutes allocated to CA021, *perform procedure/service---NOT directly related to physician work time* for this work. A second clinical staff type, cardiovascular technician (L038B), completes the scanning analysis. Clinical staff review data, rhythms, and beats to identify the various types of abnormalities (blocks, ectopics, AF, tachycardias, etc.) to include in the multiple page reports. These are custom generated by the cardiovascular technician for every case. After data analysis, the staff generates a report and completes a quality verification before report release. The specialty society consulted with IDTFs that provide the service. The IDTFs informally queried technicians deemed to be efficient by managers and the typical time for scanning analysis and report generation was 104 minutes. The RUC recommends 104 minutes allocated to CA021, *perform procedure/service---NOT directly related to physician work time* for this work.

The RUC is steadfast in its policy that all information and invoices regarding pricing are only informational and provided with the RUC practice expense recommendations when appropriate for CMS' use in determining appropriate pricing. The RUC does not make recommendations about the purchase price of supplies and equipment. Generally, the RUC would not provide information about the cost of supplies and equipment in this document; however, the RUC is providing some clarifying information for this new technology. Because, the scanning analysis code (93247) is currently reported by IDTFs directly to Medicare and the patch is provided and not purchased by the physician practice for the recording code (93246), the specialty society was not able to provide a traditional invoice for the *extended external ECG patch, medical magnetic tape recorder*. However, the society did present a method whereby the company/ IDTF that is the dominant provider of extended ECG services up-to-15 days summarized a weighted median of services provided 1/1/17-10/31/19. That table is presented below and can also be found in the PE SOR for these codes. The specialty society presents this as a reasonable proxy for the various patch technologies that are typically used for 7-day services. In addition, CMS and its contractors have been paying for these services under Category III codes 0297T since 2013. The Agency should have the necessary information to parse out appropriate average pricing for the patch used in both the 7-day and the 15-day service based on contractor pricing.

	# Claims	**Weighted Median**
Contracted/Commercial	336,281	$525
Contracted/Medicare	37,410	$350
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Total	**411,880**	**$497**
Minus 93247 Rec. Inputs		-$58.06
Patch Price		**$438.94**

The PE Subcommittee also clarified that supply item SA002 *kit, ambulatory Holter* is included in the services that include the *ECG patch*, not because the ECG patch is a Holter, but because services utilizing the patch also require the supplies included in the kit such as gloves, swabs and razors to apply the patch. Finally, equipment item ED021 *computer, desktop, w-monitor* is included for all codes that include scanning

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analysis with report (93247 and 93245) using the default formula because clinical staff use the computer to perform the data download, analysis, and report generation.

Practice Expense
The Practice Expense Subcommittee made minor adjustments to supply items for gloves and alcohol wipes. The Subcommittee meticulously reviewed the equipment minutes to ensure they were correct. Such as, how long the equipment was in use and that the owner of the equipment received the correct equipment minutes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

New Technology/New Service
The RUC recommends that 93241-93248 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Prolonged Services (Tab 19)
Megan Adamson, MD (AAFP); Amy Aronsky, DO (AOA); Joshua M. Liao, MD (ACP); Korrine Van Keuren, DNP (ANA) and Elisabeth Volpert, DNP (ANA)

In September 2019, the CPT Editorial Panel added a new table to the CPT introductory language for Prolonged Services that illustrates the elements of all existing and new prolonged care services and how they are to be reported. This clarification was in response to a request of CMS in the July 2019 Proposed Rule for the 2020 Medicare Physician Payment Schedule. CMS also stated that the valuation of CPT codes 99358 and 99359 be reviewed.

In the Final Rule for 2020, CMS indicated:

> Since Medicare began separately paying for CPT codes 99358-99359 in 2017 under the PFS, their PFS utilization has increased more than ten-fold from approximately 10,000 claim lines in 2016 to approximately 126,000 claim lines in 2018. While this remains a small percentage of E/M visit claims, utilization may further increase once all office/outpatient E/M visits can be reported based on time alone and new activities such as documenting clinical information are explicitly counted as qualifying time. We continue to believe that the new CPT prefatory language on these codes is difficult to follow and interpret. For example, it states, "for prolonged time without direct patient contact on the date of office or other outpatient services, use 99XXX. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to-face encounter." But for CPT code 99XXX it states not to report 99XXX in conjunction with 99358, 99359 which could mean not to report 99358-99359 if 99XXX is reported, even on a separate day. Additionally, CPT would allow reporting at the midpoint of time for CPT codes 99358-99359 but not 99XXX, and these codes have discrepant time increments (one hour for CPT codes 99358-9 reportable after the midpoint, and 15 minutes for CPT code 99XXX not reportable after the midpoint). Under the new CPT framework allowing the use of time to select visit level and the new list of qualifying activities, there is a new Medicare program vulnerability and potential increased beneficiary cost sharing associated with the inability to assess what visit(s) prolonged service codes reported on a date other than the visit are associated with and, accordingly, to assess whether the prolonged time was reasonable and necessary. If more than one visit was furnished (for example, if a beneficiary has an inpatient visit or another outpatient

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> visit by the same practitioner within a wide time range of a given office/outpatient visit), it would not be clear which visit the prolonged time reported under CPT codes 99358-99359 is associated with for evaluating medical necessity and increments of time in relation to the base/companion code.
>
> We continue to believe it would be administratively simpler and improve payment accuracy and program integrity to have only a single add-on code specific to prolonged office/outpatient E/M visits that is clearly linked to the companion E/M office/outpatient visit code. **We believe that under the new coding framework, CPT codes 99358-99359 are potentially misvalued, need to be revised for clarity and present new program integrity challenges**. Therefore, we are finalizing our proposal that CPT codes 99358-99359 will not be payable in association with office/outpatient E/M visits beginning in CY 2021. We will consider future changes made to these codes by the CPT Editorial Panel or the RUC for possible future rulemaking. We note that a number of other codes such as CCM, TCM, and other care management codes may be used to report time spent outside the direct patient contact on dates other than the office/outpatient visit, if the reporting requirements for those services are met. While these care management codes are not identical to the prolonged visit codes, they can be used to report a number of similar activities.

In January 2020, no specialty societies indicated an interest to survey these services. The American Academy of Family Physicians indicated that they interpreted the CPT changes as editorial only. In the Final Rule, CMS had ongoing concern and confusion with 99358 and 99359 and their guidelines, even in the wake of the CPT Editorial Panel's action in September 2019. Further, the specialty societies would like to address questions and concerns that CMS has in this regard, so these prolonged services codes may be appropriately used in conjunction with the E/M office visit codes in 2021 and beyond, after needed CPT clarification. The specialty societies recommended that these services be referred to CPT prior to a resurvey of these services.

The RUC discussed this issue and recommends that CPT codes 99358 and 99359 be referred to the May 2020 CPT Editorial Panel to clarify how these services may be reported with other Evaluation and Management (E/M) services.

> **<u>Chronic Care Management Services (Tab 20)</u>**
> **Megan Adamson, MD (AAFP); Amy Aronsky, DO (AOA); Audrey Chun, MD (AGS); Joshua M. Liao, MD (ACP); Korrine Van Keuren, DNP, (ANA) and Elisabeth Volpert, DNP (ANA)**

In September 2019, the CPT Editorial Panel revised CPT code 99490 to describe the first 20 minutes of clinical staff time and created a new add-on code to describe each additional 20 minutes of clinical staff time for chronic care management (CCM) services. The Panel also revised codes 99487 and 99489 to eliminate the requirement to establish a care plan and revised the chronic care management services guidelines.

During the process of the societies preparing to survey, CMS published its Final Rule for CY2020, which included the creation of several new care management HCPCS codes. These included two codes for principal care management and code G2058, which has a descriptor identical to that of 99439. When these codes were released, the specialty societies decided to submit a code change proposal to CPT for the May 2020 meeting. This proposal would establish new principal care management codes, like those in the Final Rule. Because these new codes would potentially be part of the CCM family, the entire CCM family would need to be surveyed after the codes were approved by CPT. Specifically, assuming the new

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principal care management codes are approved at the May 2020 CPT meeting, the entire CCM family will need to be surveyed for the October 2020 RUC meeting. Therefore, if the specialty societies surveyed the CCM family for the January 2020 RUC meeting because of new code 99439, the exact same family of codes would need to be surveyed again for the October 2020 RUC meeting.

Since CMS had already established payment for the new codes for CY 2020 (including G2058), the specialty societies met with the Research Subcommittee and requested to make a presentation to the RUC requesting a temporary crosswalk to value 99439 on an interim basis for 2021 before it is surveyed in 2020 as part of the 2022 CPT and Medicare Physician Payment Schedule. The specialty societies also requested to
recommend maintaining the current value of the existing CCM codes until the entire family is surveyed later in 2020.

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)

The RUC reviewed the recommended interim crosswalk of 0.54 work RVUs and 15 minutes intra-service time for CPT code 99439. The RUC agreed with the specialty societies to crosswalk the work value and time for CPT code 99439 to CPT code 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)* (work RVU = 0.54 and 15 minutes intra-service time). The specialty societies also indicated CPT code 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)* (work RVU = 0.54 and 15 minutes intra-service time), which the RUC agreed is also an appropriate interim crosswalk for the physician work and time required to perform 99439. The RUC notes that the recommended 15 minutes of intra-service and the work RVU are the same as that of G2058 *Chronic care management services, 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 = 0.54 and 15 minutes intra-service time) as assigned by CMS. **The RUC recommends an interim work RVU of 0.54 for CPT code 99439.**

Practice Expense

The RUC recommends crosswalking the clinical staff time of 20 minutes CA021 *Perform procedure/service—NOT directly related to physician work time* L037D *RN/LPN/MTA* to CPT code 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.* **The RUC recommends the direct practice expense inputs as submitted by the specialty society for 99439. The RUC affirmed the direct practice expense inputs for 99490, 99491, 99487 and 99489.**

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Refer to CPT
The specialty societies are developing a CPT coding change application (CCA) to establish two principal care management codes for the May 2020 CPT Editorial Panel meeting. CPT codes 99490, 99439, 99491, 99487 and 99489 will be resurveyed as part of this family of services.

X. CMS Request/Relativity Assessment Identified Codes

Fine Needle Aspiration (Tab 21)
Curtis Anderson, MD (SIR); Lauren Golding, MD (ACR); R Peter Manes, MD (AAO-HNS); Lance Manning, MD (AAO-HNS); Swati Mehrotra, MD (CAP); Andrew Moriarity, MD (ACR) and Kurt Schoppe, MD (ACR)

In November 2018, AMA RUC staff discovered that CMS erroneously double-counted the utilization for new codes that had image guidance bundled, causing the Agency to incorrectly believe that the RUC was recommending a 20 percent increase in physician work for the Fine Needle Aspiration code family. Based on the Agency's rationale articulated in rulemaking for CY2019, it appeared that this was the principle reason CMS rejected the RUC recommendations for the codes in these two families. AMA RUC Staff clarified the error on a call with CMS officials in December 2018 and the three Agency officials verbally concurred that the Agency's analysis had a utilization crosswalk error. AMA RUC staff requested for the Agency to reconsider their rejection of the RUC recommendations for CY2019. They declined to do so for CY2019, noting that their utilization projections in the NPRM addenda materials were available for public comment. However, the CMS officials offered that the surveying specialties could write a letter to CMS to nominate the affected codes from these families as being potentially misvalued. Once flagged, these services could again be added to the RUC's agenda for an upcoming meeting and the RUC could affirm the previous recommendations. Eight specialty societies submitted a letter to CMS in January 2019. In the CY2020 Medicare Physician Fee Schedule Proposed Rule, the Agency identified two of the codes in this code family for review via their public nomination process for potentially misvalued services and the RUC added this code family to its agenda for the January 2020 RUC meeting.

As part of the Agency's response to the RUC's and other stakeholder's CY2019 NPRM comments, CMS included the below table in the CY2019 Final Rule. For deleted code 10022 FNA w/ guidance, the aggregate utilization for codes 10004-10012 should have exactly equaled the utilization of delete code 10022 FNA w/ guidance. Instead, CMS doubled the utilization since they added the utilization of 10022 to the bundled utilization of each guidance code. For example, in the table below, the utilization of the new code 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* alone was erroneously 1.5 times that of deleted code 10022 *Fine needle aspiration; with imaging guidance*.

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HCPCS code	Utilization source	Utilization destination	Work RVU source	Work pool source	Work RVU destination	Work pool destination	Work pool RVU change	Work pool % change
10021	23,755	21,380	1.27	30,169	1.20	25,655	−4,513	−15
10004	0	2,376	0.00	0	0.80	1,900	1,900	
10005	0	270,753	0.00	0	1.63	441,327	441,327	
10006	0	30,621	0.00	0	1.00	30,621	30,621	
10007	0	6,857	0.00	0	1.81	12,411	12,411	
10008	0	873	0.00	0	1.18	1,030	1,030	
10009	0	60,665	0.00	0	2.43	147,416	147,416	
10010	0	6,831	0.00	0	1.65	11,271	11,271	
10011	0	83	0.00	0	C	0	0	
10012	0	3	0.00	0	C	0	0	
10022	186,455	0	1.27	236,798	0.00	0	−236,798	−100
76942	558,081	488,321	0.67	373,914	0.67	327,175	−46,739	−13
7694226	641,346	561,178	0.67	429,702	0.67	375,989	−53,713	−13
76942TC	8,588	7,515	0.00	0	0.00	0	0	
77002	311,280	308,790	0.54	168,091	0.54	166,746	−1,345	−1
7700226	180,964	179,516	0.54	97,721	0.54	96,939	−782	−1
77002TC	7,936	7,873	0.00	0	0.00	0	0	
77012	9,343	7,792	1.16	10,838	1.50	11,688	850	8
7701226	194,611	162,306	1.16	225,749	1.50	243,458	17,710	8
77012TC	469	391	0.00	0	0.00	0	0	
77021	1,481	1,432	1.50	2,222	1.50	2,148	−73	−3
7702126	1,038	1,004	1.50	1,557	1.50	1,506	−51	−3
77021TC	67	65	0.00	0	0.00	0	0	
Totals	2,125,414	2,126,622		1,576,760		1,897,282	320,523	20

Following correction of the double counting error made in CMS' CY2019 Final Rule table, the table would show a slight reduction in physician work while also counting the total volume of all of the guidance codes as CMS did in the CY2019 Final Rule (even though these image guidance codes are reported with many other procedures unrelated to FNA). **However, if only considering the FNA codes in isolation along with only the volume of the guidance codes that were bundled into the new FNA code structure, the data shows that the October 2017 RUC recommendation resulted in a 15% decrease in physician work for Fine Needle Aspiration Services:**

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HCPCS Code	Utilization Source	Utilization Destination	Work RVU Source	Work Pool Source	Work RVU Destination	Work Pool Destination	Work Pool RVU Change	Work Pool % Change
10021	23,755	21,380	1.27	30,169	1.2	25,656	-4,513	-15%
10004	0	1,188	0	0	0.8	950	950	-
10005	0	135,377	0	0	1.63	220,664	220,664	-
10006	0	15,311	0	0	1	15,311	15,311	-
10007	0	3,429	0	0	1.81	6,206	6,206	-
10008	0	437	0	0	1.18	515	515	-
10009	0	30,333	0	0	2.43	73,708	73,708	-
10010	0	3,416	0	0	1.65	5,636	5,636	-
10011	0	42	0	0	C	0	0	-
10012	0	2	0	0	C	0	0	-
10022	186,455	0	1.27	236,798	0	0	-236,798	-100%
76942	558,081	488,321	0.67	373,914	0.67	327,175	-46,739	-12%
7694226	641,346	561,178	0.67	429,702	0.67	375,989	-53,713	-12%
76942TC	8,588	7,515	0	0	0	0	0	-
77002	311,280	308,790	0.54	168,091	0.54	166,747	-1,345	-1%
7700226	180,964	179,516	0.54	97,721	0.54	96,939	-782	-1%
77002TC	7,936	7,873	0	0	0	0	0	-
77012	9,343	7,792	1.16	10,838	1.5	11,688	850	8%
7701226	194,611	162,306	1.16	225,749	1.5	243,459	17,710	8%
77012TC	469	391	0	0	0	0	0	-
77021	1,481	1,432	1.5	2,222	1.5	2,148	-74	-3%
7702126	1,038	1,004	1.5	1,557	1.5	1,506	-51	-3%
77021TC	67	65	0	0	0	0	0	-
Totals	**2,125,414**	**1,937,094**		**1,576,760**		**1,574,295**	**-2,464**	**-0.16%**

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Affirmation of RUC Recommendations
The RUC noted that the RUC recommendations are higher than the 2020 CMS work values for 10021 *Fine needle aspiration biopsy, without imaging guidance; first lesion* (RUC recommended work RVU=1.20), 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* (RUC recommended work RVU= 1.63) and 10009 *Fine needle aspiration biopsy, including CT guidance; first lesion* (RUC recommended work RVU= 2.43); the RUC recommendations for these services are more appropriate than the current CMS values as the current CMS values create rank order anomalies. The RUC recommendations are strongly supported by the RUC recommendations for CY2019, which the RUC is resubmitting to the Agency. **The RUC affirmed the recent RUC recommendations for physician work and direct practice expense for CPT codes 10021, 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011 and 10012.**

Work Neutrality
Had CMS implemented the RUC recommendations for CY2019, there would have been a 15 percent overall work savings that should have been redistributed back to the Medicare conversion factor. CMS should implement the RUC recommendations and implement in 2021, while also applying the savings to the Medicare conversion factor.

Modified Radical Mastectomy (Tab 22)
Richard Fine, MD (ASBrS); Charles Mabry, MD (ACS); Nader Massarweh, MD (ACS) and Walton Taylor, MD (ASBrS)

The Relativity Assessment Workgroup identified services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. The RUC recommended these services, including 19307, be surveyed for January 2020.

19307 ***Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle***
The RUC reviewed the survey results from 89 breast and general surgeons and recommends: 40 minutes of pre-service evaluation time, 10 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 30 minutes for immediate post-time, 0.5 99238, 1-99214 and 3-99213. The RUC noted that the current times for this service are over 25 years old from the Harvard study and may include data elements for visits that are flawed. During the initial Harvard study, only time were surveyed for postoperative work; data on the number and level of hospital and office post-operative visits were not collected. The hospital total time was estimated at 56 minutes and the office visit total time was estimated at 76 minutes. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm in 1997 several years after the original Harvard study. The specialties provided information that the Harvard times do not line up with the subsequent visits assigned by algorithm. The specialties noted that the total CY2020 time for 1 x 99231 on the day of the procedure and 1 x 99238 the next day equals 58 minutes. This would mean that there is no difference in time from the original Harvard study estimated time of 56 minutes. Similarly, the total CY2020 time for 1 x 99214 and 3 x 99213 equals 109 minutes, which is more than the Harvard study time of 76 minutes for office work. This is the first time the RUC has had the opportunity to review the hospital and office visits for code 19307 and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best.

The RUC also discussed whether reconstruction would typically be performed at the same operative session. The specialties noted that it would be rare for breast reconstruction to be performed by a plastic

surgeon immediately following the radical mastectomy with axillary lymphadenectomy as these patients will likely still need additional radiation treatment.

CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (e.g., 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. If the survey results indicate that a 23-hour stay with a subsequent hospital visit is typical and the Medicare claims data show that the service is typically performed in the outpatient setting, then the surveying specialties may add the post-operative visit intra-service time to the immediate post-operative physician time and not list a subsequent hospital visit in the recommendation. Survey code 19307 meets all of these criteria, as the 2018 Medicare claims data shows that 19307 was performed 73 percent of the time in the hospital outpatient setting, 97 percent of survey respondents indicated their typical patient stays overnight and survey respondents indicated that a same-day 99231 hospital visit is typical. Therefore, it is appropriate to add 10 minutes of time (the intra-service time of 99231) to the immediate postoperative survey time of 20 minutes resulting in 30 minutes of immediate postoperative time.

The RUC reviewed the survey 25th percentile work RVU of 17.99 and agreed that this value appropriately accounts for physician work involved when performing this service. The RUC compared the survey code to CPT code 19303 *Mastectomy, simple, complete* (work RVU =15.00, intra-service time = 90 minutes, total time = 283 minutes) which was recently reviewed by the RUC (2016) and CMS (2018). The RUC noted that the survey code involves much more intra-service and total time than 19303. The RUC agreed with the presenting specialties that the survey code compares most closely to 19303 as it is essentially the work of 19303 plus a lymphadenectomy... The additional time and additional office visit for 19307 are related to the additional work of the axillary lymph node dissection which adds complexity to the procedure and requires additional care of drains, wounds, seromas, and lymphedema. The additional pre-operative time is primarily related to additional positioning. The RUC noted that the reference code also has one 99214 post-operative visit that was recommended by the RUC and approved by CMS for CY2018, supporting the RUC's recommendation for one 99214 for CPT code 19307. At this visit for both codes, there is extensive time required for reviewing pathology reports and counseling the patient on further necessary treatment options, in addition to wound and drain care. To support the recommendation for 19303, the RUC compared the survey code to CPT code 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* (work RVU= 19.00, intra-service time of 120 minutes, total time of 348 minutes) and noted that both services have identical intra-service times and very similar total times. The RUC agreed that the intraoperative intensity of 67113 and 19303 is similar Furthermore, the RUC compared the survey code to MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU= 21.16, intra-service time of 120 minutes, total time of 404 minutes) and noted that although both codes involve identical intra-service time, the reference code involves much more total time, supporting a lower value for the survey code. **The RUC recommends a work RVU of 17.99 for CPT code 19307.**

Practice Expense

The Practice Expense Subcommittee removed the desktop computer that was proposed by the specialties, as the computer would not be solely dedicated to the performance of this service**. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

Closed Treatment of Vertebral Body Fracture(s) (Tab 23)
William Creevy, MD (AAOS); Hussein Elkousy, MD (AAOS); Morgan Lorio, MD (ISASS); Kano Mayer, MD (NASS); Clemens Schirmer, MD (CNS) and Karin Swartz, MD (NASS)

The Relativity Assessment Workgroup (RAW) identified services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. The RUC recommended that these services be surveyed for January 2020. The specialty societies indicated that this service was recently surveyed. The post-operative visits were revised at the April 2018 RUC meeting. The RAW data was based on data prior to these changes for CY 2019. In the 2020 CMS Medicare Physician Fee Schedule Final Rule, released November 1, 2019, CMS finalized the work RVU for CPT code 22310 at 3.45. The specialty societies requested that considering the recent survey, RUC should affirm the 2018 accepted times and the current 2020 work RVU value of 3.45. The current times do not include inpatient visits as the 55 survey respondents indicated their typical patient was discharged either the same day, or on the next day, but less than 24 hours and did not require inpatient visits.

The specialties noted that the current work RVU of 3.45 is below the April 2018 RUC recommended work RVU and considerably below the survey median and 25th percentile work RVU and yields an IWPUT of 0.019. The RUC agreed that the survey from 2018 was appropriate and found no reason to resurvey. The RUC concurred with the specialties' request that the current value be affirmed. It was noted, however, that the original RUC recommendation of 3.75 yielded a more appropriate IWPUT value. **The RUC affirms the April 2018 RUC recommendations for time and the current 2020 work RUV of 3.45 for CPT code 22310.**

Future Review Flag
The RUC questioned the plan for education on the use of CPT code 22310. The specialty societies indicated that they plan to educate members on the appropriate reporting of this service. The plan is for education internally within the specialty, but it was evident that a CPT Assistant article may be warranted to help disseminate education about what place of service is appropriate for this service. **The RUC recommends that the Relativity Assessment Workgroup review this service in three years to examine the site of service and ensure that education has been effective.**

Practice Expense
The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs from April 2018 without modification. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

Repair Recurrent Hernia (Tab 24)
Charles Mabry, MD (ACS); Nader Massarweh, MD (ACS); Don Selzer, MD (SAGES) and Ketan Sheth, MD (SAGES)

In October 2019, the Relativity Assessment Workgroup identified CPT code 49565 as performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2018e Medicare utilization over 5,000. The RUC recommended this service be surveyed for January 2020.

In January 2020, the specialty societies requested that CPT code 49565 be referred to the May 2020 CPT Editorial Panel to update the descriptor to current standard of practice and typical patient presentation; for example, mesh insertion and removal, and size and number of defects. The RUC questioned if CPT codes 49560, 49561, 49566 and/or 49568 are considered part of this family of services. The specialty society indicated they will define the family of services on the coding change application (CCA). **The RUC recommends that these services be referred to the May 2020 CPT Editorial Panel.**

Percutaneous Nephrostolithotomy (Tab 25)
Jonathan Kiechle, MD (AUA); Kyle Richards, MD (AUA) and Thomas Turk, MD (AUA)

The Relativity Assessment Workgroup identified services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. The RUC recommends these services be surveyed for January 2020.

In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. The specialty societies will then survey the new codes for the October 2020 RUC meeting. **The RUC recommends that these services be referred to the CPT Editorial Panel.**

Colpopexy (Tab 26)
Jon Hathaway, MD (ACOG); Jonathan Kiechle, MD (AUA); Kyle Richards, MD (AUA); Mitch Schuster, MD (ACOG) and Thomas Turk, MD (AUA)
Pre-Facilitation: Facilitation Committee #1

The Relativity Assessment Workgroup identified services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. CPT codes 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* and 57283 *Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)* were identified on this screen. The services are now typically performed as an outpatient procedure with at least 90% having an overnight hospital stay for both codes. In 2005 the CPT editorial panel revised CPT code 57282 and created 57283. At that time only 57283 was surveyed as the revisions to 57282 were considered editorial. At the time the RUC recommended 14.00 for 57283 and to maintain what was the current work value of 8.85 for 57282. Although the Agency stated that they agreed with the relativity established by the RUC between the two codes, they did not accept the RUC recommendations and reduced the work value for both services based on a work neutrality adjustment.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to recommend an increase in the value for CPT code 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* and 57283 *Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)* based on evidence that physician work has increased due to different technique and new knowledge based on a change in technology. First, the change in technology is due to functional MRI studies which provide more information on the essential steps. The functional MRI studies have increased what is known about pelvic organ prolapse and what structures are important to successful repair. The specialty society provided a series of articles as supporting documentation to illustrate that knowledge of the pelvic floor and pelvic support is increasing. For 57282 the extent of dissection required to engage these target ligaments and tissues as well as the importance of suturing the tissues with more precision is now standardized. Second, the technique now is different, mostly in that the support sutures are placed at multiple points of attachment, which has increased the intra-service time. Third, the extensive dissection that is required to

isolate the sacrospinous ligament increases risk of trauma and debilitating complications due to the proximity of the sacrospinous ligament to the pudendal nerve and vessel. For CPT code 57283 the extent of dissection required to engage the target ligaments and tissues as well as the importance of suturing the tissues with more precision is now standardized. Second, the extensive dissection that is required to isolate the uterosacral ligament increases risk of trauma and debilitating complications due to the proximity of the uterosacral ligament to the ureter. Thus, the ureter must be checked to confirm that it has not been trapped or kinked in the repair. A RUC member asked what the reason for the drop in utilization is and the specialty societies explained that many patients are having the procedure laparoscopically and increasingly there are fellowships in female pelvic reconstruction surgery (FPRS) that provide a better alternative for some of the patient population. **The RUC agreed that there is compelling evidence that there has been a change in the physician work necessary to perform these services due to a change in technique and knowledge of the problem. The compelling evidence is supported by documentation in the peer-reviewed medical literature.**

57282 ***Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)***
The RUC reviewed the survey results from 127 gynecologists and urologists and determined that the survey 25th percentile work RVU of 13.48 accurately reflects the typical physician work necessary for this service. The RUC recommends 33 minutes evaluation, 8 minutes position and 10 minutes scrub, dress and wait for a total of 51 minutes pre-service time, 88 minutes intra-service time and 25 minutes post-service time. The RUC recommends ½ discharge management (99238) as well as two post-operative visits (99213). The RUC notes that there are 5 extra minutes of positioning time to put the patient in the dorsal lithotomy position. Confirmation that no compression of nerves in the arms, hands, legs and feet is performed and hip flexion is evaluated for possible nerve stretch injury. A RUC member asked the specialty to explain the intra-service time as there is a larger increase in the work RVU recommended when compared to the modest increase in intra-service time. The presenters confirmed that, because this service has not been surveyed, the intra-service time established by the Harvard study is what the current RVU is based on. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times and work RVU (0.014) is inappropriately low for this intense major surgical procedure, not that much higher than the intensity for pre-service scrub/dress/wait time, which strongly implies the current total times are inflated relative to the current work RVU and not valid for comparison to the new times. During the initial Harvard study, only overall post-operative time data was surveyed; data on the number and level of hospital and office post-operative visits were not collected. The hospital total time was estimated at 88 minutes and the office visit total time was estimated at 57.5 minutes. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC has had the opportunity to review the hospital and office visits for code 57282 and also the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times precarious at best. In addition, the difference in the intra-service time can be attributed to the multiple points of attachment which was not done in the past. The largest difference in the total time comes from the hospital visit time assigned by Harvard in 1992. The RUC questioned if patients really stayed in the hospital for 4 days at that time or if the assignment was flawed. A RUC member practicing obstetrics-gynecology and performing these procedures at that time offered a point of information to confirm that it was typical several decades ago for patient to stay in the hospital for several days.

The RUC compared the survey code to the top key reference service, CPT code 57260 *Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;* (work RVU = 13.25, 90 minutes intra-service time and 241 minutes total time), noting that the intra-service and total time are similar and the codes should be valued similarly. The RUC also noted that most survey respondents indicated that CPT code 57282 is somewhat more or much more intense and complex to perform than the key reference code and should be valued slightly higher. The reference code is less intense and complex

to perform because the areas of the vagina are more distal and easier to access, whereas the surveyed code is at the apex of the vagina. Suturing the apex of the vagina to structures further up in the body while also avoiding injury to other areas of the body, such as the spine, increases intensity. The RUC also compared the surveyed code to MPC code 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, 75 minutes intra-service and 236 minutes total time), which has the same post-operative visits and noted that the work values should be similar but the lower intra-service time for the comparator code justifies the lower work value. The RUC also compared the survey code to reference code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)* (work RVU = 13.60, 100 minutes intra-service and 274 minutes total time), noting that the intra-service and total time are similar and the codes should be valued similarly. The RUC also noted that the higher intra-service and total minutes and additional post-operative (99213) visit justifies the higher work value. **The RUC recommends a work RVU of 13.48 for CPT code 57282.**

57283 ***Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)***
The RUC reviewed the survey results from 127 gynecologists and urologists and determined that the survey 25th percentile work RVU of 13.51 accurately reflects the typical physician work necessary for this service. The RUC recommends 33 minutes evaluation, 8 minutes position and 10 minutes scrub, dress and wait for a total of 51 minutes pre-service time, 90 minutes intra-service time and 25 minutes post-service time. The RUC recommends ½ discharge management (99238) as well as two post-operative visits (99213). The RUC notes that there are 5 extra minutes of positioning time to put the patient in the dorsal lithotomy position. Confirmation that no compression of nerves in the arms, hands, legs and feet is performed and hip flexion is evaluated for possible nerve stretch injury. The RUC noted that the IWPUT for the current times and work RVU (0.046) is inappropriately low for this intense major surgical procedure. It is low because when it was surveyed in 2005 by the RUC, the RUC recommended 14.00 for 57283 and CMS did not accept the RUC recommendations and reduced the work value for the service based on a work neutrality adjustment. CMS made no adjustment to the RUC recommended times from 2005 when they greatly reduced the work RVU relative to the RUC recommendation, resulting in the IWPUT dropping inappropriately by 35 percent relative to the RUC recommendation (from 0.071 to 0.046). The RUC agreed that these surgical procedures have changed, noting that a minimum of 3 sutures if required for markedly better outcomes then in the past. The RUC also noted that the surveyed intra-service times for 57282 and 57283 have only 2 minutes difference. The level of intensity and complexity for the two services has converged and the work values should reflect that similarity. The RUC added that, in reviewing 090-day global services reviewed by the RUC within the past 9 years, these work values are only slightly above the median work value. The RUC inquired about the intensity and complexity of these open service as compared to the laparoscopic approach (code 57425) and the specialty society clarified that they are so markedly different that it is difficult to compare.

The RUC compared the survey code to the top key reference service, CPT code 57260 *Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;* (work RVU = 13.25, 90 minutes intra-service time and 241 minutes total time), noting that the intra-service times are identical and the codes should be valued similarly. The RUC also noted that most survey respondents indicated that CPT code 57283 is somewhat more or much more intense and complex to perform than the key reference code and should be valued slightly higher. The RUC also compared the survey code to reference code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)* (work RVU = 13.60, 100 minutes intra-service and 274 minutes total time), noting that the intra-service and total time are similar and the codes should be valued similarly. The RUC also noted that the higher intra-service and total minutes and additional post-operative (99213) visit justifies the higher work value. **The RUC recommends a work RVU of 13.51 for CPT code 57283.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

Laparoscopic Colpopexy (Tab 27)
Jon Hathaway, MD (ACOG); Jonathan Kiechle, MD (AUA); Kyle Richards, MD (AUA); Mitch Schuster, MD (ACOG) and Thomas Turk, MD (AUA)
Pre-Facilitation: Facilitation Committee #1

The Relativity Assessment Workgroup identified services performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period and 2018e Medicare utilization over 5,000. The RUC recommends these services be surveyed for January 2020.

Compelling Evidence
The specialty societies presented compelling evidence for CPT code 57425 based on changes in surgical techniques and technology. Specifically, the technique is now much more standardized than when this service was last surveyed in 2003. All the steps are now standard and must be followed to get a definitive result. Reports of complications from mesh, first introduced in 2003, increased dramatically from 2007-2011 due to different types of meshes used. As a result, the technique was refined and limited the number of meshes available. This decreased the complication rate and has changed the work. Functional MRI studies have provided more information on the essential steps. The functional MRI studies have increased what is known about pelvic organ prolapse and what structures are important for successful repair. The specialty society provided a series of articles as supporting documentation to illustrate that knowledge of the pelvic floor and pelvic support is increasing. Additionally, new information on complications have shown which mesh types to use and the proper way to attach them to the vagina and the sacrum (permanent, monofilament). Avoiding these complications requires more extensive dissection of both sites to identify the lumbar disk and to reperitonealize the mesh. Extending dissection down to the bladder neck anteriorly and to the perineal body posteriorly with increased sutures to secure mesh attachment to the vagina has been shown to avoid additional complications. This dissection is difficult and requires more time, as shown in the survey. The RUC approved the specialty societies' compelling evidence argument based on changes in surgical techniques and technology.

57425 ***Laparoscopy, surgical, colpopexy (suspension of vaginal apex)***
The RUC reviewed the survey results from 104 obstetricians/gynecologists and urologists and determined that the survey 25th percentile work RVU of 18.02 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 50 minutes of immediate post-service time, one half-day discharge (99238), and two office visits (99213). The RUC recommends pre-service time package 3 and post-service time package 9B. The Centers for Medicare & Medicaid Services (CMS) labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (e.g. 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. If the survey results indicate that a 23-hour stay with a subsequent hospital visit is typical and the Medicare claims data show that the service is typically performed in the outpatient setting, then the surveying specialties may add the post-operative visit intra-service time to the immediate post-operative physician time and not list a subsequent hospital visit in the recommendation. Survey code 57425 meets all of these criteria, as the 2018 Medicare claims data shows that it was performed 86 percent of the time in the hospital outpatient setting, 90 percent of survey respondents indicated that their typical patient stays overnight and also indicated that a same-day 99232

hospital visit is typical. Therefore, it is appropriate to add 20 minutes of time (the intra-service time of 99232) to the immediate post-service period to increase the immediate post-service time to 50 minutes.

The RUC initially compared the survey code to both top key reference codes 58572 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;* (work RVU=17.71 and intra-service time of 120 minutes) and 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU= 16.84 and intra-service time of 150 minutes) and noted that the survey code requires more physician time and work than both key reference services and thus valued appropriately. The RUC also compared the survey code to CPT code 69930 *Cochlear device implantation, with or without mastoidectomy* (work RVU= 17.73, intra-service time of 180 minutes, and total time of 387 minutes) and noted that both codes have identical intra-service time, similar total time and should be valued similarly. Additionally, the RUC compared the survey code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180 minutes, and total time of 383 minutes) and noted that both codes have identical intra-servive time and similar total time. The RUC agreed that both reference codes 66930 and 42420 appropriately bracket the survey code, further warranting the recommended survey 25th percentile work value of 18.02. **The RUC recommends a work RVU of 18.02 for CPT code 57425.**

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

X-Ray of Eye (Tab 28)
Melissa Chen, MD (ASNR); Lauren Golding, MD (ACR); Andrew Moriartiy, MD (ACR) and Kurt Schoppe, MD (ACR)

In April 2019, the Relativity Assessment Workgroup lowered the threshold of CMS/Other source codes with Medicare utilization over 20,000. CPT code 70030 was identified in the updated screen.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to recommend an increase in the value for CPT code 70030 *Radiologic examination, eye, for detection of foreign body* because the prior methodology for valuing the code is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. **The RUC agreed that there is compelling evidence that incorrect assumptions were made in the previous valuation of the service.**

70030 *Radiologic examination, eye, for detection of foreign body*
The RUC reviewed the survey results from 49 radiologists and determined that the survey 25th percentile work RVU of 0.18 accurately reflects the typical physician work necessary for this service. The RUC recommends 1 minute pre-service time, 3 minutes intra-service time and 1 minute post-service time. The service is typically a two view x-ray of the orbits involving axial structures performed on patients with whom there is clinical concern for metallic foreign body in the eye or orbital soft tissues (i.e., patients with a history of working with metal (welding, grinding, machinist) or have had metal fragments/filings in their eyes). The service can also be performed on patients whose history is unknown or cannot be obtained. An MRI is contraindicated if a ferromagnetic foreign body is suspected because the magnetic force may cause a metallic foreign body to heat up and and/or move, causing serious damage to surrounding tissues. The specialty societies originally recommended the survey median post-service time of 2 minutes. The specialties explained that the technologist identifies some concerning feature of the patient history and does the orbital exam to rule out a foreign body in order to gain clearance for a needed

MRI. This means that after the exam is performed the technologist must contact the radiologist immediately by phone to discuss the results of the exam so that the technologist can move forward with the MRI in real time, if no foreign body is found. Although communication takes place for all x-ray codes, 70030 requires the radiologist to take the call from the technologist, close out of the study they are currently reviewing, immediately interpret the images for presence of orbital foreign body, and relay that interpretation back to the technologist who is waiting on the phone. The RUC reduced the time to 1 minute because although the communication by phone between the technologist and the physician must take place immediately, the RUC disagreed that the phone call requires an additional minute and agreed that the time necessary is consistent with other radiological examinations.

The RUC compared the survey code to the top key reference service, CPT code 70220 *Radiologic examination, sinuses, paranasal, complete, minimum of 3 views* (work RVU = 0.22, 4 minutes intra-service time and 6 minutes total time). Although the intensity is similar because the anatomy is similar, CPT code 70220 typically includes 3 views while CPT code 70030 typically includes 2 views, both involving axial structures. The additional view in the key reference service accounts for the additional minute of intra service time, and the slightly lower work RVU for the survey code. The RUC also compared the survey code to MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes intra-service time and 6 minutes total time), noting that the survey code requires evaluation of axial anatomy which is more complex, accounting for the higher work RVU for 70030. **The RUC recommends a work RVU of 0.18 for CPT code 70030.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

<u>Venography (Tab 29)</u>
Curtis Anderson, MD (SIR); Minhajuddin Khaja, MD (SIR); Andrew Moriarity, MD (ACR); Mark Schoenfeld, MD (HRS); Matthew Sideman, MD (SVS); and Richard Wright, MD (ACC)

In April 2019, the Relativity Assessment Workgroup lowered the threshold of CMS/Other source codes with Medicare utilization over 20,000. CPT code 75820 was identified in the updated screen and CPT code 75822 was reviewed as part of the family.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to recommend an increase in the value for CPT codes 75820 *Venography, extremity, unilateral, radiological supervision and interpretation* and 75822 *Venography, extremity, bilateral, radiological supervision and interpretation* based on evidence that there were incorrect assumptions made in the previous valuation, that there has been a change in patient population and a change in technology. First, the prior methodology for valuing the code is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The specialty societies noted that comparison of the survey time results, and other RUC reviewed supervision and interpretation codes show that the existing value greatly underestimates the work of CPT codes 75820 and 75822. Second, there has been a change in physician work for CPT codes 75820 and 75822 since CMS assigned a value and time in 1992 due to changes in technique, technology, and patient population. In 1992, the typical patient underwent a venogram for purely diagnostic reasons. Today, the patient population has changed. CTA and MRA, as well as more widespread use of vascular ultrasound, have largely replaced purely diagnostic venography for most patients. Invasive catheter-based imaging is reserved for the most complex patients where intervention is being planned or considered. Improvements in technology including the transition from analog to digital

imaging allow for the safer acquisition of significantly more and higher quality images of the peripheral and central venous system. Third, there has been a change in the dominant specialty. For 75820, in 1993, diagnostic radiology represented 94% of all claims and cardiology and vascular surgery represented less than 0.25% of the claims. In 2018, Medicare data indicate that diagnostic radiology is 21%, vascular surgery is 19%, cardiac electrophysiology is 19%, cardiology is 18%, interventional radiology is 9% of Medicare claims. This significant shift in specialties providing this service is consistent with the change in technique, technology and patient population. For 75822, in 1992, diagnostic radiology represented 93% of all claims, cardiology and vascular surgery represented less than 0.50% of the claims. In 2018, Medicare data indicate that diagnostic radiology is 22%, cardiology is 21%, vascular surgery is 18%, interventional radiology is 14% and interventional cardiology is 12% of 2018 Medicare claims. This significant shift in specialties providing this service is consistent with the change in technique, technology and patient population. **The RUC agreed that there is compelling evidence that there has been a change in the physician work necessary to perform these services as well as a change in the dominant specialty.**

75820 ***Venography, extremity, unilateral, radiological supervision and interpretation***
The RUC reviewed the survey results from 161 cardiac electrophysiologists, radiologists, cardiologists, vascular surgeons, interventional radiologists and interventional cardiologists and determined that the survey 25th percentile work RVU of 1.05 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 12 minutes pre-service time, 20 minutes intra-service time and 10 minutes post-service time. The work of this service involves a supervision and interpretation of a contrast injection and imaging of either the upper or lower extremity. A RUC member asked if there is overlap in the pre-service and post-service time that is part of this code and CPT code 36005 which the reported together data indicates is reported with the survey code slightly more than half the time. The specialty societies clarified that although it is typical for the same physician to perform both services, the pre-service time in code 36005 is positioning time related to preparing the limb for axis placement, whereas the positioning time for the survey code is to ensure that it is possible to perform imaging of the entire extremity. The specialty explained that the two services are very different and there is not overlap in the pre- and post-time. The specialty further explained that overall vascular imaging has higher pre- and post-service times than standard imaging because it is used to evaluate abnormalities that are more complex and require a more thorough evaluation. Further, although there was no survey conducted at the time that this code was initially valued, there has been a significant decrease in the volume of this code over that time period because MRI and CT studies have weeded out the people with normal studies and these codes are used almost exclusively for patients with abnormalities.

The RUC compared the survey code to the top key reference service, CPT code 75710 *Angiography, extremity, unilateral, radiological supervision and interpretation* (work RVU = 1.75 and 40 minutes intra-service time), noting that the intra-service time is greater justifying the higher work value. The RUC also compared the survey code to MPC code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86 and 10 minutes intra-service time), noting that the survey code has higher intra-service time justifying the higher work value. **The RUC recommends a work RVU of 1.05 for CPT code 75820.**

75822 ***Venography, extremity, bilateral, radiological supervision and interpretation***
The RUC reviewed the survey results from 159 cardiac electrophysiologists, radiologists, cardiologists, vascular surgeons, interventional radiologists and interventional cardiologists and determined that the survey 25th percentile work RVU of 1.48 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 15 minutes pre-service time, 30 minutes intra-service time and 12 minutes post-service time. The RUC agreed that 10 more minutes intra-service time for this bilateral code when compared to the unilateral code, 75820, is appropriate. The work of this service involves supervision and interpretation of a contrast injection and imaging *on both* of either upper or lower extremities. A RUC member asked if there is overlap in the pre-service and post-service time that is

part of this code and CPT code 36005 which the reported together data indicates is reported with the survey code slightly more than half the time. The specialty societies clarified that although it is typical for the same physician to perform both services the pre-service time in code 36005 is positioning time related to preparing the limb for axis placement, whereas the positioning time for the survey code is to ensure that it is possible to perform imaging of the entire extremity. The specialty explained that the two services are very different and there is not overlap in the pre- and post-time. The specialty further explained that overall vascular imaging has higher pre- and post-service times than standard imaging because it is used to evaluate abnormalities that are more complex and require a more thorough evaluation. Further, although there was no survey conducted at the time that this code was initially valued, there has been a significant decrease in the volume of this code over that time period because MRI and CT studies have weeded out the people with normal studies and these codes are used almost exclusively for patients with abnormalities.

The RUC compared the survey code to the top key reference service, CPT code 75716 *Angiography, extremity, bilateral, radiological supervision and interpretation* (work RVU = 1.97, 50 minutes intra-service time), noting that the intra-service time is greater justifying the higher work value. The RUC also compared the survey code to MPC code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time), noting that the survey code has higher intra-service time justifying the higher work value. **The RUC recommends a work RVU of 1.48 for CPT code 75822.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

3D Rendering with Interpretation and Report (Tab 30)
Curtis Anderson, MD (SIR); Melissa Chen, MD (SIR); Lauren Golding, MD (ACR); Andrew Moriarity, MD (ACR) and Kurt Schoppe, MD (ACR)

In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation* as potentially misvalued. The Agency views CPT code 76377 to be part of the same family as CPT code 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76376 also be reviewed to maintain relativity within the code family.

The specialty societies disagreed with CMS' rationale for the nomination of CPT code 76377 as potentially misvalued and the specialties do not believe that CPT codes 76376 and 76377 are in the same code family, although the descriptors are similar. The societies noted that the two codes are different because they are utilized on different patient populations (as evidenced by the ICD-10 diagnoses.) They also noted that the technical and professional resources required for 76376 and 76377 are significantly different. **For these reasons, the specialty societies recommended, and the RUC agreed to refer CPT codes 76377 and 76376 to the CPT Editorial Panel for further review and potential revision. The specialty societies noted that they will determine the family of services including whether the codes remain a family, based on the recommendations of the CPT Editorial Panel.**

Radiation Treatment Delivery (PE Only) (Tab 31)
Brent R. Moody, MD (AADA)

In October 2018, CPT code 77401 was identified by the High-Volume Growth screen, for services with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. In January 2019, the RUC recommended to refer to CPT May 2019/RUC Oct 2019 to better define the set of services associated with delivery of superficial radiation therapy (SRT). The specialty societies withdrew this code from the May 2019 CPT Editorial Panel meeting. At the January 2020 RUC meeting, the Practice Expense (PE) Subcommittee reviewed the PE recommendations for CPT code 77401.

Compelling Evidence
When the practice expense inputs were defined in 2002, it was based on practice patterns related to radiation oncology. Currently the service is provided primarily by dermatologists according to utilization data (84% of the time). Due to change in presenting specialty, there has been a change in PE inputs including clinical staff type. **The PE Subcommittee agreed that there is compelling evidence that there has been a change in the physician work necessary to perform this service based on change in dominant specialty.**

77401 ***Radiation treatment delivery, superficial and/or ortho voltage, per day.***
The presenters explained that all elements of the service including greeting and gowning the patient and obtaining vital signs would take place in the treatment room. This means that the equipment formula for the treatment room is not highly technical, rather it is the default formula because the patient is taken directly to the room and all clinical activities are performed within the room. Following these standard activities, a lead apron, thyroid shield and eye shield would be put on the patient. The clinical staff would then use stabilizing devices such as foam and sand bags to position the patient. These devices are used because it is critically important that the patient not move during treatment. The treatment is for areas that are only a few centimeters in diameter and if the dosage is not applied to the correct area, it is as if the treatment was not given. The lead shield and video camera are positioned, and it is confirmed that the equipment arm is precisely in line with hole in the lead shield. Following that positioning, the technologist leaves the room and uses the controlling console to deliver the treatment. The technologist reenters the room, cleans the treatment area and reapplies the dressing. The technologist would then return to the room later to clean the lead apron, shields and all other equipment.

The PE Subcommittee expressed concerns about the typicality of a lead-lined room to perform this service. The specialty explained that although a typical dermatologist office would not have a lead-lined dedicated room, the subset of dermatology offices that perform this service must have a dedicated lead-lined room as dictated by state protocols and that room is used all day, every day that the practice is open. The specialty society noted, and the RUC agreed, that because the lead-lined room is not a typical dermatology office expense, it should be allocated as a direct practice expense input rather than assumed to be covered by dermatology indirect practice expense. Some of the PE Subcommittee members brought forward concerns that the service may have changed as the marketing materials on the manufacturer's website state that the system is portable. The specialty society confirmed that although the system is on wheels and can be moved, the purpose of that portability is to move the system around the patient within the room and not from room to room. The specialty reiterated that it is unsafe to perform the service outside of a lead-lined room and in practice the equipment is only used in a lead-lined room as dictated by state regulations. In addition, the physicians who perform the service also must have a state-issued radiation license. In a typical practice that performs this service, there is one machine and one lead-lined room and the materials for the service, including the SRT system, do not move from the dedicated lead-lined treatment room. It was also noted that nowhere on the manufacturer's website does it state that a lead-lined room is not required.

The specialty society provided additional documentation to substantiate that a lead-lined room is used every time this service is performed. The documents include state requirements, two examples of architectural

drawing for a lead-lined room and information added to the PE SOR for a website showing that 40 out of 50 states have requirements for a lead-lined room. In addition, Sensus, the company that produces the SRT-100 equipment, attested that the equipment cannot be installed without ensuring that a shielding report compiled by a contract medical physicist is on file with the state radiation regulatory agency. The attestation document states the following:

> "The SRT-100 is considered a "Therapeutic Radiation Device in the Healing Arts". The 100 stands for 100 kilovolts of energy, which puts it in a category that requires shielding at all times to protect the operator and patient as well as the surrounding area of the x-ray room."

The PE Subcommittee inquired about the extra time for cleaning and the specialty explained that because the code is used for wound care, the time to clean the room is recommended at 5 minutes above the PE Subcommittee standard of 3 minutes. The rationale for 5 minutes is that there is additional cleaning time for supplies and equipment that comes in contact with the patient wound such as the lead apron, thyroid shield, the device and the applicator. Three fresh pairs of *gloves, non-sterile, nitrile* (SB023) are required to remove the patient's bandages, replace bandages after the treatment and clean the equipment. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Liver Elastography (Tab 32)
R. Bruce Cameron, MD (ACG); Seth Gross, MD (ASGE); Vivek Kaul, MD (ASGE) and Shivan Mehta, MD (AGA)
Pre-Facilitation: Facilitation Committee #2

These services were flagged via the new technology/new services list. The RUC reviewed three years of available Medicare claims data (2016, 2017 and 2018e) and recommended to survey for January 2020.

91200 ***Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report***
The RUC reviewed the survey results from 50 gastroenterologists and determined that the survey 25th percentile work RVU of 0.21 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 1 minute of pre-service time, 10 minutes of intra-service time, 3 minutes of immediate post-service time. The 10 minutes of intra-service time includes reviewing at least 10 valid images to determine whether each measurement of sheer wave speed is correct. The stiffness measurement is correlated with the fibrosis stage and compared with the patient's history, prior imaging studies, and any prior liver biopsy and clinical laboratory values to establish a final diagnosis. It was noted that this service is not anatomic imaging, but wave form imaging. The RUC agreed that this service is not typically reported with an office visit on the same day.

The RUC compared the survey code to the top key reference code 97035 *Application of a modality to 1 or more areas; ultrasound, each 15 minutes* (work RVU= 0.21, intra-service time of 10 minutes and total time of 13 minutes) and noted that both codes have identical intra-service time, similar total time, and should be valued identically. Most survey respondents that selected this reference code also rated the survey code identical to somewhat more intense/complex than the top key reference service, further warranting the recommended survey 25th percentile work value of 0.21. Additionally, the RUC compared the survey code to code 96369 *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)* (work RVU= 0.21 and intra-service time of 10 minutes) and noted that both codes require the same physician work and intra-service time. **The RUC recommends a work RVU of 0.21 for CPT code 91200.**
RUC Database Flag

The RUC recommends to flag CPT code 91200 as "do not use to validate for physician work" since the survey respondents may have overestimated the intra-service time due in part to the language in the vignette.

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

Practice Expense
The Practice Expense (PE) Subcommittee added one paper, laser printing (each sheet) (SK057). **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

Insertion/ Removal of Implantable Interstitial Glucose Sensor System (Tab 33)
Felice Caldarella, MD (AACE)

In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that "the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems." Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting.

The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.

CMS clarified that its request was for RUC valuation of CPT codes 0446T, 0447T and 0448T, not for conversion from Category III to Category I. During the RUC discussion, CMS did not have available the exact source of the comment which lead to the direct request for valuation of these Category III codes. Contractor pricing appeared to be causing confusion and was possibly inhibiting use of the codes. The Agency indicated that it would like the codes valued but does not plan to create a G-code as this was not announced during the rule-making.

There is currently insufficient data (0 claims filed in 2018) with approximately 200 physicians recently trained (in 2019) in providing the services. The RUC acknowledged that the utilization of these services is unknown but likely to increase. The specialties agreed but predicted a slow up-take and low utilization. Unlike a subcutaneous sensor, this is a new device that requires a procedure in the office with an incision, so the expertise required by the physician for this procedure to place the device is different than just placing a subcutaneous sensor in the office then teaching the patient to do so on their own. It is an entirely different device than a continuous glucose monitoring device that is commercially available, so the numbers for a survey were predicted to be quite low.

The RUC suggested that a targeted survey of the 200 trained physicians could be accomplished. Historically, when the Category III codes were first implemented by CPT, CMS indicated that it would not be establishing relative values but would carrier-price the services *unless they found a specific programmatic need* at which point the RUC would review those codes. Nonetheless, the specialties maintained that it would be difficult to perform an adequate targeted survey due to low utilization and the fact that there are currently no Medicare claims. Given the specialties' reluctance to attempt a targeted survey, the RUC believes that recommendations on appropriate valuation for these services is inappropriate at this time. **Therefore, the RUC recommends that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel *time uncertain*.**

Visit Complexity E/M Add-On (Tab 34)
Megan Adamson, MD (AAFP); Joshua M. Liao, MD (ACP); Charles Mabry, MD (ACS); Stephen Sentovich, MD (ASCRS); Matthew Sideman, MD (SVS) and Marianna Spanaki, MD (AAN)

In the Proposed Rule for the 2019 Medicare Physician Payment Schedule, CMS proposed reduction in the payment variation for Evaluation and Management (E/M) office visit levels by paying a single blended rate for E/M office visit levels two through five and reducing physician burden by requiring less documentation. CMS also proposed two HCPCS add-on codes:

GCG0X, *Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit),* would be reported "with an E/M service to describe the additional resource costs for specialty professionals for whom E/M visits make up a large percentage of their overall allowed charges and whose treatment approaches we believe are generally reported using the level four and level five E/M visit codes rather than procedural coding because the proposed single payment rate for E/M levels two through five visit codes would not necessarily reflect the resource costs of those types of visits."

GPC1X, *Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)*, would be reported "with the generic E/M code set to adjust payment to account for additional costs beyond the typical resources accounted for in the single payment rate for the levels two through five visits." CMS additionally stated that a primary care visit is partially defined by an ongoing relationship with the patient and this add-on code could be appended to an E/M visit provided to an established patient. GPC1X could be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other codes. CMS specifically stated that the resource costs are for additional time spent coordinating patient care, collaborating with other physicians, and communicating with patients.

The proposed elimination by CMS of differentiated payment for levels two through five of E/M office visits led to negative impacts to those physician specialties that perform a high percentage of level four and five E/M office visits. It was assumed that CMS introduced GPC1X and GCG0X, to offset these unintended impacts.

On August 30, 2018, the RUC commented, that the proposed add-on codes GPC1X and GCG0X were not resource-based and not well articulated in the Proposed Rule for the 2019 Medicare Physician Payment Schedule. For example, the proposed payment for GPC1X is not resource-based, relying on a partial crosswalk to another code that is unrelated and not comparable. The RUC noted that there may be merit

in rewarding complexity for currently undescribed resource costs in additional CPT codes (e.g., a new shorter prolonged services code), however, the RUC urged CMS to work through the current processes to ensure such services are adequately described and valued.

In August 2018, the CPT Editorial Panel and the RUC created a workgroup, the CPT/RUC Workgroup on E/M, to develop a coding proposal to simplify the documentation burden related to the provision of E/M office visits and develop an alternative to the CMS proposed payment collapse and add-on code framework. In February 2019, the CPT Editorial Panel approved the Workgroup's recommended new CPT guidelines and revised code descriptors for the E/M office visits 99202-99205 and 99211-99215 to report code levels based on medical decision making or time spent on the date of encounter to be effective for CPT 2021. In addition, CPT code 99201 will be deleted. The Panel also created add-on code 99XXX *Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)* to describe extended E/M office visits.

For the April 2019 RUC meeting, the E/M office visit survey yielded the highest number of responses in the history of the RUC process, with nearly 1,700 physicians completing the survey. The survey was the concerted effort of 51 specialty societies and other health care professional organizations who represent 95 percent of Medicare claims for E/M office visits. Each survey respondent chose his/her specialty that he/she identifies with from a list of 66 Medicare specialty designations (specialties with more than $1 million in Medicare allowed charges for E/M office visits reported separately and bundled). The RUC analyzed the responses and noted that the number of survey responses received per specialty correlated with those who perform E/M office visits in the Medicare Physician Payment Schedule. These data were summarized by categories of specialties (primary care, surgical and medicine/other) and the number of respondents by category was representative of Medicare allowed charges for E/M office visits for those same categories. The RUC recommendations were representative of all specialties who perform E/M office visits.

In the Proposed Rule for the 2020 Medicare Physician Payment Schedule, CMS accepted the RUC work value recommendations for the E/M office visits, for implementation January 1, 2021. However, CMS proposed not to apply the E/M office visit code increases to the visits bundled into global surgery payment. CMS also proposed to simplify the coding by consolidating the two add-on codes into a single add-on code and revising the single code descriptor for CY 2021, code GPC1X, and clarified that any physician would be allowed to report it. CMS revised GPC1X as *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)*. The revised add-on code may be reported with both new and established office E/M visit levels, not simply the established patient E/M office visits as originally proposed.

In the RUC comments on the new CY 2020 proposal, the Committee surmised CMS' intent to recognize costs associated with patients that are outliers to the typical patient described in the valuation of E/M office visits. The RUC noted, however, that the vignettes utilized in the recent RUC E/M office visits surveys describe a patient that would have ongoing primary care services and/or have a single, serious, or complex chronic condition. For example, the vignette for 99215 is *Office visit for an established patient with a chronic illness in a 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.* Therefore, in the RUC comment letter on the Proposed Rule for 2020, the RUC agreed that regardless of service performed, a surgical procedure or an

E/M office visit, physicians should already have a way to identify outlier patients where additional payment is warranted, precluding the need for GPC1X. Further, the proposed code GPC1X is not well defined. For example, what is the definition of "serious" in this code descriptor? The RUC recommended that CMS postpone the implementation of this add-on code, allowing the CPT Editorial Panel to better define the service to meet its intended purpose.

In the Final Rule for 2020, CMS stated that the revised E/M office visits and RUC-recommended values more accurately reflect the resources associated with a typical visit. CMS further stated that the typical visit described by the revised code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. CMS argued that there is still a need for an add-on code because the revised E/M office visits do not recognize that there are additional resource costs inherent in furnishing some kinds of E/M office visits.

CMS also clarified "HCPCS code GPC1X does not describe outlier visits, but visits associated with primary care or care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition(s), which we maintain is qualitatively different from the work accounted for in the revalued office/outpatient E/M visits."

CMS stated that the add-on code is not intended to reflect any difference in payment based on specialty, but rather the recognition of different per-visit resource costs based on the kinds of care the physician or other qualified health care professional provides, regardless of their specialty. Therefore, CMS proposed to simplify the coding by consolidating the two add-on codes into a single add-on code and revising the single code descriptor to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. CMS indicated these per-visit resource costs are assumed to be 11 minutes of time spent coordinating patient care, collaborating with other physicians, and communicating with patients. However, the RUC notes that new E/M office visit coding and guidelines allow for reporting by time to account for these additional resources.

CMS encouraged the public to submit additional information and recommendations regarding utilization for HCPCS code GPC1X prior to the February 10, 2020 deadline for submission of RUC and stakeholder valuation recommendations to be considered in CY 2021 rulemaking.

In January 2020, the RUC reviewed letters submitted by various specialty societies and extensively discussed potential RUC recommendations for code GPC1X. The specialties offered such recommendations as refer to CPT to better define its intended purpose; recommend zero physician work, time or practice expense inputs; and CMS rescission of the code. However, it became apparent that there was significant confusion about the underlying intent, definition and potential use of the code. The RUC was unable to address these questions from the information provided in rulemaking to date. The RUC questioned: 1) what are the resources involved in this code and is this physician work already described by other codes?; 2) what is the description of the typical patient receiving this service?; 3) who can report this code and how will reporting of this code be monitored?; and 4) what is the definition of this service and how can service period time be determined for an undefined service?

Resources

CMS initially defined the additional resources that GPC1X was created to capture the additional time spent coordinating patient care, collaborating with other physicians, and communicating with patients. The cost of these resources are already captured in the newly defined E/M office visits, prolonged services (99358, 99359 and 99XXX), online digital management services (99421-99423), telephone E/M services (99441-99443), interprofessional telephone/internet/electronic health record consultations services (99446-99452), chronic care management services (99490 and 99491), complex chronic care

management services (99487 and 99489) or transitional care management services (99495 and 99496). CMS should provide clarification on the exact additional resources it intends to capture by creating GPC1X that are not already defined in existing CPT codes.

Typical Patient
The typical patient to receive GPC1X services is not defined. The RUC and CMS deliberate relative valuation and resource costs based on a description of the typical patient. Is GPC1X intended to describe the additional work with the most complex patients? The RUC vignettes for higher level E/M codes described complex patients. CMS utilization data predicts that 57% of all E/M office visits will now have this visit complexity add-on code appended. This is, therefore, extremely confusing as the resources utilized in performing these visits would have already been incorporated into the typical patient described in the E/M office visits or reported with a higher level of visit using time for reporting. The RUC discussed the vignette issue and was unable to identify a vignette for GPC1X that differentiated the code from the typical patient in the E/M office visit vignettes.

Reporting and Monitoring.
The RUC questioned who will report these services? CMS states that any physician or other qualified health care professional may report the service. However, based on the budget neutrality assumptions, it appears primary care physicians and specific specialties are assumed to report the add-on with 100% of their E/M office visits. Given the questions about what additional resources are used and what the typical patient would be, the RUC agreed the utilization was severely misestimated. There is also little information regarding the required documentation to report the service and how this documentation will be reviewed and monitored.

Time and Definition
CMS allocates 11 minutes physician time for GPC1X, which was crosswalked from CPT code 90785 *Interactive complexity (List separately in addition to the code for primary procedure)*. The 11 minutes of intra-service time for CPT code 90785 is meant to be reported for time spent specifically related to managing a patient's anxiety, maladaptive communications, emotional reactivity and conflict of non-patient participants present during a session. A typical scenario for CPT code 90785 was to be for the extra time to prepare for play therapy with a young child and additional interaction with the parents. In contrast, code GPC1X is the visit complexity associated with ongoing care related to a patient's single, serious, or complex chronic condition. The RUC is confused regarding how the 11 additional minutes described in GPCIX would not already be accounted for in the new E/M office visit structure that allows coding to the next level if additional time is spent on the date of encounter.

The RUC is unable to provide a recommendation on code GPC1X due to the lack of clarity on the purpose, use of and reporting of the code.

Estimate of Utilization for GPC1X
For purposes of estimating the budget neutrality impacts CMS assumed that the following specialties would report code GPC1X with 100% of their new or established patient E/M office visits: family medicine, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease.

Therefore, out of the 251 million E/M office visits, CMS assumes 142 million claims will be reported for code GPC1X in 2021, resulting in an approximate $2.6 billion increase in spending and a 3% decrease to the 2021 Medicare conversion factor. The RUC is concerned about the significant impact this will have

on all physicians and other health care professionals. **It is essential that CMS re-examine the utilization assumptions.**

The utilization estimates for the transitional care management (TCM) services serve as a cautionary example regarding the impact of overestimating utilization of new codes. In 2013, CMS overestimated utilization for new TCM codes 99495 and 99496, resulting in an overestimated budget offset of approximately **$700 million** in 2013. This reduction was permanently removed from the Medicare Physician Payment Schedule, therefore reducing annual physician spending significantly each year since implementation.

CPT Code	Descriptor	CPT cycle	2013 work RVU	CMS Estimated Medicare Utilization for Budget Neutrality	2013 Actual Medicare Utilization	2018 Actual Medicare Utilization	2013 Payment Rate	2013 CMS Projected Allowed Charges	2013 Actual Allowed Charges	Over-estimated Allowed Charges for TCM
99495	Transitional care management within 14 days of discharge	CPT 2013	2.11	4,244,533	162,104	673,916	$163.99	$696 million (-$200 million) offset for office visits	$27 million	$469 million
99496	Transitional care management within 7 days of discharge	CPT 2013	3.05	1,398,767	136,160	617,906	$231.66	$324 million (-$39 million offset for office visits)	$32 million	$253 million

The RUC is concerned that overestimating utilization, especially for the initial year of implementation will occur again if CMS goes forward with their proposed utilization estimate of 142 million claims for GPC1X. The current utilization for the TCM services is still significantly less than what CMS estimated for the initial year. CMS currently estimates that GPC1X will be reported with 57% of all E/M office visits. This estimate significantly overstates the actual application of a code that is not well defined or understood. **The RUC recommends that the CMS estimates of utilization for code GPC1X should be more conservative.**

XI. Practice Expense Subcommittee (Tab 35)

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

- **Clinical Staff Time Surveys Workgroup**

At the last meeting there was concern around the clinical staff time for CA021 *perform procedure/service---NOT directly related to physician work time*. When this clinical activity is part of a specialty societies' direct practice expense recommendation it generally indicates that the clinical staff is performing a component of the service independent of a physician. In response a workgroup was formed and primarily discussed clinical activity CA021. The Workgroup pulled all the available CA021 inputs and reviewed the range of time allocated to CA021. The PE Subcommittee suggests that specialty societies tasked with developing PE recommendations for a service(s) that currently, or is anticipated to, include time for CA021 consider the option of conducting some form of data collection for the clinical activity. The PE Subcommittee will continue the discussion at the next meeting and review similar data to that provided to the Clinical Staff Time Surveys Workgroup to facilitate discussion of potential validation options. This data includes 295 CPT codes that have been brought to the RUC recently enough to have time allocated to CA021 (implemented with the PE spreadsheet update) and the data will include utilization information. A PE Subcommittee member suggested indicating if there was a PE survey associated with the CPT code. RUC staff will provide data on CPT codes with clinical staff time for CA021 for PE Subcommittee review and discussion at the April 2020 RUC meeting.

- **090 Day Global Pre-Service Time Standard Workgroup**

The 090 Day Global Pre-Service Time Standard Workgroup met to determine if any revisions to the time components for that standard are necessary. The Workgroup reviewed the history related to the determination of the current pre-service clinical activity standards for major surgical services. The standard was developed by the Practice Expense Advisory Committee (PEAC) in 2000 and in the past 20 years the time could have changed. The Workgroup examined groups of codes that exceed the 60 minute standard which primarily fall into two groups: solid organ transplantation and spine surgery codes. The consensus of the Workgroup and the PE Subcommittee is that it is appropriate to maintain the current pre-service time standard of 60 minutes in the facility setting for 090-day global services.

- **Equipment Utilization Rate**

The PE Subcommittee discussed CMS' 50 percent equipment utilization assumption used in CMS' computation of equipment cost per minute. The 50 percent utilization assumption is the default equipment usage factor. CMS also maintains a 90 percent utilization assumption applied by statute to equipment over 1 million dollars. The PE Subcommittee recognized that the RUC has little ability to impact these statutory requirements and determined that it is not an appropriate use of resources at this time.

- **000 and 010 Day Global Pre-Service Time Workgroup**

During discussion of the 090 Day Global Pre-Service Time Standard Workgroup report a PE Subcommittee member suggested review and validation of 000 and 010-day global pre-service clinical staff time. This review would be to identify 000- and 010-day global services that are major surgeries and do not have clinical staff pre-service time consistent with major surgeries. The Subcommittee member suspects that some of these services have inappropriately low pre-service time because the pre-service clinical staff time standard for 000 and 010-day globals is zero minutes. In addition to the standard of zero pre-service staff time in the non-facility and facility there are also times allocated if the service is proven

to require minimal use of clinical staff or extensive use of clinical staff. There are also pre-service time standards for endoscopy services. The Subcommittee agreed that it is appropriate to form a Workgroup to compile data on 000 and 010-day pre-service clinical staff time and determine whether the RUC continues to be well served by those standards.

- **Separate Payment for High Cost Medical Supplies**

At this meeting there were two ENT tabs that included disposable medical supplies over $2,000. Very expensive medical supplies included in a code also cause the code to pull in several indirect practice expense RVUs. The PE Subcommittee discussed data regarding 40 supplies items with a purchase price over $1,000. When utilization is applied these supplies account for close to 1 billion dollars in expense. The Subcommittee supported further review and discussion of the data at the next RUC meeting. The PE Subcommittee requested staff to provide a list of all medical supplies arrayed from high to low cost, including utilization and specialty impact for PE Subcommittee discussion at the April 2020 RUC meeting. The PE Subcommittee will also discuss the impact of separate coding and payment for high cost medical supplies on the redistributive effect for indirect PE RVUs within the system.

- **Discharge Management Clinical Staff Time Workgroup**

A PE Subcommittee member brought forward a concern about the clinical staff time standard for discharge management. The member questioned if the clinical staff time for same day and next day discharge is appropriately 6 minutes and 12 minutes respectively. The Subcommittee agreed that it is appropriate to form a Workgroup to review the historical information and report back to the PE Subcommittee at the April 2020 RUC meeting.

The RUC approved the Practice Expense Subcommittee Report.

XII. Administrative Subcommittee (Tab 36)

Doctor G. Edward Vates, Chair, provided the Administrative Subcommittee report:

The Subcommittee reviewed the rotating seat election rules and candidates nominated and confirmed all the candidates met the requirements.

Confidentiality Agreement
The Subcommittee reviewed the confidentiality agreement that the AMA Office of General Counsel (OGC) revised to modernize based on different forms of current communication as well as define consistently with the CPT Editorial Panel Confidentiality Agreement changes. **The Administrative Subcommittee recommends adoption of the Confidentiality Agreement as revised by the OGC.** ***The final Confidentiality Agreement is attached to these minutes.***

A RUC member questioned who will make the determination regarding confidentiality agreement item 7. "Violators of this Agreement may be barred from participation or attendance at future Meetings or otherwise sanctioned." AMA staff answered that the American Medical Association works with the Office of General Counsel to make any determinations when we are aware of an individual who has violated the confidentiality agreement.

Financial Disclosure, Financial Disclosure Review Process Document, Conflict of Interest Policy and Statement of Compliance
At the October 2019 RUC meeting, the Chair of the Administrative Subcommittee recommended that the Subcommittee revisit the RUC conflict of interest (COI) policies. AMA Staff worked with the AMA

OGC to revise the RUC Financial Disclosure form, Financial Disclosure Review Process document and the Conflict of Interest Policy/Statement of Compliance. The AMA OGC suggested general revisions to ensure that references to certain roles are consistent across documents, clarify defined terms and modernize the language. The major revisions include not only defining one's financial interests from the past 24 months but looking forward to any financial interests *anticipated in the next 24 months* and modifying the administrative process for review and potential escalation of disclosures, so that the Financial Disclosure Review Workgroup is not called into session for every item, but rather, only if staff is seeking assistance.

Doctor Vates indicated that the Subcommittee modified the financial disclosure review process. Previously, there were three possible outcomes from a review of a presenter's financial interests disclosed. 1. No restriction; 2. Presenter may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table but may answer questions from the floor limited to the procedure itself; or 3. Presenter may not present to the Practice Expense Subcommittee or the RUC. The Subcommittee determined that the current options were vague and therefore simplified the outcomes that either a presenter participates in in the RUC process or not. These rules apply to pre-facilitation and facilitation. AMA staff will have the discretion to review these disclosures and contact the individual for further information and/or Administrative Subcommittee to make a final determination. Presenters may appeal the AMA decision. The Financial Disclosure Review Workgroup will review the appeal.

The Subcommittee noted that the OGC confirmed that the 2009 definition of "material income" as $10,000 is appropriate and consistent with CPT. **The Subcommittee recommends maintaining that material income is defined as $10,000.** The Subcommittee clarified that the $10,000 constitutes the past 24 months **or** anticipated in the next 24 months, not a total of a 48-month period. The Subcommittee further discussed the disclosure of a direct financial interest for "any other interest that a reasonable person would consider relevant to or potentially impacting the judgment or decisions of the disclosing individual in the context of RUC business", noting that this definition of direct financial interests is purposefully left to the individual to determine and if one determines that their financial interest, albeit less than $10,000 may inhibit their independent judgment or abilities in working with the RUC, then it is at their discretion to choose to disclose said interest. It was also noted that a discloser may choose to disclose financial interests, in amounts lower than the specified $10,000 threshold, that the discloser believes would not inhibit their independent judgment but which the discloser believes are important to disclose for transparency purposes.

The Subcommittee recommended the following changes in addition to those in track changes by AMA OGC:

- Financial Disclosure Statement for Presenters: The language in the table does not exactly track the past 24 **or** the upcoming 24-month period. **Therefore, the Subcommittee recommends striking the "/" in the table and replace it with "or" to mirror the language from the definition.**
- Conflict of Interest Policy for RUC and HCPAC Members and Alternates: The Subcommittee suggested that the title should match the one for presenters. **The Subcommittee recommends changing the title from "Conflict of Interest" to "Financial Disclosure" on the current Policy and Statement of Compliance.**
- Financial Disclosure Statement of Compliance: The Subcommittee discussed that RUC and HCPAC Members and Alternates may submit any disclosures to the RUC Chair in writing or orally and therefore did not accept the change the AMA OGC proposed to specifically indicate only oral disclosures. The Subcommittee noted that any disclosures will be reflected in the minutes.

- Financial Disclosure Review Processes document:
  - The Subcommittee clarified that the appeals process will begin with the Financial Disclosure Review Workgroup and then proceed to the full Administrative Subcommittee if necessary.
  - The Subcommittee noted that since it agreed with the changes to simplify the Financial Disclosure Review process and eliminated the different levels in which presenters may present before the RUC, **the reference to presenter restrictions at the pre-facilitation or facilitation meetings no longer applies and should be stricken.**

The Administrative Subcommittee recommends the attached Financial Disclosure Statement for Presenters, Financial Disclosure Policy and Statement of Compliance and Financial Disclosure Review process documents.

RUC Voting Member Practice Requirements

The Administrative Subcommittee considered whether there should be requirements for RUC voting members to be engaged in active clinical practice. The discussion weighed whether the credibility of the RUC would be questioned if its members were not all practicing physicians versus the value of aptitude and institutional memory, particularly recognizing the RUC's steep learning curve. Information was provided that the AMA does not mandate that a physician be in clinical practice to be a member of the House of Delegates, the Board of Trustees or any Council. Further, since 2005, the official letters seeking appointment and nomination of RUC members clearly request that the organizations appoint/nominate an individual "who is currently engaged for a substantial portion of his or her professional activities with the practice of medicine either in active patient care or closely-related activities." Subcommittee members acknowledged that, ultimately, the appointment decision is up to the specialty societies who nominate their RUC representatives. They were confident that the societies view the appointment decisions earnestly and concluded that encouragement by the RUC to consider a clinical connection should be continued.

The Administrative Subcommittee recommends that the RUC maintain its current process of encouraging that its members are clinically engaged with the practice of medicine via its appointment/nomination letters as follows:

The AMA requests that specialty societies appoint/nominate an individual who is currently engaged for a substantial portion of his or her professional activities with the practice of medicine either in active patient care or closely-related activities.

The RUC approved the Administrative Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 37)

Doctor Margie Andreae, Chair, provided the Relativity Assessment Workgroup (RAW) report:

The Workgroup reviewed 48 action plans for 30 code families identified by nine different screens. The Workgroup had a robust discussion on each action plan and the recommendations are summarized in the full report attached to these minutes. Doctor Andreae reminded specialty societies to consider the code families when bringing forward codes to survey or for CPT consideration.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Research Subcommittee (Tab 38)

Doctor Ezequiel Silva, Chair, provided the report of the Research Subcommittee:

- **The Subcommittee reviewed and accepted the October 2019 and November 2019 Research Subcommittee reports.**

The Research Subcommittee report from the October 15th and November 5th conference calls and separate electronic review included in Tab 38 of the January 2020 agenda materials were approved without modification.

- **Review Script for an *Understanding the RUC Survey Process – Anesthesia Services* YouTube Video**

At the October 2019 RUC meeting, the Anesthesia Workgroup noted that the creation of a YouTube explaining the RUC survey process to potential anesthesia services survey respondents would be beneficial. The American Society of Anesthesiologists (ASA) advisors and staff drafted an initial script and PowerPoint for the Research Subcommittee to consider at the January 2020 meeting based in part on the previously Research-approved materials for other YouTube videos. The Subcommittee noted that overall the PowerPoint and script are appropriate and should be useful to potential Anesthesia services survey respondents. The Subcommittee noted that the proposed template had language specific to the ASA and that, although it would be unlikely that anesthesia surveys would also be conducted by other organizations, it would be more appropriate to make the script and slides specialty society agnostic, as is the case with all previously approved RUC educational materials. A Subcommittee member proposed for slide 11 to be revised to insert the word "or" as follows: "Do not report time or work of technicians **or** OR staff". **The Research Subcommittee approved the survey video scripts and PowerPoint slides with the minor modifications as described above.**

- **Survey Sample Size Definition**

During the Subcommittee's discussion related to potentially removing the response percentage field from the Summary of Recommendation Form (SOR) at the October 2019 meeting, a Subcommittee member proposed for AMA staff to prepare a staff note for the next meeting regarding the feasibility of redefining the denominator (i.e., survey sample size) to include only survey respondents that opened the email, viewed the email or clicked on the survey link. AMA staff noted that societies use disparate email distribution systems that may not have these capabilities. The Research Subcommittee requested for AMA staff to review the feasibility of what would be possible/appropriate and to provide a staff note for the next Subcommittee meeting on this topic. AMA Staff drafted a staff note for the Subcommittee to review, included under tab 38 of the January 2020 RUC agenda materials. **The Subcommittee reviewed the history and concurred with the earlier RUC action to remove the response % field from the SOR**. The Subcommittee agreed the issue required no further discussion or action.

- **Pre-service Evaluation IWPUT input and WPUT**

During the RUC's other business discussion at the April 2019 RUC meeting, a RUC member questioned whether the Harvard-based pre-service evaluation time intensity input in the Intra-service Work Per Unit of Time (IWPUT) formula remains correct. The member pointed out that when considering the compelling evidence for the office visits codes, the IWPUT for the pre-service evaluation time was higher than the previously standardized value of 0.0224. The volume-weighted work per unit of time (WPUT) of the RUC's May 2019 office visit recommendation was 0.0409. The member asked if the same increase in

work may apply to the pre-service evaluation component of other services. The RUC agreed to refer the issue to the Research Subcommittee for consideration.

The Subcommittee continued its review of this issue at the January 2020 meeting. The Subcommittee affirmed that this discussion not prompt retroactive valuation changes to existing codes, but is solely to potentially modernize the IWPUT formula. Following an October 2019, request from the Subcommittee, AMA Staff had provided an analysis which included the current (2020) volume-weighted WPUT and IWPUT for each section of the CPT book, as well as each global period. The analysis also modeled several scenarios replacing the 0.0224 intensity with either 0.04 (the WPUT intensity from the April 2019 Office Visit recommendations) or an intensity of 0.03 (selected arbitrarily for illustrative purposes by AMA staff as an intensity partway between the current intensity and the Office visit intensity.) Several Subcommittee members noted that these data were very informative and will assist the Subcommittee in its continued evaluation of this topic. Regarding next steps on potential IWPUT updates, a Subcommittee member noted that it would also be beneficial to review the hypothetical alternate IWPUTs in a spreadsheet for all individual services for each global period at the next in-person meeting. There was interest in reviewing which codes would be a negative IWPUT if the 0.0409 intensity is applied to the pre-service valuation, positioning and immediate post-service components.

Regarding the addition of WPUT as an additional metric for code valuation, the potential utility of this as a metric was considered. A Subcommittee member shared their observation that for very short procedures (e.g. less than 10 minutes of total time), the IWPUT metric becomes less reliable. They suggested that the work per unit time metric may be particularly useful when evaluating these services.

The Subcommittee agreed to continue this discussion at its next face-to-face meeting in April 2020. The Chair reminded stakeholders that, if the Subcommittee decides to recommend a change to any of the inputs in the IWPUT formula, and the RUC agrees, these changes would need to be proposed to CMS and reviewed through rulemaking.

The RUC approved the Research Subcommittee Report.

XV. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 39)

Doctor Scott Collins, Chair, provided the Multi-Specialty Points of Comparison (MPC) Workgroup report:

Review of Specialty Code Recommendations
The MPC Workgroup members reviewed proposals from several specialties for codes to be added or removed from the MPC list. Representatives from the specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members also noted that specialty societies should be encouraged to take full advantage of the MPC review process to both add new services and remove services that are no longer appropriate for the list. Finally, the MPC Workgroup reminded the specialty societies of the rule that any specialty with 10% or more of the utilization of the code has the right to comment on the appropriateness of addition or deletion of the code. AMA staff indicated that the appropriate specialties either have already been contacted or will be, to ensure that the nominated codes are appropriate. In the end, the MPC Workgroup members agreed to add eight specialty recommended codes to the MPC list and agreed to delete the two codes the specialties recommended for deletion along with one code that was deleted for the CPT 2020 cycle.

The MPC Workgroup recommends that the following CPT codes as recommended by the specialty not be added to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2018 Frequency
51720	Bladder instillation of anticarcinogenic agent (including retention time)	0.87	000	2016-01	190708
11981	Insertion, non-biodegradable drug delivery implant	1.14	XXX	2018-10	13123
11982	Removal, non-biodegradable drug delivery implant	1.34	XXX	2018-10	4362
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	1.47	000	2016-01	55477
11983	Removal with reinsertion, non-biodegradable drug delivery implant	1.91	XXX	2018-10	2388
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	3.03	000	2017-01	5793
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	5.93	090	2018-01	2818
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	12.13	090	2018-04	2983

To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties. The MPC Workgroup reviewed proposals from several specialty societies and agreed that codes 51703, 51720 and 53852 are performed primarily by one specialty and not performed by multiple specialties. For codes 11981, 11982, 11983 and 27279, CMS did not accept the RUC recommendations. Codes added to the MPC list should have current work RVUs that the specialty(s), RUC, and CMS accept as valid. And finally, for code 55874, the MPC Workgroup did not accept the specialty's recommendation to add this code to the MPC list because this service is currently on the new technology list.

The MPC Workgroup recommends that the following CPT codes be added to the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2018 Frequency
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	0.35	XXX	2012-10	
51700	Bladder irrigation, simple, lavage and/or instillation	0.60	000	2016-01	189244
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	1.10	000	2014-01	33152
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.50	000	2016-01	148981

52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	8.00	000	2013-04	70091
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	10.08	090	2017-01	9271
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	10.08	090	2017-01	8142
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	26.80	090	2015-04	19109

*AMA staff will flag code 99446 and will bring back to the MPC Workgroup to review once utilization data is available.

The MPC Workgroup recommends that the following CPT codes be deleted from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2018 Frequency
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	0.1	XXX	2001-02	43616
52640	Transurethral resection; of postoperative bladder neck contracture	4.79	090	2010-10	1588
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	8.00	000	2011-09	8908

The RUC approved the Multi-Specialty Points of Comparison (MPC) Workgroup Report.

XVI. RUC Rotating Seat Elections

- Kathleen K. Cain, MD, FAAP, American Academy of Pediatrics (AAP), was elected to the RUC's Primary Care rotating seat.

- Timothy Laing, MD, American College of Rheumatology (ACRh), was elected to the RUC's Internal Medicine rotating seat.

- The term for the rotating seats is two years, beginning in March 2020 and ending in February 2022 with the provision of final recommendations to CMS.

XVII. New/ Other Business

Referrals to the Research Subcommittee:

- A RUC member requested that the Research Subcommittee clearly define the conditions where subgroup breakouts of survey respondents on the SOR are appropriate or not appropriate/too difficult. The chair noted that the subcommittee has looked at mandating the breakout by specialty but it is difficult when there is overlap of societies. It becomes burdensome especially where experience is 1-10 or 10-100.

- A RUC member questioned whether there might be a systematic problem with the intensity measures and requested that the Research Subcommittee look specifically at the last two years of codes to determine what percentage were judged "somewhat more" intense or "significantly more" intense than the KRS. The RUC Chair noted that the Research Subcommittee is already reviewing work intensity and could address this requested analysis.

Referrals to the Administrative Subcommittee:

- A RUC member observed that, in addition to the Primary Care rotating seat, there are three other rotating seats which provide the subspecialists an opportunity to participate. Two internal medicine (IM) rotating seats are available to nine subspecialties and all remaining subspecialties can apply for the one "Any Other" seat. A referral to the Administrative Subcommittee was requested to consider revising the three rotating seats designations as follows:
  1 internal medicine subspecialty
  1 other non-internal medicine or non-surgical subspecialty
  1 surgical subspecialty

  The member believed that redefining the rotating seats would provide more subspecialties with the ability to participate in the RUC. The Director noted that a primary reason there are two IM rotating seats is because there are many IM subspecialties that are very close to meeting the requirements for a permanent seat but are fully represented by an umbrella organization. The RUC Chair noted that it would require a 2/3 vote to change the structure.

- Term length of the RUC rotating seats was also referred to consider extending the term to three-years, consistent with the other seats at the table. The terms for HCPAC were added to this request. It is noted that the HCPAC would need to first review the request before changes would be considered by the Administrative Subcommittee.

RUC Process Clarifications

- A RUC member inquired how industry-provided email lists are used for targeted RUC surveys. The RUC member asked whether it is best practice for the surveying specialty to use a random sample of the vendor list or the entire list. They expressed concern that if the industry partner selects the list, it could skew the results. AMA Staff responded that the specialty must always request for the full list of eligible survey respondents from the vendor and the specialty must either utilize a simple random sample of the providers, or if the list only includes only a few hundred physicians, then the entire population (all emails that were provided). These lists should contain all US-physicians which the vendor has contact information on that have purchased the device or product from the vendor and/or received sufficient training on the service under review.

  The RUC requires that all vendors that provide these lists sign a Vendor-attestation statement that they have not contacted and will not contact any users in connection with the survey. The use of vendor email lists and non-standard survey sample methodologies always requires Research Subcommittee approval. Furthermore, the RUC survey instruments also have each survey respondent fill out financial disclosure questions and asks whether they were contacted by an outside party concerning this survey. If they answer that they have a conflict or were inappropriately contacted, then Qualtrics will not let them complete the survey.

The RUC adjourned at 2:40 p.m. on Saturday, January 18, 2020.