- Doctor Smith welcomed the following member of the AMA Board of Trustees:
  - Russell W.H. Kridel, MD – Chair-elect

  Doctor Kridel extended his deep appreciation to the RUC members for their hard work and dedication. Doctor Kridel thanked the RUC for its phenomenal work with CPT and the Federation in regard to the Evaluation and Management codes and expressed his gratitude for the incredible effort involved in convening all the respective groups to reach a solution.

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

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

- Doctor Smith congratulated the following new RUC Alternate Members:
  - Audrey Chun, MD – American Geriatric Society (AGS)
  - James Shoemaker Jr, MD – American College of Emergency Physicians (ACEP)
  - Clarice Sinn, DO – American Academy of Physical Medicine & Rehabilitation (AAPM&R)

- Doctor Smith wished a fond farewell to the following departing RUC Member:
  - Walter Larimore, MD – American Academy of Family Physicians (AAFP)
    Doctor Larimore was involved in the RUC since its inception, serving as an Advisor at the first RUC meeting in October 1991, and most recently ten years as a voting RUC member.

- 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.
  - 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 shared 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 and on placards outside the meeting room.

- 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.
  - 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:
    - RUC votes are published annually on the AMA RBRVS 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.

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 described a meeting with CMS in September 2019 that focused on process improvements, communication, and the overall efficiency and credibility of the CPT, the RUC, and CMS moving forward as it relates to all issues regarding the RBRVS and the Physician Payment Schedule.

- Physician Practice Information Survey – The RUC has urged CMS for years to re-engage in collecting practice cost information to measure the indirect practice costs, similar to the former Socioeconomic Monitoring Survey and the PPI survey organized by the AMA. Little action over the last decade prompted an HOD resolution from the Texas delegation at the 2019 Annual meeting asking that the AMA examine the overall practice costs and how they have changed for physicians over the last decade. The AMA Board of Trustees has approved funding for 2020 for the AMA to engage in this activity in terms of discussing with CMS its essential data needs and determining the best methodology to obtain the data from physician practices in today's environment. The AMA is prepared to conduct pilot studies in 2021. Initial conversations with CMS are underway.

IV. Approval of Minutes from April 2019 RUC Meeting

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

V. CPT Editorial Panel Update (Informational)

Doctor Pritzker provided the CPT Editorial Panel update. The Panel met twice since the April 2019 RUC meeting:

- **May 2019** – 56 CCA tabs with 7 tabs withdrawn before meeting as a result of pre-meeting review, Cat III = 12 tabs, Cat III to I = 1 tab, Mopath/lab = 15 tabs.

  Tab 8 was the only RUC referred issue for Superficial and-or Orthovoltage Treatment which was a specialty society request to establish three codes to report superficial and/or orthovoltage radiology treatment and delete code 77401. The specialty society withdrew the application before the meeting and indicated they would resubmit the application for the September 2019 meeting; however, a CCA was not submitted for the September meeting and staff will be following up with the specialty on next steps.

- **September 2019** – last meeting for the 2021 code set had 81 tabs, 19 tabs were withdrawn before the meeting based on pre-meeting review work, Cat III 12 tabs, Cat III to I 19 tabs, mopath/genomics/lab 15 tabs. The following RUC-referred issues were addressed:

  Tab 14-Shoulder Debridement- a request for Revision to 29822, 29823 for number of discrete structures debrided per code.

  Tab 25-Nerve Injection with Image Guidance Bundle for codes in range 64400 – 64448.

  This issue was postponed in order for the specialties to coordinate with other interested specialties as well as consider necessary changes to the guidelines and other related code families. Specifically, which codes included imaging such as ultrasound.

  Tab 27-antegrade Urography code - a request to revise the parenthetical for 74425 to report

74425 in conjunction with 50390 (Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous), 50396 (Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter), 50684 (injection for ureterography), 50690 (injection procedure for ileal conduit).

Tab 28-Ophthalmic Ultrasound Anterior Segment- a request to revise code 76513 with language "unilateral or bilateral."

The Image Bundling Workgroup met for a face-to-face meeting Friday morning.

Workgroup Charge: To address how image bundling is integrated within CPT.

The Workgroup is focused on identifying a set of criteria that will help the Panel determine if and how imaging guidance should be bundled into new/revised CPT codes. RUC practice expense implications are a major topic and the results of this workgroup will be shared with the RUC, when available.

- The Panel's next meeting is February 6-8, 2020 in San Francisco, CA. This meeting starts the next cycle for the 2022 Code Set.

  The CCA submission deadline is November 6, 2019.

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

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

- Introduced staff from CMS attending this meeting:
  - Karen Nakano, MD – Medical Officer

  The staff contingent is smaller than usual due to the work underway on the Final Rule for the Medicare Physicians' Payment Schedule for CY2020.

- It was noted that the RUC comments on the NPRM were received ahead of the deadline and were the first of thousands of comments received by CMS. Expected release of the Final Rule is on or about November 1st. Please reach out to CMS *as soon as possible* about any issues regarding codes or policy proposals.

VII. Contractor Medical Director Update (Informational)

Doctor Richard W. Whitten, Medicare Contractor Medical Director, and Doctor Eileen Moynihan provided the Contractor Medical Director update:

- Highlighted the consolidation that has occurred in Medicare Administrative Contractors (MACs) across the country:
  - Medicare Part A/B MACs – From over 100 contractors, there are now 12 contracts and seven contractors.
  - Durable Medical Equipment (DME) MAC jurisdictions –There are four contracts and only two contractors. Proven ability of DME contractors to coordinate together; all policies done jointly.

- Recent MAC Awards:
  - Jurisdiction H – re-awarded (5/30/2019) to Novitas Solutions, Inc.
    (States of Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas)
  - Jurisdiction 5 – re-awarded (9/20/2019) to Wisconsin Physicians Service Government Health Administrators
    (States of Iowa, Kansas, Missouri, and Nebraska)

- Upcoming MAC Re-Procurements:
  - Jurisdiction E – Posted September 2019
    (States of California, Hawaii, Nevada, American Samoa, Guam, & Northern Mariana Islands)
    Targeted Award Date July 2020
  - Jurisdiction C – To be posted December 2019
    DME (Southeast states)
    (Targeted Award Date October 2020)
  - Jurisdiction L – To be posted May 2020
    (States of Delaware, District of Columbia, Maryland, New Jersey & Pennsylvania)
    Targeted Award Date March 2021

- The 21st Century Cures Act has dramatically changed the Local Coverage Determinations (LCD) process including the evolution of Contractor Advisory Committees (CACs) for consultation of a proposed LCD or revision. The CACs were previously individual state-wide groups of advisors to the contractor. The CACs are evolving and can now be multi-jurisdictional, or regionally-based, CAC with representation from each state. They serve as evidentiary panels to discuss a specific topic with all the contractors. Doctor Moynihan described this new process as convened with the subject matter expert testimony group on the topic of Percutaneous Vertebral Augmentation. **Specialty societies may play a significant role in identifying experts in the field and as presenters depending on the topics. Input and feedback from the specialties was requested.**

- New & Revised LCDs – DME
  - Tumor Treatment Field Therapy (TTFT)
    "…DME MAC shall establish multi-jurisdictional CACs when necessary for consultation of a proposed Local Coverage Determination (LCD) or revision. The DME MAC shall include a summary of the recommendations from the CAC regarding the policy in the final LCD."
    Multi-jurisdictional CAC 03/06/2019:
    https://med.noridianmedicare.com/web/jddme/policies/lcd/contractor-advisory-committee
    Open Public Meeting 06/24/2019:
    https://med.noridianmedicare.com/web/jadme/policies/lcd/open-meeting

- New & Revised LCDs – Parts A/B
  - Percutaneous Vertebral Augmentation (PVA) for Osteoportic Vertebral Compression Fracture (Multi-jurisdictional CAC 03/20/2019):
    https://med.noridianmedicare.com/web/jeb/article-detail/-/view/10525/vertebral-augmentation-cac-voting-results
  - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea
  - MicroInvasive Glaucoma Surgery (MIGS)
  - Cardiac Free Fractional Reserve Cardiac Scan
  - Open Public Meeting November 12
  - Fluid Jet Ablation of Prostate
    Contractor Advisory Committee Meeting - November 12
    "CAC" is now for the purpose of evidence collection/discussion.

VIII. Washington Update (Informational)

Jennifer McLaughlin, AMA Lobbyist, provided her inaugural Washington report:

- Health IT proposed rules
  - AMA filed extensive comments on proposals from ONC and CMS relating to health IT in early June
    - Proposed rules focused on interoperability, electronic health record performance, physician burden, and information blocking
    - AMA supported several proposals, including those related to application programming interface (API) standards, EHR certification, and EHR vendor business practices
    - Concern that many other proposals will negatively impact patient privacy and safety, data security, and add to physician burden and burnout
  - AMA continues to engage with HHS and Congress
    - Congressional sign-on highlighting concerns and pushing for changes in final rules
  - Final Rules expected later this year or early 2020

- Prior Authorization
  - CMS planning to address prior authorization in its Patients Over Paperwork initiative
  - AMA led sign-on letter to CMS urging the agency to implement comprehensive strategy to reduce burdens of PA

- CY 2020 Physician Fee Schedule/Quality Payment Program Proposed Rule
  - Evaluation and Management (E/M)
    - Proposes to align E/M office visit coding changes with framework adopted by CPT Editorial Panel
    - Proposed acceptance of RUC valuations for stand-alone office visits
    - Proposed add-on code for E/M office visits for ongoing care related to complex chronic conditions
    - CMS is not proposing to apply the office visit increases to visits bundled into the global surgery packages.
    - The AMA is urging CMS to increase the value of the E/M visits bundled into the global surgical codes.
    - E/M changes would be effective January 2021
  - Care management services
    - Transitional care management – CMS proposes changes to documentation requirements and payment as recommended by the RUC to increase utilization
    - Chronic care management – Proposes new add-on code for additional time spent in certain cases
    - Principal care management – Proposes 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
  - MIPS Value Pathways (MVPs)
    - New MIPS participation framework that would break down siloed legacy programs and creating an approach focused on episodes of care
    - AMA continues to have concerns, such as the mandatory nature of the MVPs
    - Proposed rule includes RFI seeking comment on future of MIPS and on the development/structure of MVPs
  - MIPS proposals would:

    - Increase performance threshold to 45 points in 2020, 60 points in 2021
    - 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
    - Ramp up cost category
      - Proposes to increase cost category weight from 15% to 20%
      - Proposes to add 10 episode-based cost measures and revise existing measures
  - QPP Payment adjustments – set in statute

- MACRA Improvements
  - Continuing focus on improvement to these programs both through the regulatory process and legislation
  - June 2019 sign-on letter from 120 state and national specialty medical societies to Congress outlines three priorities:
    1. Replacing zero percent updates in 2020-2025 with positive updates
    2. Extending Advanced APM bonuses for an additional time period
    3. 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.

- Medicare PFS updates
  - According to data from the Medicare Trustees, Medicare physician pay has barely changed for nearly two decades, increasing just 7 percent from 2001 to 2019, or just 0.4 percent per year on average. In comparison:
    - Medicare hospital updates totaled more than 50 percent between 2001 and 2019, with average annual increases of 2.5 percent per year for inpatient services, and 2.4 percent per year for outpatient services.
    - Medicare skilled nursing facility updates totaled 56 percent between 2001 and 2019, or 2.5 percent per year.
    - 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, is measured by the Medicare Economic Index (MEI).
    - Economy-wide inflation, as measured the Consumer Price Index, increased 45 percent over this time period (or 2.1 percent per year, on average).

  - 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.
  - Congressional action is needed to address a six-year freeze in Medicare PFS service updates from 2020-2025 under MACRA.
  - The window for congressional action this year quickly closing, limited legislative days left
  - A significant amount of work on the table, but only a handful of must pass items:
    - Appropriations must be completed; Fiscal year ended September 30.
    - Continuing Resolution until November 21 – further extensions seem likely
  - Any appropriations packages that move will likely be vehicles for remaining priorities, such as conversion factor update and extenders.

Ms. McLaughlin answered questions following her presentation. A RUC member asked about balance billing and whether the AMA has taken a position related to recent balance billing legislation. Also, has

the AMA been involved in any activities related to Medicaid block grants. She explained the existing AMA policy on balance billing. Ms. McLaughlin followed up with the RUC member on specific questions following the meeting.

IX. Relative Value Recommendations for *CPT 2021*

Breast Reconstruction (Tab 4)
Jeff Kozlow, MD (ASPS) and Mark Villa, MD (ASPS)
Pre-Facilitation: Facilitation Committee #3

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.

The RUC recommends surveying the following 14 codes for the January 2020 RUC meeting:

- Non Breast Tissue Expander (11960)
- Implant/Expander Placement (11970, 19325, 19340, 19342, 19357)
- Implant/Expander Removal (11971, 19328, 19330)
- Secondary Breast Mound Procedure (19370, 19371, 19380)
- Breast Lift/Reduction (19316, 19318)

The RUC noted that the following 8 codes are no longer identified for review and that any changes made to the codes by CPT were editorial:

- Autologous Reconstruction (19361, 19364, 19367, 19368, 19369)
- Nipple Procedures (19350, 19355)
- Moulage Formation (19396)

Percutaneous Ventricular Assist Device Insertion (Tab 5)
Lyndon Box, MD (SCAI); Edward Tuohy, MD (ACC); Richard Wright, MD (ACC)
Pre-Facilitation: Facilitation Committee #3

In May 2019, the CPT Editorial Panel approved the revision of guidelines and revision of four codes to clarify the insertion and removal of right and left heart percutaneous ventricular assist devices (PVAD), and the addition of two codes to report insertion of PVAD venous access and removal of right heart PVAD. PVADs are used for certain patients as aides to recovery following percutaneous coronary interventions or in patients with cardiogenic shock as a bridge to other therapies. This technology is distinct from the more commonly known ventricular assist devices that are implanted by surgeons. Since codes for this technology were first created and valued in 2012 for left-heart arterial use, additional indications have been approved for right-heart venous use. The four existing codes for insertion, removal at a separate session, and repositioning were revised and two new codes for right-heart venous insertion and removal at a separate session were created. While these services are becoming more common, they are still fairly low in utilization overall.

33990 *Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only*
CPT code 33990 is the revised code for left-heart arterial PVAD and the most commonly used in the PVAD family. It is infrequently performed as an elective procedure rather the patients frequently present in cardiogenic shock and are acutely ill, often receiving cardiopulmonary resuscitation simultaneously, resulting in an intense procedure with a risk of the patient bleeding to death due to the femoral arterial access that is required. The RUC confirmed that the patient population has not changed but is skewed now to the sicker patient. The procedure is being used less frequently in the stable patient and more frequently in "salvage" patients who would have been expiring upon presentation due to the degree of cardiogenic shock.

The RUC reviewed the survey results from 70 interventional cardiologists and determined that a work RVU of 6.75 which falls below the current value and below the survey 25th percentile accurately accounts for the physician work required to perform this procedure. The RUC recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 45 minutes and post-service time of 28 minutes. Although below the survey times, pre-service time package 2 was selected because general anesthesia is typically not utilized. The patient is complex, but the procedure is usually performed under sedation not general anesthesia. The RUC confirmed that 33990 will **not** be modifier -51 exempt. There is a distribution of interventions that can be done in this patient population and a host of percutaneous coronary intervention (PCI) codes with which this procedure can be reported, although none reach the 50% threshold. The modifier will be used because, in aggregate, the code is most frequently reported with another code and is therefore subject to the multiple procedure reduction.

The RUC agreed that survey respondents overestimated the physician work involved and determined that applying a crosswalk would appropriately address the decrease in intra-service time reflected in the survey. To determine an appropriate work RVU, the RUC compared CPT code 33990 to the proposed crosswalk CPT code 31276 *Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed* (work RVU = 6.75, 33 minutes pre-service time, 45 minutes intra-service time, 20 minutes post-service time) and noted that the services have identical intra-service and total times and require the same amount of physician work. For additional support, the RUC compared CPT code 33990 to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 53 minutes pre-service time, 45 minutes intra-service time, 20 minutes post-service time) and noted that this comparison also yields the same intra-service time and physician work. Unlike the survey code, the reference code utilizes general anesthesia (pre-service time package 3).
The RUC concluded that a work RVU of 6.75 for CPT code 33990, which falls below the current value and below the survey 25th percentile, is appropriate. Thus, the RUC recommends a crosswalk from CPT code 31276 to 33990. **The RUC recommends a work RVU of 6.75 for CPT code 33990.**

The RUC agreed that survey respondents overestimated the physician work involved and determined that applying a crosswalk would appropriately address the decrease in intra-service time reflected in the survey. To determine an appropriate work RVU, the RUC compared CPT code 33991 to the proposed crosswalk CPT code 43276 *Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged* (work RVU = 8.84, 38 minutes pre-service time, 60 minutes intra-service time, 25 minutes post-service time) and noted that the services have identical intra-service time and physician work and similar intensity. The survey code has 10 minutes less total time, given the pre-service time package, and is a slightly more intense service.

The RUC further noted that CPT code 33991 is appropriately bracketed by MPC codes 52354 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion (ureteral catheterization is included)* (work RVU = 8.00, 53 minutes pre-service time, 60 minutes intra-service time, 20 minutes post-service time) and 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU = 9.00, 31 minutes pre-service time, 75 minutes intra-service time, 20 minutes post-service time).

The RUC concluded that a work RVU of 8.84 for CPT code 33991 which falls below the current value and below the survey 25th percentile is appropriate. Thus, the RUC recommends a crosswalk from CPT code 43276 to 33991. **The RUC recommends a work RVU of 8.84 for CPT code 33991.**

33992 *Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), separate and distinct session from insertion*

CPT code 33992 is the revised code for removal of a left-heart arterial or arterial and venous PVAD. The RUC reviewed the survey results from 64 interventional cardiologists and determined that a work RVU of 3.55 which falls below the current value and below the survey 25th percentile accurately accounts for the physician work required to perform this procedure. The RUC recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 38 minutes and post-service time of 20 minutes. Although below the survey times, pre-service time package 2 was selected as with the other codes in the family. The RUC determined that the package is appropriate because, unlike removal of a Swan Ganz catheter, there is indeed pre-service time associated with the removal of the PVAD. The pre-service evaluation time incorporates the physician's decision about whether it is time to remove the left ventricular assist device, typically a day or two later, as well as decisions about adjusting the flow and weaning the patient. One of the major components when assessing a patient for removal of this device is the arterial access and patient hemodynamic stability. CPT code 33992 is not typically reported with an Evaluation and Management (E/M) code. However, it is rarely reported alone (27%); there are a host of other imaging codes that are reported at the same time. For example, bedside echocardiography is frequently used in assessing the patient during removal, and interpretation of the echo or EKG. These are separately identifiable services and do not overlap with the pre-service time in the survey code.

The RUC agreed that survey respondents overestimated the physician work involved and determined that applying a crosswalk would appropriately address the decrease in intra-service time reflected in the survey. To determine an appropriate work RVU, the RUC compared CPT code 33992 to the proposed crosswalk MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.55, 18 minutes pre-service time, 40 minutes intra-service time, 20 minutes post-service time) and noted that the services involve the

33993 ***Repositioning of percutaneous right or left heart ventricular assist device, with imaging guidance, at separate and distinct session from insertion***
CPT code 33993 is the revised code for repositioning of a PVAD on either side of the heart. The RUC reviewed the survey results from 70 interventional cardiologists and determined that a work RVU of 3.10 which falls below the current value and below the survey 25th percentile accurately accounts for the physician work required to perform this procedure. The RUC agreed that this recommendation appropriately values the survey code compared to the removal codes because, although repositioning takes less time, 33993 is a more intense procedure. The RUC clarified that this service is typically reported on a separate day.

The RUC recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 25 minutes and post-service time of 20 minutes. Although below the survey times, pre-service time package 2 was selected as with the other codes in the family. The RUC determined that the package is appropriate and noted that CPT code 33993 will rarely be reported alone (25%). The repositioning events occur with echocardiographic guidance and often that is performed by a different provider. These are separately identifiable services and do not overlap with the evaluation time in the survey code which is utilizing the pre-service time package.

The RUC agreed that survey respondents overestimated the physician work involved and determined that applying a crosswalk would appropriately address the decrease in intra-service time reflected in the survey. To determine an appropriate work RVU, the RUC compared CPT code 33993 to the proposed crosswalk CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU = 3.10, 21 minutes pre-service time, 25 minutes intra-service time, 15 minutes post-service time) and noted that the services involve the same amount of physician work and identical intra-service times. For additional support, the RUC compared CPT code 33993 to the top key reference service code 33211 *Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)* (work RVU = 3.14, 50 minutes pre-service time, 45 minutes intra-service time, 45 minutes post-service time) and noted that the amount of physician work is similar but the reference code has 20 minutes more intra-service time and twice as much total time, and therefore, appropriately lower intensity than the survey code.

The RUC further noted that CPT code 33993 is appropriately bracketed by MPC codes 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.55, 18 minutes pre-service time, 40 minutes intra-service time, 20 minutes post-service time) and 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU = 3.20, 32 minutes pre-service time, 21 minutes intra-service time, 15 minutes post-service time).

The RUC concluded that a work RVU of 3.10 for CPT code 33993 which falls below the current value and below the survey 25th percentile is appropriate and relative to the removal codes. Thus, the RUC recommends a crosswalk from CPT code 31296 to 33993. **The RUC recommends a work RVU of 3.10 for CPT code 33993.**

Change in Global Period
The family of PVAD codes were surveyed as 000-day global, similar to other coronary interventions, although they are currently XXX services. In comparing the survey templates, the difference between the 000-no visit survey and the XXX-major surgical survey is that the 000-day template asks the day preceding time and the XXX does not; that is the only time field that differs. The RUC does not believe this change fundamentally altered the survey outcome in comparison to XXX valuation. The RUC noted that every key reference service in the family of cardiology procedures is a 000-day global. Also, PVADs are placed and removed during a single hospital stay. With the absence of post-operative visits and pre-

identical in overall complexity and intensity relative to the key reference code. The RUC also compared CPT code 71250 to the second key reference service code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 5 minutes pre-service time, 22 minutes intra-service time, 5 minutes post-service time). Both codes are computed tomography codes, with the reference code involving more anatomic regions than the survey code. Evaluating both the abdomen and pelvis requires more time than evaluating the thorax alone which is reflected in the higher intra service and total times and in the appropriately higher valuation of the reference code.

For further support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the reference code has four more minutes of intra-service time compared to the survey code. This is necessary to evaluate the abdomen on CT both with and without contrast and is reflected in the appropriately higher work value for the reference code. Additionally, the recommended work value is supported by bracketing between two CT codes 70487 *Computed tomography, maxillofacial area; with contrast material(s)* (work RVU = 1.13, 5 minutes pre-service time, 12 minutes intra-service time, 5 minutes post-service time) and 70488 *Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, 5 minutes pre-service time, 15 minutes intra-service time, 5 minutes post-service time).

The RUC agreed that the current work RVU of 1.16 for CPT code 71250 should be maintained. Further, this recommendation maintains relativity across the four codes for CT of the thorax as well as other recently reviewed CT code families. **The RUC recommends a work RVU of 1.16 for CPT code 71250.**

71260 *Computed tomography, thorax, diagnostic; with contrast material(s)*
CPT code 71260 describes an important service for diagnosing and characterizing pathology in the thorax particularly when there is concern for malignancy. The addition of contrast material increases the amount of physician work because the reviewing physician needs to assess the pulmonary parenchyma, mediastinal/ hilar structures, and chest wall for enhancing lesions, as well as meticulously interrogate the major arteries and veins for abnormalities. The RUC reviewed the survey results from 104 radiologists and recommends pre-service time of 4 minutes, intra-service time of 15 minutes and post-service time of 3 minutes. The RUC noted that the one minute decrease in intra-service time from 2016 to 2019 was attributed to survey variation: two surveys support the current intra-service time (2016 survey of 71260 with 16 minutes intra-service time and the 2019 survey of 71260 with 14 minutes intra-service time. The overall 3 minute reduction in the total pre- and post-service time was attributed to a change in survey instruction since 2016 to a more precise measurement without rounding. Current surveys specify that surveyees should, for example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. The RUC noted that this change likely accounted for the decrease in pre- and post- service time for this code, which was recently surveyed in 2016 with no interval change in physician work.
The RUC determined that the current value of 1.24, which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC compared CPT code 71260 to the top key reference service code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, 3 minutes pre-service time, 15 minutes intra-service time, 5 minutes post-service time) and noted that the services involve identical intra-service time and a similar amount of physician work and are supported by the survey respondents who selected the reference code, 88% of whom reported 71260 as identical in overall complexity and intensity relative to the key reference code. The RUC also compared CPT code 71260 to the second key reference service code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time). Both codes are computed tomography codes that involve

assessment of the thorax; however, the work of CTA of the chest requires more time to individually interrogate the pulmonary artery branches that are opacified with contrast during this exam. Thus, the reference code is appropriately valued higher due to the increased time.

For further support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the reference code has three more minutes of intra-service time compared to the survey code. This is necessary to evaluate the abdomen on CT both with and without contrast and is reflected in the appropriately higher work value for the reference code. Additionally, the recommended work value is supported by bracketing between two CT codes 70487 *Computed tomography, maxillofacial area; with contrast material(s)* (work RVU = 1.13, 5 minutes pre-service time, 12 minutes intra-service time, 5 minutes post-service time) and 70488 *Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, 5 minutes pre-service time, 15 minutes intra-service time, 5 minutes post-service time).

The RUC agreed that the current work RVU of 1.24 for CPT code 71260 should be maintained. Further, this recommendation maintains relativity across the four codes for CT of the thorax as well as other recently reviewed CT code families. **The RUC recommends a work RVU of 1.24 for CPT code 71260.**

71270 *Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections*
CPT code 71270 describes an important service for investigating pathology in the thorax, particularly when there is concern for malignancy. It is a technically challenging examination to interpret and subtle findings or pattern/distribution of abnormalities in the pulmonary parenchyma may define a certain disease process, which guides treatment for patients. The RUC reviewed the survey results from 104 radiologists and recommends pre-service time of 5 minutes, intra-service time of 18 minutes and post-service time of 4 minutes. The RUC noted that the two minute decrease in intra-service time from 2016 to 2019 was attributed to survey variation: two surveys support the current intra-service time (2016 survey of 71270 with 20 minutes intra-service time and the 2019 survey of 71270 with 18 minutes intra-service time. The 1 minute reduction in the post-service time was attributed to a change in survey instruction since 2016 to a more precise measurement without rounding. Current surveys specify that surveyees should, for example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. The RUC noted that this change likely accounted for the decrease in post- service time for this code, which was recently surveyed in 2016 with no interval change in physician work.

The RUC determined that the current value of 1.38 which falls below the survey 25th percentile appropriately accounts for the physician work required to perform this service. The RUC compared CPT code 71270 to the top key reference service code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time) and noted that the reference code requires more time and more physician work in comparison to the survey code. More time is required to individually interrogate the pulmonary artery branches that are opacified with contrast during this exam; thus, the reference code is appropriately valued higher than the survey code. The RUC also compared CPT code 71270 to the second key reference service code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the intra-service times are identical, and the amount of physician work is similar.

The RUC compared the survey code to the top key reference service, CPT code 92250 *Fundus photography with interpretation and report* (work RVU = 0.40; 10 minutes intra-service time), noting that the work of the codes are very similar, although, the survey code involves interpretation at a remote site. The survey respondents that selected this reference code indicated that CPT code 92250 is very similar in intensity and complexity to the survey code but requires more time to perform justifying the higher work value. The value is also supported by CPT code 72083 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views* (work RVU=0.35 and 1 minutes pre-service time, 7 intra-service time and 1 minutes post-service time) and CPT code 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU=0.32 and 4 minutes pre-service time, 5 intra-service time and 2 minutes post-service time). **The RUC recommends a work RVU of 0.32 for CPT code 92228.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed PE-only services CPT codes 92227 and ,□as well as CPT code 92228, which has both physician work and practice expense. The Subcommittee discussed that there is clinical staff time in both the physicians' office where the imaging is acquired referred to as the "acquiring site" as well as a small amount of clinical staff time in the remote office where the review and report is being done by clinical staff or the interpretation and report is being done by a physician referred to as the "reading site".

92227 ***Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral.***

For this service there are certain direct practice expense inputs that require time at both the acquiring site and reading site. In addition to the 6 minutes of clinical staff time that clinical staff type L037D *RN/LPN/MTA* requires at the acquiring site to obtain the images, the clinical staff L038A *COMT/COT/RN/CST* performing the review and report for this service requires time as well. This time is recorded under intra-service time CA021, p*erform procedure/service---NOT directly related to physician work time.* The specialty explained, and the RUC agreed that the reading site clinical staff spends the same amount of time as the physician to perform the remote activities for this service, so the time should parallel the 7 minutes of intra-service physician work time for CPT code 92228. In addition to the 2 minutes of clinical staff time that clinical staff type L037D *RN/LPN/MTA* requires at the acquiring site for clinical activity CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*, the clinical staff L038A *COMT/COT/RN/CST* requires 1 minutes for the same activity at the reading site. However, they are using that time to log into the EHR, confirm the order, and download the images from the acquiring site. The patient's interval history and prior photographs are reviewed. Finally, there is 1 minute for clinical activity CA038 *Coordinate post-procedure services* at the reading site, however they are using that time to record the interpretation into the EMR and log completion of task then a report with results and recommendations is sent to the acquiring site.

92228 ***Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral.***

For CPT code 92228, the majority of the clinical staff time is performed at the acquiring site, however in addition to the 2 minutes of clinical staff time that clinical staff type L037D *RN/LPN/MTA* needs at the acquiring site for clinical activity CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*, the clinical staff L038A *COMT/COT/RN/CST* requires 1 minutes for the same activity at the reading site, however they are using that time to logs into the EHR, confirm the order, download the images from the acquiring site and log them into the reading EHR. The technician prepares a message for the reading physician to review and interpret the photographs. The reading technician comments on image quality and readability.

92229 ***Imaging of retina for detection or monitoring of disease; with point-of-care automated analysis with diagnostic report; unilateral or bilateral***
New supply item, *Analysis fee for remote imaging* is a fee charged to the acquiring primary care practice by the company that creates this technology. This fee is a single, per-patient interpretation fee that is incurred in addition to the cost of the camera. The cost of this fee falls into a range, but the discounted cost is reflected in several invoices submitted with this recommendation and the discounted purchase price is the amount that is reflected in the PE spreadsheet. New equipment item, *camera, retinal, for remote imaging* is a new camera that is typically used for all the services in this family. The camera takes non-mydriatic photos and can support point-of-service automated intelligence, as described by the analysis fee, interpretation of photographs. The camera typically used for these services is the Topcon NW 400.

The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

New Technology/New Service
These services will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Exercise Test for Bronchospasm (Tab 10)
Robert DeMarco, MD (CHEST); Kevin Kovitz, MD (CHEST); Katina Nicolacakis, MD (ATS) and Alan Plummer, MD (ATS)

In the Final Rule for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 94620 *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)*, which has since been deleted for CPT 2018, was identified via that screen. In January 2016, the specialty explained that they submitted a Code Change Application (CCA) for the February 2016 CPT Editorial Panel meeting as CPT codes 94620 and 94621 required revisions that would allow the survey respondents to better value these services. Code 94620 described two different tests commonly performed for evaluation of dyspnea, the six-minute walk test as well as pre-exercise and post-exercise spirometry. These tests are entirely different, and it was determined that they should be described with two separate codes. In addition, code 94620 described a “simple” pulmonary exercise test and code 94621 a “complex” pulmonary exercise test. The RUC referred CPT code 94620 to the CPT Editorial Panel. In February 2016, the CPT Editorial Panel deleted code 94620, added two new codes 94617 and 94618 to report an exercise test for bronchospasm, and revised code 94621 to describe a cardiopulmonary exercise test. The CPT Editorial Panel created new CPT codes 94617, 94618 and 94621 for CPT 2018. Shortly after the new codes were created the specialty society became aware that some providers were performing code 94617 without ECG monitoring. This created a gap in coding for services that were previously reported under the old coding structure. The specialty submitted a CCA to the CPT Editorial Panel to correct this gap and in February 2019, the Panel approved the revision of code 94617 and the addition of a new code (94619) to report exercise testing for bronchospasm with or without electrocardiographic recordings. For the October 2019 RUC meeting, the specialty societies surveyed CPT code 94619 and requested affirmation of CPT family codes 94617, 94618, and 94621, which were recently surveyed for the CPT 2018 cycle.

94619 ***Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; without electrocardiographic recording(s)***
The RUC reviewed the survey results from 43 pulmonologists and recommends 5 minutes of pre-service time, 9 minutes of intra-service time, and 10 minutes of immediate post-service time. For code 94619, the RUC agreed that 1 minute less of pre-service time and 1 minute less of intra-service time in comparison

to the times for code 94617 seemed appropriate since they are not interpreting the electrocardiographic recording(s) in the new service. The specialty expert panel noted and the RUC agreed that this service is not typically reported with an E/M, therefore the RUC accepted the survey median pre- and post-service times. For CPT 2018, the RUC had recommended that code 94617 was not typically reported with E/M, as noted in that code's RUC recommendation, and CMS had accepted the RUC work value and physician times implying the Agency's agreement with that recommendation. CPT code 94619 is very similar to code 94617, with the difference being that 94619 is without electrocardiographic recordings. The RUC thoroughly reviewed the recommended work involved in this service and agreed that the survey median of 0.49 correctly accounts for the physician work involved.

The RUC compared the survey code to CPT code 75901 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation* (work RVU= 0.49 and intra-service time of 9 minutes) and noted that both codes have identical intra-service time and should be valued identically. Additionally, the RUC compared the survey code to CPT code 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* (work RVU= 0.54 and intra-service time of 10 minutes), and noted that the survey code has just 1 minute less of intra-service time than the reference code, warranting the slightly lower work value for the survey code. **The RUC recommends a work RVU of 0.49 for CPT code 94619.**

Affirmation of RUC Recommendations

CPT codes 94617, 94618 and 94621 were surveyed in October 2016 and approved by CMS for the CPT 2018 cycle. The RUC-recommended physician times and work values were accepted by CMS for CPT 2018 for codes 94617, 94618 and 94621. These recommendations as noted in the RUC rationale, were based on codes 94617 and 94621 typically not being performed on the same day with E/M, whereas 94618 was valued by the RUC and CMS as typically being reported with E/M. Deleted code 94620, which was split into codes 94617 and 94618, was typically reported with an E/M service 51 percent of the time (per the 2017 Medicare 5 percent file). CPT code 94618 received over 90 percent of deleted code 94620's Medicare volume. The available data for deleted code 94620 supports the specialty's expert panel recommendation that code 94618 is typically reported with an E/M service and code 94617 is typically not. The 2017 Medicare 5 percent file reported together data for code 94621 confirms the RUC's previous recommendation for that service, that it is only reported with an E/M service 24 percent of the time. The RUC noted that their CPT 2018 recommendation for codes 94617, 94618 and 94621 continues to be appropriate as the work has not changed for these existing/revised services. **The RUC affirms the work RVU of 0.70 for CPT code 94617, the work RVU of 0.48 for CPT code 94618, and the work RVU of 1.42 for CPT code 94621.**

Practice Expense
The Practice Expense (PE) Subcommittee made minor modifications, including the addition of *gloves, non-sterile* (SB022) for codes 94619, 94617 and 94621. For codes 94619 and 94617, the *Vmax 29s (spirometry testing equip, computer system)* (EQ043) was replaced with the new *PFT System with PC and printer* because the original equipment is no longer available. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

X. CMS Request/Relativity Assessment Identified Codes

Hip/Knee Arthroplasty (Tab 11)
William Creevy, MD (AAOS); Hussein Elkousky, MD (AAOS); Adolph Yates, MD (AAHKS)
A presenter was precluded from speaking due to a financial conflict. Pre-Facilitation: Facilitation Committee #2

In the Final Rule for 2019, CMS indicated that seven CPT codes were nominated by Anthem for review. In its request, Anthem hypothesized a systemic overvaluation of work RVUs in certain procedures and tests based "on a number of GAO and MedPAC reports, media reports regarding time inflation of specific services, and the January 19, 2017 Urban Institute report for CMS." Anthem suggested that the physician time CMS assumes in estimating work RVUs are inaccurate for procedures, especially due to substantial overestimates of pre-service and post-service time, including follow-up inpatient and outpatient visits that do not take place. According to Anthem, the intra-time estimates for tests and some other procedures are also overstated. Anthem stated that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. The RUC noted that they recommended reductions in 2013 and CMS did not accept the RUC recommendation. However, the CMS accepted values did result in decreases of 2.53 for 27447 and 1.07 for 27130 from the current values at that time. The RUC placed these services on the LOI for review at the April 2019 RUC meeting. The specialty societies did not survey these services for April 2019 citing a lack of compelling data to justify the request and recommended maintaining the 2013 CMS values and times. At the April RUC, the RUC recommended that these services be surveyed for October 2019 and the specialty surveyed the services in the summer of 2019.

Pre-Service Work
In October 2019, the RUC discussed the change in the way total hip and knee arthroplasties are provided. Total hip and knee arthroplasty are increasingly part of a mandatory Medicare bundled payment program (Comprehensive Care for Joint Replacement [CJR]) or an optional Medicare bundled payment program (Bundled Payment for Care Initiative [BPCI]). Similar alternative payment models are employed in many states by both Medicaid and private insurers. Physicians are also more commonly participating in accountable care organizations (shared savings programs) with Medicare, Medicaid and other payors. All hospitals, regardless of participating in a bundle, are being measured for the 90-day episode of cost for total hip and knee surgery for Medicare patients, affecting both the value based program and hospital quality reporting processes. In all these programs, physicians and hospitals have financial incentives to reduce costs and improve quality.

For total joint replacement, one of the key strategies has been improving preoperative identification and optimization of medical co-morbidities to shorten hospital length of stay and reduce complications, including readmissions. In a 2019 New England Journal of Medicine (NEJM) study on the outcomes of patients in the CJR program, the mean number of chronic medical conditions was seven. Considerable work by the clinical staff, surgeons, and qualified healthcare providers (QHPs) is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. The service has also evolved in that patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

The RUC agreed that all this work is not explicitly captured in the standard RUC survey, nor is it included in the current RUC pre-time packages, but the work is certainly being performed on a routine basis for the typical patient.

Prior to surveying, the specialty societies requested to modify the standard 090-day survey to include language regarding pre-operative planning physician time, care coordination time, non-face-to-face post-operative physician time, the impacts of bundled care initiatives (e.g., ACE demonstration, CJR, and BPCI Advanced) and clinical staff time. The specialty societies noted these arthroplasty procedures typically require additional planning time that is often performed more than 24 hours prior to the procedure. The current survey tool and CMS policy defines the pre-operative period as the day before the procedure and, therefore, precludes the survey respondent from being able account for this pre-planning time. The RUC maintains the current CMS pre-service period definition and did not modify the pre-service period question. The RUC noted that the clinical staff pre-service period time in the PE determinations begins after the decision for surgery. Therefore, the Research Subcommittee did approve a question asking how much time the clinical staff (e.g., RN, LPN, MA) spends per patient on planning, preparation, optimization and care coordination activities prior to surgery.

The specialty societies noted that the individual performing the work to prepare the patient for surgery and the processes and protocols is different in various practices or institutions. However, it is typical that the physician/QHP will spend 30 minutes after the decision for surgery but prior to surgery for these planning activities.

The RUC agreed that the pre-service planning activities occur, however the current code and 090-day global period structure is not the way to capture it. The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP. The RUC indicated that separate planning codes may be developed or the current prolonged services, CPT codes 99358 *Prolonged evaluation and management service before and/or after direct patient care; first hour* or 99359 *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)* may be reported for these activities. It was recognized that such codes are intended to capture a single episode of time and that the added work in the preoperative period does not occur in such units of time (e.g., 30 minutes in one session as opposed to over the course of a few days/calls). The RUC also noted that the additional clinical staff activities would not be captured within the prolonged service codes.

The RUC reviewed the current description of pre-service work and acknowledged additional pre-service work may be occurring. However, the specialty societies revised the description of work to include only the work of the physician or QHP on the day of surgery or the day prior to surgery.

Median Intra-Service Time Data

Anthem's letter to CMS cited an Urban Institute study "*Collecting Empirical Physician Time Data Piloting an Approach for Validating Work Relativity Value Units*; *Zuckerman, 2016"* as part of their rationale for nominating these services as potentially misvalued. This study was based on a very limited data set. The study indicated a median of 87 minutes for total hip arthroplasty and a median of 83 minutes for total knee arthroplasty.

The specialty societies quoted three studies from large institutions on over 20,000 total hip and knee arthroplasty services, provided by over 100 surgeons, which support the current and recommended median intra-service time of 100 (THA) and 97 (TKA) minutes.

1. *Surgeon Mean Operative Times in Total Knee Arthroplasty in a Variety of Settings in a Health System; Khanuja, 2019*
   - Median Operative Time: **103 minutes (TKA)**
   - The Johns Hopkins University – 4 hospitals 2 community centers and 2 academic medical centers
   - 6,003 cases, primary TKA
   - 41 surgeons
   - EHR data from 2015-2018

2. *Is operative Time a Predictor for Post-Operative Infection in Primary Total Knee Arthroplasty?; Anis, 2019*
   - Median Operative Time: **102 minutes (TKA)**
   - Cleveland Clinic and Lenox Hill: 16 centers
   - 11,840 cases primary TKA
   - EHR data 2014-2017

3. *Average Operative Times for 1,313 Primary TKA and 1,300 TKA over 39 Months Are Roughly Equal to Medicare Attributed Operative Times; Shah, 2019*
   - Median Operative Time: **113 minutes (TKA) and 99 minutes (THA)**
   - Columbia University
   - 4 surgeons
   - Data from 2015-March 2019

27130 ***Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft***
The RUC reviewed the survey results from 206 orthopaedic and hip/knee surgeons and determined a work RVU of 19.60 appropriately accounts for the work required to perform 27130. The RUC developed this recommendation by crosswalking 27130 to the work of 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60 and 90 minutes intra-service time, 355 minutes of total time). These two services require similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform and therefore should be valued the same. For further support, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU = 19.44 and 100 minutes intra-service time), 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35 and 90 minutes intra-service time) and CPT code 35650 *Bypass graft, with other than vein; axillary-axillary* (work RVU = 20.16 and 110 minutes intra-service time) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that the physician work and time is greater for CPT 23472, thus appropriately valued higher.

The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning, 15 minutes scrub/dress/wait time, 100 minutes intra-service time, 20 minutes immediate post-service time. The RUC indicated that the intra-service time of 100 minutes is confirmed by the RUC survey of 206 physician performing this service as well as the three studies sited above, from three large institutions and over 20,000 total hip/knee arthroplasties.

The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits (2) 99232, one discharge day (1) 99238, and three office visits (3) 99213 were appropriate. The RUC noted that one of the currently bundled hospital visits (1) 99231 is no

longer typical. The RUC noted that the typical length of stay, thus hospital visits, have decreased from four visits prior to 2013 to two visits now in 2019 due to the pre-operative identification and optimization of medical co-morbidities work not explicitly captured in the standard survey or pre-service time. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. A second hospital visit occurs on post-operative day 1 and the patient is typically discharged on post-operative day 2. **The RUC recommends a work RVU of 19.60 for CPT code 27130.**

27447 ***Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)***
The RUC reviewed the survey results from 206 orthopaedic and hip/knee surgeons and determined a work RVU of 19.60 appropriately accounts for the work required to perform 27447. The RUC developed this recommendation by crosswalking 27447 to the work of 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time, 355 minutes of total time). These two services require similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform and therefore should be valued the same. For further support, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU = 19.44 and 100 minutes intra-service time), 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35 and 90 minutes intra-service time) and CPT code 35650 *Bypass graft, with other than vein; axillary-axillary* (work RVU = 20.16 and 110 minutes intra-service time) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that the physician work and time is greater for CPT 23472, thus appropriately valued higher.

The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning, 15 minutes scrub/dress/wait time, 97 minutes intra-service time, 20 minutes immediate post-service time. The RUC indicated that the intra-service time of 97 minutes is confirmed by the RUC survey of 206 physician performing this service as well as the three studies sited above, from three large institutions and over 20,000 total hip/knee arthroplasties.

The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits (2) 99232, one discharge day (1) 99238, and three office visits (3) 99213 were appropriate. The RUC noted that one of the currently bundled hospital visits (1) 99231 is no longer typical. The RUC noted that the typical length of stay, thus hospital visits, have decreased from four visits prior to 2013 to two visits now in 2019 due to the pre-operative identification and optimization of medical co-morbidities work not explicitly captured in the standard survey or pre-service time. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. A second hospital visit occurs on post-operative day 1 and the patient is typically discharged on post-operative day 2. **The RUC recommends a work RVU of 19.60 for CPT code 27447.**

Practice Expense
The Practice Expense Subcommittee thoroughly discussed the clinical staff time for pre-service pre-operative planning activities. The survey respondents indicated, and the specialty societies recommended the median of 90 minutes to provide these services. The PE Subcommittee accepted the compelling evidence that the clinical work involved in the services had changed. Based on acceptance of compelling evidence. The PE Subcommittee entertained accepting the specialty society recommendation of an additional 30 minutes or an alternative of 15 minutes for these activities. The PE Subcommittee noted that

the standard pre-service time package is 60 minutes for 090-day global period services, which was the survey 25th percentile. The PE Subcommittee entertained accepting the specialty society recommendation of an additional 30 minutes or an alternative of 15 minutes for these activities. The Subcommittee questioned who is performing the pre-operative planning work and at what setting: the orthopaedic practice, the consulting physician's practice or hospital employees. The PE Subcommittee noted that adding additional clinical staff time for these services would create an anomaly and provide discrepancies with other 090-day global services. Ultimately, the PE Subcommittee did not accept additional clinical staff time for these pre-service activities. The RUC also discussed capturing this additional clinical staff time and agreed with the PE Subcommittee not to capture any additional pre-operative planning time for clinical staff. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee**.

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

Spirometry (Tab 12)
Robert DeMarco, MD (CHEST); Kevin Kovitz, MD (CHEST); Alan Plummer, MD (ATS)
Pre-Facilitation: Facilitation Committee #2

In January 2019, the Relativity Assessment Workgroup reviewed action plans on the status of services that were RUC referrals to develop CPT Assistant articles from 2013-2016. The RUC recommended that this service be surveyed.

94010 ***Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation***
The RUC reviewed the survey results from 92 pulmonary medicine physicians and determined that the current work RVU of 0.17, which is below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes of intra-service and 2 minutes of immediate post-service time. The RUC noted that this service is typically reported with an Evaluation and Management (E/M) service on the same day, therefore the survey pre and post-service times were reduced to account for any overlap in these services. Based on the reviewer comments, the specialty societies revised the description of pre-, intra- and post-service work to describe only the work of the physician or qualified healthcare professional.

The RUC compared CPT code 94010 to the second key reference service, 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17) noting that these services require the same intra-service time of 5 minutes and similar total time (6 and 7 minutes, respectively), therefore should be valued the same. Additionally, approximately two-thirds of the respondents that selected this reference code indicated that these services require identical overall intensity and complexity to perform. For additional support the RUC noted that there are many services that require similar physician work and time, such as MPC code 93042 *Rhythm ECG, 1-3 leads; interpretation and report only* (work RVU = 0.15, intra-service time of 3 minutes and total time of 7 minutes), MPC code 96374 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug* (work RVU = 0.18 and intra-service time of 5 minutes and total time of 9 minutes) and CPT code 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* (work RVU = 0.17, intra-service time of 5 minutes and total time of 7 minutes). **The RUC recommends a work RVU of 0.17 for CPT code 94010.**

94060 ***Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration***

The RUC reviewed the survey results from 93 pulmonary medicine physicians and determined that the survey 25th percentile work RVU of 0.22 accounts for the work required to perform this service. The RUC recommends 5 minutes of intra-service time and 3 minutes of immediate post-service time. The RUC noted that this service is typically reported with an Evaluation and Management (E/M) service on the same day, therefore the survey pre and post-service times were reduced to account for any overlap in these services. Based on the reviewer comments, the specialty societies revised the description of pre-, intra- and post-service work to describe only the work of the physician or qualified healthcare professional.

The RUC noted that the survey intra-service time decreased by two and a half minutes from the current time and therefore the RUC accepted the survey median intra-service time of 5 minutes and lowered the current work RVU. The RUC notes that 94010 and 94060 now require the same intra-service time. Although CPT code 94060 now only requires one more minute of total time to complete than 94010, it does require more intense work, as it includes the work of the spirometry and evaluation of the three to eight maneuvers both pre- and post- bronchodilator. CPT code 94060 is appropriately slightly more intense and complex than 94010, which the recommended work RVU and time support.

The RUC compared CPT code 94060 to the second key reference service, CPT code 71046 *Radiologic examination, chest; 2 views* (work RVU = 0.22 and 6 minutes total time) and noted that 94060 requires similar physician time and intensity and complexity and thus should be valued similarly. For additional support the RUC referenced MPC code 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes total time), which requires similar physician work and time. **The RUC recommends a work RVU of 0.22 for CPT code 94060.**

Practice Expense
The Practice Expense Subcommittee approved the addition of *gloves, non-sterile* (SB022) and the obsolete *Vmax 29s (spirometry testing equip, computer system)* (EQ043) was replaced with the currently available system *PFT System with PC and printer.* **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

Molecular Pathology Interpretation (Tab 13)
Aaron Bossler, MD (CAP); Michael Idowu, MD (CAP); Ronald McLawhon, MD, PhD (CAP); Roger McLendon, MD (CAP); Swati Mehrotra, MD (CAP)

In January 2019, the Relativity Assessment Workgroup reviewed CMS/Other Source codes with 2017e Medicare utilization over 30,000. The RUC recommended this service be surveyed for October 2019. The Research Subcommittee reviewed and approved a new vignette and custom survey template for the October 2019 RUC meeting.

Compelling Evidence
The specialty society presented compelling evidence for CPT code G0452 based on a change in technology, change in patient population and a flawed methodology used in the previous valuation. G0452 was created as a replacement code for deleted CPT code 83912 *Molecular diagnostics; interpretation and report*. In response to payer requests, the CPT Editorial Panel developed a new coding structure for CPT 2013 to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. By CPT 2013, the Panel had accepted

107 Tier 1 codes and 9 Tier 2 codes. For CPT 2013, the RUC had recommended physician work and time values for 80 Tier 1 codes and 9 Tier 2 codes, while the other codes were classified as not typically requiring physician work. However, the Agency determined to cover these services all under the Clinical Lab Fee Schedule (CLFS) and only create G0452 for when interpretation and report required a physician's judgement. G0452 was created by crosswalking the work RVU and physician times from deleted code 83912, which the specialty indicated was via a flawed methodology and did not sufficiently consider the surveys they conducted for over 80 CPT codes. The initial valuation of 83912 by the RUC and CMS from 1995 was based on the most frequently performed tests at the time (simple blood tests) on the general population — it is unclear what methodology the Agency used to determine if that assumption was still valid for CY2013 when G0452 was created as a replacement code. In addition, when the original service was surveyed for 1995, only 16 pathologists completed the survey which does not meet the RUC's current minimum threshold for a survey. Deleted code 83912 had 525,521 Medicare Utilization in CY2012, whereas G0452 now only has 117,592, as a result of the large change in the coding structure and data which implies many of the molecular pathology services that were formerly reported with code 83912 are no longer reported using G0452 and are solely covered under the CLFS.

One hundred of those initial codes were identified as the most frequently performed tests (Tier 1 molecular pathology codes). The remainder were recognized as clinically valid but less frequently performed (Tier 2 molecular pathology codes). The former consisted of relatively simple blood-based tests to identify common polymorphisms with generally straightforward interpretation (eg, Factor V Leiden for thrombotic risk). The Tier 2 coded services were stratified according to technical complexity (eg, DNA sequencing), the number of genes that needed to be evaluated, and the complexity of interpreting large amount of often ambiguous information. Tests for constitutional syndromic genetic abnormalities comprised the majority of the initial Tier 2 tests. Later, multianalyte panels to identify oncologic driver mutations that could direct targeted therapies for cancer patients became a substantial part of the Tier 2 code set. The more recent addition of new codes in the Genomic Sequencing Procedures section recognized the frequent performance of molecular test procedures for evaluating complex inherited syndromes and characterizing both hematologic and solid tumor malignancies. These additions to the code set reflect significant technical advances that allow for greater amounts of genetic information to be evaluated simultaneously, which markedly affects the complexity of interpretation. The identification of multiple aberrations, their potential interaction, often equivocal understanding of their clinical significance, the limitations of the available specimen, and the clinical implications of all these factors distinguish these complex services from the relatively simple binary interpretation associated with the early molecular tests on which the initial G0452 valuation was made. The interpretation of the complex procedures requires detailed knowledge of the technology and its limitations for addressing specific clinical questions, the limitations of available specimen types and the consequences of those limitations on the test result, an extensive familiarity with data processing, as well as an understanding of the strength of medical evidence related to specific identified genetic abnormalities. The length and complexity of current molecular test reports attest to the additional interpretive efforts needed in understanding the test results and their clinical significance.
Due to changes in technology, the availability of new tests and the coding structure, the patient population for which the majority of molecular testing is currently performed (with G0452) is now dominated by oncology patients and those with complex inherited disorders, including those syndromes predictive for cancer risk and potential response to specific targeted therapies. At the October 2019 RUC meeting, the RUC agreed with the specialty that there is evidence of a change in patient populations being tested. Additionally, the RUC noted it is clear from Medicare current ICD-10 data and the survey data that the typical patient for G0452 has acute leukemia. In 1995, the typical patient was listed as "Using polymerase chain reaction (PCR), evaluation and report of DNA probe study of vaginal swab obtained from a pregnant 28-year-old suspected of gonococcal infection."

The RUC approved the societies' compelling evidence based on flawed methodology, change in technology and a change in patient population.

G0452 ***Molecular pathology procedure; physician interpretation and report***
The RUC reviewed the survey results from 58 molecular pathologists and recommends: 27 minutes of intra-service time. The RUC noted that the amount of time needed for this procedure has increased because it is now typically being used for interpretation of much more complex molecular pathology tests due to improvements in technology since this service was last valued in 1995. The typical test has switched from a simple test to the analysis and molecular/genomic classification of bone marrow for a patient with acute myeloid leukemia. Furthermore, this service is typically reported alone (81 percent of the time per the 2017 Medicare 5% file).

The RUC reviewed the survey 25th percentile work RVU of 0.93 and agreed that this value appropriately accounts for the physician work involved. The RUC compared the survey code to CPT code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology* (work RVU= 0.95, intra-service time of 25 minutes) and noted that both services involve a similar amount of physician work and a similar amount of physician time. The RUC also compared the survey code to CPT code 85097 *Bone marrow, smear interpretation* (work RVU= 0.94, intra-service of 25 minutes) and noted that both services involve a similar amount of time and a similar amount of physician work. Furthermore, both services are pathology services whose typical vignette is for a bone marrow specimen for a patient with acute myeloid leukemia. **The RUC recommends 0.93 work RVU for HCPCS code G0452.**

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

External Counterpulsation (PE Only) (Tab 14)
Edward Tuohy, MD (ACC) and Richard Wright, MD (ACC)

In the NPRM for 2020, this service was nominated as potentially misvalued. CPT code G0166 was originally flagged for RUC review in 2017 under CMS/Other utilization over 100,000 screen by the RAW and was reviewed for the CY 2019 PFS *Final Rule* (83 FR 59578). During that review it was determined that an individual session of External Counterpulsation (ECP) includes no physician work and 0.07 work RVUs were removed. Adjustments were also made to supplies, equipment, and clinical staff practice expense inputs. The work RVU and direct PE inputs as recommended by the AMA RUC were finalized by CMS without refinements. However, the commenter noted that the PE inputs that were considered for this code did not fully reflect the total resources required to deliver the service. CMS noted they will review the commenter's submission of additional new data and public comments received in combination with what was previously presented in the CY 2019 PFS *Final Rule*. The RUC reviewed the direct practice expense inputs for G0166 at the October 2019 RUC meeting and CMS will consider the new information for the *Final Rule* for 2020.

The RUC found that additional information about the direct practice expense inputs required to provide ECP warrants consideration of revisions to direct practice expense inputs submitted by the RUC for the 2019 *Final Rule*. ECP providers incur distinct, attributable costs for staff, supplies, and equipment resources for specialized pants, hoses, cuffs, and bladders that have not been previously accounted. This more detailed information was not available when the service was reviewed by the RUC in 2017.

The Practice Expense (PE) Subcommittee discussed the clinical staff time necessary for this service and agreed with the specialty recommended increase from the May 2017 RUC recommendations for certain clinical activities. The RUC agreed with the specialty that in addition to the standard 3 minutes for clinical activity CA010, *obtain vital signs,* before the session in the pre-service of the service period another set of vitals is appropriate after the session in the post-service of the service period. For both clinical activities the staff obtains blood pressure, heart rate, respiratory rate, and weight. The additional 4 minutes over the standard for clinical activity CA016, *prepare, set-up and start IV, initial positioning and monitoring of patient* is recommended for patient positioning to account for the difficulty of wrapping the 6 pressure cuffs. This is necessary to maximize therapeutic benefit by ensuring bladders are placed correctly over the femoral artery and avoid wrinkle or folds that commonly create blisters on patients. Lastly, the RUC agreed that clinical activity CA027, *complete post-procedure diagnostic forms, lab and x-ray requisitions* requires 3 minutes for clinical staff to performing post-procedure waveform calculations and analysis as noted in the ECP user manual included with this recommendation. These times are supported by feedback and times collected from experienced experts from one of the leading group practices performing the service. The RUC did not agree that an additional 8 minutes of time was necessary for clinical activity CA021, *perform procedure/service---NOT directly related to physician work time* and this clinical activity was reduced from the specialty recommended 68 minutes to existing 60 minutes. In addition, clinical activity CA035, *Review home care instructions, coordinate visits/prescriptions* was reduced from the specialty recommended 2 minutes to 0 minutes.

The PE Subcommittee determined that additional supply items 3 *sanitizing cloth-wipe (surface, instruments, equipment)* (SM022) was appropriate, however tissue (Kleenex) (SK114) is not necessary. The PE Subcommittee discuss that equipment item *EECP, external counterpulsation system* (EQ012) had a purchase price of $150,000 in 2018. For 2019 CMS' equipment repricing effort resulted in a lower purchase price of $127,873. In 2020 the machine is proposed to be priced at $105,745 under year 2 of the phase-in. The RUC recommends that CMS review new information regarding the purchase price for EQ012 rather than complete the phase-in of the repricing which will result in a final purchase price of $61,491 after the four-year phase-in is complete. Two paid invoices are included with this recommendation for the item. The purchase price of $101,247.50 listed on the PE spreadsheet is an average of the two prices listed on the invoices. In addition, the RUC recommends two new equipment items for this service. The EECP compression equipment package includes cuffs, bladders, and hoses that are necessary as direct practice expense and have not been previously included. Manufacturer guidance requires sets of cuffs to be replaced every 100 hours of treatment or roughly 1/5 of a year, so the RUC recommends that the equipment have a 0.20-year useful life. The EECP electrical equipment package included invoECG cable, ECG adapter, and pleth cable that are replaced annually, so the RUC recommends this equipment package have a 1-year useful life. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

Equipment Utilization Rate of 25 Percent
The RUC noted that EQ012 *EECP, external counterpulsation system* is the only equipment input in the RBRVS with an equipment utilization rate of 25 percent. All other equipment inputs in the RBRVS have at least a 50 percent equipment utilization rate. The practice expense RVU for this service assumes that the equipment is only in use 1/4th of a 50-hour work week. The 25 percent utilization rate has been in place since G0166 was created for CY2000 — the rationale for this decision was not stated in previous rulemaking. The RUC recommends for the Agency to review the equipment utilization for this service and explain why it differs from all other medical equipment.

XI. Practice Expense Subcommittee (Tab 15)

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

- **Direct and Indirect Practice Expense Workgroup**

At the April 2019 RUC Practice Expense (PE) Subcommittee meeting there was extensive discussion about determining whether practice expense inputs are direct or indirect. Specifically, criteria on when an ED021 *computer, desktop, w-monitor* should be included as a direct expense in a specific CPT code. The Direct and Indirect Practice Expense Workgroup, chaired by Doctor Cohen, met via conference call on June 10, 2019 to discuss the criteria and review data on the CPT codes that include equipment item *computer, desktop, w-monitor*, ED021 and CPT codes that include equipment item *refrigerator, vaccine, temperature monitor w-alarm*, ED043. The Workgroup agreed that the Subcommittee should continue the current practice for computers and refrigerators of assuming they are indirect equipment. The Workgroup recommended, and the PE Subcommittee agreed that the default designation for refrigerators and computers should remain indirect practice expense and specialty societies will have the opportunity to present evidence that an exception should be considered if the use of the refrigerator is directly allocable to the individual service.

- **Fluoroscopy Rooms and Tables**

The PE Subcommittee discussed questions regarding including both equipment items: mobile c-ARM room (EL018) at a purchase price of $151,200 and fluoroscopy table (EF024) at a purchase price of $227,650 to perform one service with fluoroscopy. The PE Subcommittee discussed that there are currently no CPT codes that included both equipment items and CPT codes 6XX00, 64XX0 and 64XX1, new for CPT 2020, will be the first codes to have both equipment items. These codes appeared to have an appropriate rationale. The PE Subcommittee will be aware of the issue if it occurs in the future, however the Subcommittee determined that no further action will be taken at this time.

- **Preventing Supply Duplication**

An ongoing issue for the PE Subcommittee is duplication of supply items between the requested kits and single supply items. To assist in preventing duplication of supply items in direct practice expense recommendations the specialties will be instructed to include the contents of the kit, packs and trays in the PE summary of recommendation (SOR). The following wording will be added to the PE SOR:

> Please provide an itemized list of the description, CMS supply code, unit, item quantity and unit price (if available), for all supply kits, packs and trays included in your recommendation (please see documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays).

- **Clinical Staff Time Surveys Workgroup**

The PE Subcommittee reviewed the staff note regarding practice expense surveys and some of the historical guidelines and indications for doing PE surveys for clinical staff time, which specialties have conducted on an ad hoc basis in the past. The Subcommittee agreed that it is appropriate to form a Workgroup to develop guidance or criteria regarding how to determine when a practice expense clinical staff time survey is necessary and should be conducted. The Workgroup will be chaired by PE Subcommittee member Doctor Bradley Marple.

- **Intra-Service Clinical Staff Time Workgroup Discussion**

During discussion of Screening CT of Thorax, the PE Subcommittee discussed the clinical staff time for clinical activity CA021, *perform procedure/service---NOT directly related to physician work time.* This led to questions about the intra-service clinical staff times given how CT scanners have evolved over the years. The PE Subcommittee will form a Workgroup to review the issue. The Workgroup will be chaired by PE Subcommittee member Doctor Donald Selzer.

Staff Note: Due to specialty society concerns about this Workgroup the RUC has agreed that staff should prepare a report for the January 2020 PE Subcommittee meeting to outline the concern raised during the

PE Subcommittee discussion (internal consistency of staff time within families of advanced imaging service – egg, CT). The PE Subcommittee will review the staff note and discuss at the January 2020 meeting however the Workgroup will not meet until there is further clarification from the PE Subcommittee and RUC.

- **Major Surgery Pre-service Time Package Standard Workgroup**

During this PE Subcommittee meeting the specialty societies that presented the Hip-Knee Arthroplasty codes recommended 90 minutes of pre-service clinical staff time for the two codes in the family, CPT codes 27130 and 27447. This led to a discussion about how the practice of surgery has evolved over the years since the pre-service standard time package of 60 minutes for 090-day globals was developed about 20 years ago. The PE Subcommittee will form a Workgroup to review the history of how the standard was developed and determine if any revisions to the time components are necessary. The Workgroup will be chaired by PE Subcommittee member Doctor Neal Cohen.

- **Equipment Utilization Rate**

Lastly, The PE Subcommittee was curious about equipment utilization rates. Rates are set by CMS and the assumption is that a piece of equipment is used for 50% of the time for a 40-hour work week. Equipment with a purchase price over a million dollars is assumed to be used 90% of the time for a 40-hour work week. At this meeting the PE Subcommittee reviewed the counterpulsation codes which had a single item of equipment with a utilization rate of 25%.

RUC staff will review the issue going back to the rulemaking process and provide the historical context of how these numbers were originally determined. Staff will draft a note for review by the PE Subcommittee at the January 2020 RUC to further explore this issue and help the PE Subcommittee determine if any action is warranted.

The RUC approved the Practice Expense Subcommittee Report.

XII. Research Subcommittee (Tab 16)

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

- **The Subcommittee reviewed and accepted the June 2019 Research Subcommittee report.**

The Research Subcommittee report from the June 4, 2019, conference call and separate electronic review included in Tab 16 of the January 2019 agenda materials was approved with minor editorial modifications to the final approved text of the Hip and Knee Arthroplasty clinical labor survey text. It was noted that the specialties had appropriately used the survey text that was approved by the Subcommittee in June in their October 2019 survey, though if this text was ever used as a model for surveys going forward, the terms surgical "clearance" and "emails" should be updated to use separate more formal terms.

- **Specialty Mix of RUC Survey Samples**

At the October 2018 RUC meeting, a RUC member proposed for the Research Subcommittee to explore whether any additional instructions or rules are necessary for specialties regarding how to align the specialty mix of the survey sample relative to how often each specialty performs the service. At the January 2019 Subcommittee meeting, the Research Subcommittee had a brief discussion regarding whether additional information should be provided and/or whether new rules should be created pertaining to the specialty mix of the survey sample and survey responses — this discussion was continued at the October 2019 meeting. At both meetings, the Subcommittee members expressed concern with making any modifications to the current process, noting the additional administrative burden it would place on

specialty societies and the additional enforcement burden it would place on the RUC would not be appropriate at this time. The Subcommittee concurred that the current process is working as intended. The Subcommittee also discussed whether it would be appropriate to require multispecialty advisory committees to always breakout their summary survey data by either specialty or society. While some Subcommittee members expressed support for making this an explicit requirement, a large majority of the Subcommittee agreed that the current process, where this decision is left to the multispecialty advisory committee's discretion, is working appropriately. The Research Subcommittee agreed that no changes were needed at this time to the current processes.

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

In 2014, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without the requirement they submit a summary of the original survey data to the RUC. When this issue was discussed by the Research Subcommittee at its September 2014 meeting, the Subcommittee did not recommend the adoption of the proposal. Instead, the Subcommittee requested for AMA staff to track the occurrences with the intent to re-evaluate the issue in two years and has continued to track this issue since that time.

At the October 2019 Subcommittee meeting, AMA staff noted that there have been no instances of societies conducting surveys and not providing their summary data since the January 2017 RUC meeting. Some Subcommittee members noted that if societies were coming back with the same codes they should be compelled to provide their survey summary data from both surveys. The majority of the Subcommittee agreed that since societies have been providing data in these instances in recent years, maintaining the current process would be most appropriate. The Subcommittee agreed that providing survey summary data should continue to be at the specialty's discretion. Also, the Subcommittee noted that it would no longer be necessary to track this issue on an ongoing basis, as the Subcommittee has done since 2014.

- **Data on Length of Time to Complete a RUC Survey**

During the RUC's April 2019 other business discussion, the RUC had requested for AMA staff to work with specialty societies to collect de-identified data on the length of time it takes a physician to complete a standard Qualtrics survey for each global and then to summarize the data for the Research Subcommittee. In late June 2019, AMA staff contacted a sample of specialty staff representing over 20 societies requesting de-identified Qualtrics data on the length of time to complete a standard RUC survey. A summary of the data split out by each survey provided is included in staff note 6D of agenda item 16. Separately, AMA staff combined the data from all one code surveys (532 total respondents). For the one code survey aggregate data, the 25th percentile was 8 minutes, the median was 12 minutes and the 75th percentile was 20 minutes.

The Research Subcommittee noted that these data could be used as a reference for advisory committees by helping them to determine what survey length estimates to include in their survey distribution emails. Societies would be able to use this information as they see fit. For example, if a survey only includes one or two codes, in most cases it would be accurate to state that the "survey should take approximately 10 to 20 minutes to complete." For 3-5 code surveys, similarly, the distribution email could state that the "survey should take approximately 15 to 30 minutes to complete." If a survey is highly customized or a code family includes lengthy CPT guidelines, then longer estimates may be more appropriate on a case-by-case basis. **The Research Subcommittee recommended for AMA RUC staff to include time estimates in the "Instructions for Specialty Societies Developing Work Value Recommendations."** The Subcommittee noted that this would serve as model language but would not be mandatory.

- **Review of Potential Improvements to the RUC Survey Process**

Review Ordering of Questions

The Research Subcommittee approved a custom survey template for the office visit survey for the April 2019 RUC meeting. One of the changes approved was to reorder the performance rate question #5 and the work RVU question #6. During “Other Business” at the April 2019 meeting, a RUC member proposed for Research to look at making this change for all RUC survey templates. Subcommittee members observed that having the performance rate question between the intensity/complexity questions and the work RVU question may distract the survey respondent and that it would be best if the time question (Q2), intensity questions (q3-4) and the work RVU question were immediately adjacent to each other. The Subcommittee agreed that having the time question, the intensity/complexity questions and the work RVU question all adjacent would be appropriate, so there would be no tangential question to break up the survey respondents’ thought process. **The Research Subcommittee recommends for the performance rate question to be moved to the last question of the standard RUC survey instrument.**

Global Surgery Survey Templates

During the Subcommittee’s June 4th call, the Subcommittee reviewed proposed 090-day global surgery survey changes from AAOS and AAHKS and noted that they would also consider two of those changes, the same day E/M text and the qualified healthcare provider text, at the October 2019 meeting for potential inclusion in the standard survey template. **The Research Subcommittee made some additional editorial changes to the proposed language and approved the updated survey text for the standard 000-day with visit, 010-day and 090-day survey templates as follows:**

- **Adding the following prior to the survey Physician definition:** “Important: All references to "physician" in this survey include both "physician" and "other qualified health care professional" [QHP] (ie, advanced practice nurse or physician assistant).”
- ***Change to Same Day E-M Question Text:***
  If your patient ~~is~~ *typically* ~~**kept**~~ **remains** overnight in a hospital after surgery, after the patient is transferred from the recovery room, will you or a qualified healthcare ~~**provider**~~ **professional** ~~perform an E&M service~~ ~~**see**~~ **evaluate** and examine the patient on the floor or other hospital unit later on the same day?

Survey Reminder Emails

During “Other Business” at the April 2019 meeting, a RUC member proposed for the Research Subcommittee to evaluate whether it would be beneficial to provide advisory committees with standard survey reminder email templates and survey guidance. During the office visit survey, it did seem that societies that circulated reminder emails did have a better survey response rate — several Subcommittee members concurred with this observation. **The Research Subcommittee agreed that providing the below reminder email text as model language for societies would be appropriate:**

Subject: *Important Reminder. Please complete the [Code Family Name] Survey*

As a valued member of the [insert specialty society name], you have been selected to participate in an AMA/Specialty Society RVS Update Committee (RUC) survey for the [code family name and CPT code numbers]. This survey will help our society, in concert with the RUC, recommend accurate relative values for physician work [insert "and direct practice expense" if applicable] for these important codes to the Centers for Medicare & Medicaid Services. We only have a few short weeks to compile this critical physician input. We urge you to complete the survey now.

Begin the RUC Survey or Continue Where You Left Off

If you have difficulty accessing the survey or if you have any questions, please contact: [Insert specialty staff contact email and/or phone number]. ***Thank you in advance for your time!***

Response Rate Percentage Field in Summary of Recommendation (SOR) document
AMA RUC Staff proposed for the Research Subcommittee to consider removing the response rate percentage field from the Summary of Recommendation form (while still retaining the number of responses and sample size fields). Since the survey instructs recipients to not complete the survey if they are not familiar with the service, the denominator for the percentage calculation includes physicians that are not eligible to complete the survey. Also, commonly societies are not sure which of their members are familiar with performing certain services and conduct simple random samples of their entire US membership. There are also the associated logistical limitations of sending via email (ie incorrect/old email addresses, recipients not seeing email, etc.) The Research Subcommittee concurred that the response rate percentage datapoint seems to have little utility and is sometimes misinterpreted by stakeholders both internal to and external form the RUC process. The Subcommittee agreed that removing that field from the SOR would help reviewers/stakeholders to better focus on the absolute number of responses relative to how widely the service is performed, as well as the nature of the responses. **The Research Subcommittee recommends for the response rate percentage field to be removed from the Summary of Recommendation form.**

A Subcommittee member proposed for AMA staff to prepare a staff note for the next meeting regarding the feasibility of redefining the denominator (aka 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.**

- **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. They noted that when considering the compelling evidence for the office visits codes the same increase in work may apply to the pre-service evaluation component of other services. The volume-weighted work per unit of time (WPUT) of the RUC's May 2019 office visit recommendation was 0.0409. The RUC agreed to refer the issue to the Research Subcommittee for consideration.

At the October 2019 meeting, the Subcommittee noted that the pre-evaluation evaluation, pre-service positioning and immediate post-service components of the IWPUT formula have a "standardized" value for IWPUT of 0.0224, resulting from phase 2 and phase 3 of the Harvard studies. Subcommittee members noted that this intensity input has remained in place for over 25 years.

The Subcommittee agreed that the intent of this discussion is not to prompt retroactive valuation changes to existing codes, but solely to potentially modernize the IWPUT formula. Several Subcommittee members noted that since the 0.0224 input and the 0.0081 inputs were relatively very low, the intra-service intensity derived by the IWPUT formula may have become artificially inflated over the years. A Subcommittee member observed that both intensities (pre/post service and positioning) are much lower than the current IWPUT for a 99211 nurse's visit which would typically be used for a blood pressure check.

Several Subcommittee members noted that surgical pre-service time and immediate post-service time is analogous to E/M as it is face-to-face, the surgeon must focus solely on the patient during that time and that the intensity is similar to E/M for several of the components. During pre-service evaluation the surgeon is doing face to face E/M work and that it would be appropriate for that component to have a similar intensity to separately reported E/M services.

The Subcommittee also discussed a separate item that was referred by the RUC from the April 2019 RUC meeting. A RUC member had requested for the Research Subcommittee to explore whether the RUC should consider more routinely reviewing work per unit time (W/T) in addition to intra-service work per unit of time. Some Subcommittee members expressed support for WPUT being used as a separate metric, whereas other Subcommittee members expressed reservations. AMA Staff had provided the Subcommittee with an analysis with the current volume-weighted WPUT for several categories of hospital visits, for each global period and for several broad sections of the CPT book. That analysis showed that the surgical sections of CPT (codes 10004 – 69990) and the E/M section of CPT had similar work per unit times of 0.043 and 0.041 respectively.

The Chair observed that the Subcommittee has had a very productive discussion, though posited and the Subcommittee agreed that the discussion of these topics was at a preliminary stage and that the Subcommittee was not ready to create any defined updates or action items at this time. The Subcommittee will continue this discussion at its next face-to-face meeting.

Separately, the Subcommittee recommended for AMA staff to prepare analyses on the impact of changing the intensities of the pre and post service time components.

The RUC approved the Research Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 17)

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

The Workgroup reviewed action plans for the following screens: CMS Other Source Codes – Medicare Utilization over 20,000, High Volume Growth, Work Neutrality, New Technology/New Services and made recommendations as indicated in the full report.

Regarding CPT code 80500, identified via the CMS/Other Source codes with utilization over 20,000, which was referred to CPT for revision. The specialty societies requested that it be postposed to the September 2020 CPT meeting/January 2021 RUC meeting, so the specialty societies have enough time to specifically define this service. The RUC agreed and noted it would still be in the same cycle.

Regarding the Work Neutrality issue for CPT codes 64633-64636, initially identified in 2013. The societies tried several methods to address the issue of work neutrality considering the increased utilization. At this point the Workgroup recommended that these services be surveyed for January 2020. The specialty societies indicated to the RUC that there are multiple societies are involved in these services

and requests that the survey be postponed until April 2020. **The RUC recommends that CPT codes 64633-64636 be surveyed for April 2020.**

Doctor Andreae indicated that the Workgroup reviewed the data for the reiteration of existing screens. The Workgroup noted no new codes were identified when reviewing Medicare data from 2016-2018e performed less than 50% of the time in the inpatient setting but included inpatient hospital Evaluation and Management services within the global period with 2018e Medicare utilization over 10,000. However, nine codes are identified if the threshold is lowered to 2018 estimated Medicare utilization over 5,000. **The Workgroup recommended to lower the utilization threshold for this screen and the nine codes identified (CPT codes 19307, 19340, 19357, 22310, 49565, 50081, 57282, 57283, 57425) be placed on the level of interest for survey at the January 2020 meeting.**

The Workgroup indicated it will discuss the various criteria and thresholds for established screens at its January 2020 meeting.

The Workgroup will review action plans for the new codes identified under the Harvard valued utilization over 30,000 screen, high volume growth screen, surveyed by one specialty but now performed by a different specialty screen, post-operative visit screens and the work neutrality (CPT 2018) issues at the January 2020 meeting.

The Workgroup will also review action plans for the High Volume Category III codes identified, at the January 2020 meeting.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Anesthesia Workgroup (Tab 18)

Doctor Verdi DiSesa, Chair, provided the Anesthesia Workgroup report to the RUC. The full summary of the last three years is included in the report. The Workgroup developed a deep understanding of the previous method and rationale for determining the valuation of the provision of anesthesia services, including the concept and application of PIPPA and current building block method. The Workgroup recognized that while technically feasible there is no insight gained by converting base units to relative value units or vice versa. The Workgroup determined there is a logical flaw in the previous building block methodology, specifically a circularity in the reasoning as the existing base unit was as one of the inputs for the calculation to determine base units. The Workgroup recognized that there had not been a procedure for the periodic validation and updating of anesthesia reference services. Therefore, the Workgroup developed a new building block method based on multiple time surveys and assigned a proxy RVU to each of the five phases of anesthesia services, including the PIPPA phase. The Workgroup engaged an AMA economist with expertise in statistical analysis to review and validate the process and outcome of the development and application of the new building block method and the generation of the regression line plotting proxy RVUs versus base units. The Workgroup used this regression line in the new method to validate and propose a new reference service list for anesthesia services. The Workgroup recommends that the new building block method be used both for periodic additions to, subtractions from and validation of the RSL. Also, this methodology will be useful for valuing codes as a supplement to magnitude estimation. Specifically, the time estimates recorded by the surveyees will be used to calculate “proxy RVUs” which can be plotted on the regression line (proxy RVUs v. base units) to obtain an estimate of base units.

The Workgroup has concluded that it has accomplished the tasks for which it was appointed. The Workgroup recommends that the new building block methodology be used henceforth for the periodic validation of the Base Unit values for an Anesthesia Reference Service List. The

Workgroup further recommends that the new building block methodology be used as a supplement to magnitude estimation or other RUC methods for code valuation. The Workgroup will work with AMA staff and the ASA to develop educational materials that will be useful in the survey and RUC valuation of anesthesia codes. No further meetings of the Workgroup are anticipated at this time.

The RUC approved the Anesthesia Workgroup Report.

XV. RUC HCPAC Review Board (Tab 19)

Doctor Dee Adams Nikjeh, Co-Chair, provided a summary of the report of the RUC HCPAC Review Board:

The Health Care Professionals Advisory Committee Review Board met Friday morning. Since there were no procedure codes to value for work, the HCPAC used the time for educational and information purposes.

The RUC approved the RUC HCPAC Review Board Report.

XVI. Professional Liability Insurance Workgroup (Tab 20)

Doctor Amr Abouleish, Vice Chair, provided the Professional Liability Insurance (PLI) Workgroup report:

The Professional Liability Insurance (PLI) Workgroup met via conference call on August 13, 2019 to review and approve the PLI portion of the RUC's draft comment letter on the CMS CY2020 *Proposed Rule* on the Medicare Physician Payment Schedule. The PLI Workgroup approved the letter after discussion of five specific areas: Non-Physician Health Care Professional Premium Rates; "Surgery" Service Risk Group - Minor vs. Major Surgery; Imputation Methodology; Expected Specialty Overrides for Low Volume Services; and Technical Component (TC) Only Services.

The RUC approved the final version of the comment letter which was submitted to CMS on August 27, 2019.

The RUC approved the Professional Liability Insurance Workgroup Report.

XVII. New/ Other Business

Referrals to Administrative Subcommittee:

- The Chair of the Administrative Subcommittee recommended that the Subcommittee revisit RUC conflict of interest (COI) policies, seeking guidance from the Office of General Counsel, and formally meet in January for discussion of the issue. The goal is for the RUC to have a COI policy that is "fair, reasonable, transparent, and unambiguous without being brittle."

Some questions for consideration include:
- Is the definition of "material income" of $10,000 current and/or relevant?
- Is the policy of reviewing the adjudicating Financial Disclosures current and does it allow for ambiguity?
- How is compliance monitored? Does the "honor system" need to be revisited?

- A RUC member requested that the RUC consider requirements for RUC voting members to be engaged in active clinical practice.

Referral to the Research Subcommittee:

- A RUC member requested that the Research Subcommittee consider removing questions from the work SOR that request national estimates.

Finally, Doctor Larimore requested a point of personal privilege to offer his farewell remarks to the RUC.

The RUC adjourned at 9:10 a.m. on Saturday, October 5, 2019.