AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
October 3-5, 2019

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Friday, October 4, 2019 at 10:30 a.m. The following RUC Members were in attendance:

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

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

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.

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

- Doctor Smith welcomed the following 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.**

33995 ***Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only***
CPT code 33995 is a new code for right heart venous PVAD insertion which is a new indication approved by the FDA for this device. It is performed on patients with primary right ventricular failure who frequently present in cardiogenic shock and are acutely ill. The RUC reviewed the survey results from 58 interventional cardiologists and determined that a work RVU of 6.75, which falls well below the survey 25th percentile, accurately accounts for the physician work required to perform this procedure. The RUC agreed that insertion of a right heart venous PVAD is essentially the same work as insertion of a left heart arterial PVAD and found it appropriate for the venous insertion code to have an identical work RVU to the arterial insertion code. 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. As with 33990, the survey code will **not** be modifier -51 exempt. The modifier will be used because, in aggregate, the code will most frequently be reported with another code and will therefore be subject to the multiple procedure reduction.

The recommended value is supported by the same comparator codes as insertion code 33990. The RUC compared CPT code 33995 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 33995 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 the intra-service time and amount of physician work are the same. Unlike the survey code, the reference code utilizes general anesthesia (pre-service time package 3). The RUC also compared CPT code 33995 to CPT code 45390 *Colonoscopy, flexible; with endoscopic mucosal resection* (work RVU = 6.04, 23 minutes pre-service time, 45 minutes intra-service time, 15 minutes post-service time) and noted that the comparison code has the same intra-service time but significantly less total time, therefore the survey code is appropriately valued higher.

The RUC concluded that a work RVU of 6.75 for CPT code 33995 which falls below the survey 25th percentile and is the same as CPT code 33990 is appropriate. Thus, the RUC recommends a crosswalk from CPT code 31276 to 33995. **The RUC recommends a work RVU of 6.75 for CPT code 33995.**

33991 ***Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture***
CPT code 33991 is the revised code for left-heart arterial and venous PVAD with transseptal puncture. This is a more complex procedure in the family because the physician must punch a hole into the interatrial septum to traverse from the right heart to the left heart to achieve appropriate access so as to support the left heart in these patients with cardiogenic shock. The RUC reviewed the survey results from 47 interventional cardiologists and determined that a work RVU of 8.84 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 60 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. As with the other codes in the family, the survey code will **not** be modifier -51 exempt. The modifier will be used because, in aggregate, the code will most frequently be reported with another code and will therefore be 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 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

same amount of physician work and comparable intra-service times. For additional support, the RUC compared CPT code 33992 to other reference CPT code 36482 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated* (work RVU = 3.50, 31 minutes pre-service time, 35 minutes intra-service time, 15 minutes post-service time) and noted that the reference code has 3 minutes less intra-service time, justifying a higher work value for the survey code.

The RUC concluded that a work RVU of 3.55 for CPT code 33992 which falls below the current value and below the survey 25th percentile is appropriate. Thus, the RUC recommends a direct work RVU crosswalk from CPT code 31628 to 33992. **The RUC recommends a work RVU of 3.55 for CPT code 33992.**

33997 ***Removal of percutaneous right heart ventricular assist device, venous cannula, separate and distinct session from insertion***

CPT code 33997 is a new code for right heart venous PVAD removal and was created to allow reporting of a newly approved indication by the FDA and will also differentiate meaningful differences in physician work. The RUC reviewed the survey results from 57 interventional cardiologists and determined that a work RVU of 3.00, which falls well below the survey 25th percentile, accurately accounts for the physician work required to perform this procedure. The RUC agreed that removal of a right heart venous PVAD is less work than removal of left heart arterial PVAD and that bleeding issues from the arterial are less of an issue with the transvenous catheter placement. The RUC found it appropriate for the venous removal to be valued lower than the arterial removal and noted that the survey intra-service time for the new code is appropriately lower than CPT code 33992. The RUC recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 30 minutes and post-service time of 20 minutes. As with 33992, the RUC determined that the pre-service time package 2 is appropriate.

The RUC compared CPT code 33997 to the proposed crosswalk CPT code 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU = 3.00, 34 minutes pre-service time, 30 minutes intra-service time, 15 minutes post-service time) and noted that the services have identical intra-service time and physician work and should be valued identically. The crosswalk code represents the closest match to 33997 for intra-service time, work RVU and intensity. The RUC further noted that CPT code 33997 is appropriately bracketed by MPC codes 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.82, 21 minutes pre-service time, 25 minutes intra-service time, 10 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). Additionally, there are two MPC codes falling within the range of 2.70 – 3.70 work RVUs that contain the same intra-service time of 30 minutes and 000 global period, but they are both less intense and valued lower than the survey code: MPC codes 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU = 2.75, 26 minutes pre-service time, 30 minutes intra-service time, 20 minutes post-service time) and 11043 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less* (work RVU = 2.70, 41 minutes pre-service time, 30 minutes intra-service time, 15 minutes post-service time).

The RUC concluded that a work RVU of 3.00 for CPT code 33997 which falls below the survey 25th percentile is appropriate and relative to CPT code 33992. Thus, the RUC recommends a crosswalk from CPT code 62267 to 33997. **The RUC recommends a work RVU of 3.00 for CPT code 33997.**

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-

service time the day before the procedure not being typical, a change in global period is appropriate. **The RUC recommends that the global period for CPT codes 33990-33993, 33995 and 33997 be changed to 000-day.**

Modifier -51
The RUC confirmed that the family of PVAD codes 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 and imaging codes with which these procedures can be reported, although none reach the 50% threshold. The modifier will be used because, in aggregate, the codes are most frequently reported with another code and will therefore be subject to the multiple procedure reduction.

Vignettes
The RUC will revise the vignettes for the existing PVAD codes (33990 & 33991) to more closely match the new code vignettes that were vetted through the Research Subcommittee. The existing vignettes will be clarified for educational purposes so that they are focusing only on the PVAD work and do not imply additional work for atherectomy, stents, or other interventions. For example, inserting the words "(reported separately)" after atherectomy.

Practice Expense
There are no direct practice expenses associated with this facility-only code family.

Transrectal High Intensity Focused US Prostate Ablation (Tab 6)
Jonathan Kiechle, MD (AUA); Andrew Peterson, MD (AUA); Kyle Richards, MD (AUA); Thomas Turk, MD (AUA)

In May 2019, the CPT Editorial Panel established a new code to report ablation of malignant prostate tissue with high intensity focused ultrasound (HIFU), including ultrasound guidance.

55880 ***Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance***
The RUC reviewed the survey results from 30 urologists and recommends 33 minutes of pre-service evaluation time, 15 minutes of pre-service positing time, 10 minutes of pre-service scrub, dress, wait time, 180 minutes of intra-service time, 30 minutes of immediate post-service time, one 99238 half-day management discharge, one 99214 and two 99213 post-operative office visits. The RUC agrees with pre-service time package 3 as this corresponds best with the survey data, with 12 minutes added to the pre-service positioning time as the patient will initially be positioned supine for line and catheter placement. The patient will then be repositioned in dorsal-lithotomy with padding applied to prevent nerve damage for the three-hour procedure that consists of multiple individual HIFU micro-treatments (ablations), each one requiring individual monitoring and individual physician intervention in order to treat the entire gland. The scrub, dress, wait time and immediate post-service time were also reduced to be consistent with the survey median. The RUC thoroughly reviewed the recommended work involved in this service and agreed that the survey 25th percentile value of 20.00 accurately accounts for the physician work required to perform this procedure.

The RUC compared the survey code to the top key reference service (KRS) and MPC code 55840 *Prostatectomy, retropubic radical, with or without nerve sparing;* (work RVU= 21.36 and intra-service time of 180 minutes) and noted that both codes have identical intra-service time and should be valued similarly. The RUC also noted that although the survey code has less total time, 71 percent of the survey respondents who selected the top KRS rated the survey code more intense and complex, warranting the recommended work RVU of 20.00. For further support, the RUC compared the survey code to CPT code

31552 *Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older (*work RVU = 20.50 and intra-service time of 180 minutes) and noted that both codes have identical intra-service time and should be valued similarly. **The RUC recommends a work RVU of 20.00 for CPT code 55880.**

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

New Technology/New Service
The RUC recommends that CPT code 55880 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Screening CT of Thorax (Tab 7)
Debra Dyer, MD (ACR); Lauren Golding, MD (ACR); Andrew Moriarity, MD (ACR); Gregory Nicola, MD (ACR)
Pre-Facilitation: Facilitation Committee #1

In October 2018, AMA staff identified the CMS/Other Source codes with 2017e Medicare utilization over 30,000. CPT code G0297 was identified. In January 2019, the RUC recommended to refer to CPT Editorial Panel to establish a permanent code for this procedure. In May 2019, the CPT Editorial Panel revised three codes and added one code to distinguish diagnostic computed tomography, thorax from computed tomography, thorax, low dose for lung cancer screening.

Compelling Evidence
The code identified by the screen, CPT code G0297, is CMS/Other sourced. Therefore, how the times and values were established is unknown or flawed. CPT code 71271 is being established as a Category I code in place of CPT code G0297. The specialty society presented compelling evidence for CPT code 71271 only, based on flawed methodology. The RUC accepted compelling evidence for valuing the new code based on flawed methodology.

71250 ***Computed tomography, thorax, diagnostic; without contrast material***
CPT code 71250 describes an important service used to investigate a diverse set of pathologies in the thorax. It is an essential exam for diagnosing and characterizing pulmonary infection, primary and metastatic malignancy, autoimmune disease, interstitial lung disease, trauma, and other causes of dyspnea and chest pain. The RUC reviewed the survey results from 104 radiologists and recommends pre-service time of 3 minutes, intra-service time of 14 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: three surveys support the current intra-service time (2016 survey of 71250 with 15 minutes intra-service time, 2019 survey of 71250 with 14 minutes intra-service time, and 2019 survey of 71271 which was agreed upon as a nearly identical service with 15 minutes of intra-service time. The two minute reduction in individual 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 1.16 which falls below the survey 25th percentile appropriately accounts for the physician work required to perform this service. The RUC compared CPT code 71250 to the top key reference service code 74150 *Computed tomography, abdomen; without contrast material* (work RVU = 1.19, 3 minutes pre-service time, 12 minutes intra-service time, 5 minutes post-service time) and noted that the services involve a similar amount of physician work and time and are supported by the survey respondents who selected the reference code, 86% of whom reported 71250 as

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.

For further support, the RUC referenced CPT code 70491 *Computed tomography, soft tissue neck; with contrast material(s)* (work RVU = 1.38, 5 minutes pre-service time, 17 minutes intra-service time, 5 minutes post-service time) and noted that both are computed tomography codes with the same amount of physician work and nearly identical times. Additionally, the recommended work value is supported by bracketing between two CT codes 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.28, 5 minutes pre-service time, 15 minutes intra-service time, 5 minutes post-service time) and 70492 *Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections* (work RVU = 1.62, 5 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time).

The RUC agreed that the current work RVU of 1.38 for CPT code 71270 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 1.38 for CPT code 71270.**

71271 *Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)*
CPT code 71271 describes an important service used to screen at-risk patients for lung cancer so that tumors can be detected early. All patients have underlying lung disease but are not acutely symptomatic. They are screened with low dose helical CT which has proven to be more effective in reducing mortality from lung cancer than standard screening chest x-rays. Unlike some other screening exams, an abnormal lung cancer screening CT does not require an additional imaging study to further characterize the abnormality. The RUC reviewed the survey results from 101 radiologists and recommends pre-service time of 3 minutes, intra-service time of 15 minutes and post-service time of 3 minutes.

The RUC determined that a value of 1.16 which falls below the survey 25th percentile appropriately accounts for the physician work required to perform this service. The RUC noted that the physician work involved in the new code for low-dose screening exam is comparable to the diagnostic exam performed in CPT code 71250. CPT code 71271 is being established as a Category I code in place of CPT code G0297. In the 2016 MPFS, the society recommended that CMS crosswalk G0297 to 71250 with "additional physician work added to account for the added intensity of the service." CPT code 71250 is currently valued higher than G0297 only because 71250 was revalued in 2016, after the original crosswalk. When originally valued, the RUC recommended a value of 1.16 for 71250. However, CMS assigned a work RVU of 1.02 based on the single lowest individual response to the survey. The work RVU for 71250 was increased to its current value of 1.16 in 2016 based on this flawed methodology. G0297 was not revalued at that time.

The RUC compared CPT code 71271 to the top key reference service code 74150 *Computed tomography, abdomen; without contrast material* (work RVU = 1.19, 3 minutes pre-service time, 12 minutes intra-service time, 5 minutes post-service time) and noted that the services involve a similar amount of physician work and total time. The RUC also compared CPT code 71271 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) and noted that the reference service has substantially more intra-service and total time and is appropriately valued higher than the survey 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 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 new code involves similar work overall to CPT code 71250 and should be valued the same. 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 71271 and requests deletion of CPT code G0297. In the event this G-code is not deleted, the RUC requests that G0297 be crosswalked to 71271 and the same value and inputs be assigned.**

Practice Expense
The Practice Expense Subcommittee made minor adjustments to the clinical staff time for CPT code 71271. Clinical activity CA007 *Review patient clinical extant information and questionnaire* was reduced from 3 minutes to 1 minute. Clinical activity CA011 *Provide education/obtain consent* was increased from 2 minutes to 3 minutes. In addition, 2 minutes of clinical staff time for CA037 *Conduct patient communications* was moved to CA038 *Coordinate post-procedure services* for a total of 6 minutes for that clinical activity. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

<u>Medical Physics Dose Evaluation (PE Only) (Tab 8)</u>
Curtis Anderson, MD, (SIR); Lauren Golding, MD (ACR); Michael Hall, MD (SIR); Minhajuddin Khaja, MD (SIR); Mahadevappa Mahesh, MD, PhD (ACR); Andrew Moriarity, MD (ACR) Richard Morin, PhD (ACR); Gregory Nicola, MD (ACR)

In May 2019, the CPT Editorial Panel created a new code to describe medical physics dose evaluation for radiation exposure that exceeds institutional review threshold.

The Practice Expense (PE) Subcommittee reviewed the PE recommendations for new CPT code 76145. The clinical activities associated with the service involve high amounts of clinical staff time, and the Subcommittee had concerns that there may be overlap between some of the categories. The five clinical activities and the times proposed by the specialty societies were:

- CA012 *Review requisition, assess for special needs:* **30 minutes**
- CA014 *Confirm order, protocol exam:* **15 minutes**
- CA021 *Perform procedure/service---NOT directly related to physician work time:* **90 minutes**
- CA031 *Review examination with interpreting MD/DO:* **5 minutes**
- CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.):* **30 minutes**

The PE Subcommittee considered these time elements totaling 170 minutes of *Medical Physicist* (L152A) clinical staff time and was unable to make a recommendation to the RUC based on the specialty society expert panel proposal. The PE Subcommittee instead recommends that the specialty societies conduct a PE survey to obtain data that would drive the Subcommittee's decisions. There are two primary reasons that a PE survey is necessary to appropriately review and determine accurate direct practice expense inputs for this service. First, this is a new service with a high amount of clinical staff time and because there are no other similar services, there are no appropriate reference codes to compare the clinical staff activities and times. Second, the service is stand-alone meaning that the clinical staff type works independently from a physician and there are no elements of the practice expense that are informed by time from a physician work survey. Although it is not a common service, the specialty estimates that it is

done 16,000 per year, including both in the facility and non-facility settings. The specialty societies expressed concern that although PE surveys generally include only non-facility-based providers, it would be impossible to get a decent response rate if only this subset is included. The PE Subcommittee discussed that if the specialty society can include facility-based providers in addition to nonfacility based providers in their survey sample, a PE survey would be possible. The PE Subcommittee determined that it could not recommend the direct practice expense inputs without additional data from a PE survey and that facility-based providers should be included in the survey. **The RUC recommends that CPT code 76145 be surveyed for direct practice expense for the January 2020 RUC meeting.**

Remote Retinal Imaging (Tab 9)
David Glasser, MD (AAO); John McAllister, MD (AAO); Ankoor Shah, MD (AAO); John Thompson, MD (ASRS)
Pre-Facilitation: Facilitation Committee #1

At the May 2019 CPT Editorial Panel meeting, the Panel revised CPT codes 92227 and 92228 and created new CPT code 92229 to describe remote imaging of the retina for detection or monitoring of retinal disease.

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.***
The RUC reviewed the survey results from 38 ophthalmologists and determined a work RVU of 0.32, below the survey 25th percentile and the current work value, accurately reflects the typical physician and qualified health care professional work necessary for this service. The RUC recommends 1 minute pre-service time, 7 minutes intra-service time and 1 minute post-service time. The RUC recommended work value of 0.32 is based on a direct crosswalk to MPC code 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU=0.32, 1 minute pre-service time, 7 intra-service time and 1 minute post-service time). The coding structure for CPT code 92228 is atypical as there is work at two different sites of service and one code to use for reporting. The specialty explained that as volume for these codes and other remote services increases it will be important to account for the work being done at multiple sites. The RUC discussed potential physician work in both the physicians' office where the imaging is acquired (referred to as the "acquiring site") as well as in the remote office where the interpretation and report is being performed by a physician (referred to as the "reading site").

Although some RUC members voiced support for higher work values aligned with the physician work survey, ultimately, the RUC determined that 92228 should only account for the work of the physician at the reading site. The pre and post-service physician work times reflect discussion that the physician or qualified health care professional (QHP) work performed at the image acquisition center should not be included in this code. The specialty societies agreed to remove physician or QHP work "to place an order for the test and notify the patient" afterwards from the pre- and post-service work descriptions and reduce the pre- and post- times to 1 minute each. Some RUC members had concerns that, where previously 92227 was for detection and 92228 was for monitoring and/or management of active retinal disease, the revisions to the descriptor are that both codes can be used to report screening or monitoring services and the distinction is in whom provides the interpretation. This revision of the descriptor will result in a change in patient population to include patients with both known disease as well as those with no history of retinopathy. CPT code 92228 currently describes detection of retinal disease and therefore the test results are typically abnormal. The revised descriptor is for the detection or monitoring of retinal disease and thus will shift to a mix of abnormal and normal test results. The RUC agreed that normal exams require less work to evaluate than those with disease, making it difficult to support maintaining the current value of the code at 0.37 work RVUs. The physician intra-service work at the reading center is to locate the images in the electronic health record, review the images and formulate an interpretation.

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 92229, 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.

<u>External Counterpulsation (PE Only) (Tab 14)</u>
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.

AMA/Specialty Society RVS Update Committee **Tab 15**
Practice Expense Subcommittee
October 3, 2019

Members Present: Scott Manaker, MD, PhD, (Chair), David C. Han, MD (Vice Chair), Jordan Pritzker, MD (CPT Resource), Jennifer Aloff, MD, Amy Aronsky, DO, Gregory L. Barkley, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, Leisha Eiten, AuD, William Gee, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Donald Selzer, MD, Holly Stanley, MD, Elisabeth Volpert, APRN, Thomas Weida, MD, Adam Weinstein, MD

I. 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. This included discussion about equipment items ED043 *refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* and ED021 *computer, desktop, w-monitor.* A Workgroup was formed to clarify guidelines and recommend modifications, if necessary. The Direct and Indirect Practice Expense Workgroup met via conference call on June 10th, 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 members agreed that computer use has changed since computers were first introduced into clinical practice for documentation and administrative tasks as an alternative to paper charts. Members of the Workgroup agreed that computers are currently used for more than documentation and are an integral component to most clinical services.

To help the PE Subcommittee determine whether a desktop computer is a direct or indirect expense, the Workgroup recommended, and the PE Subcommittee agreed that the specialty societies will be required to provide documentation about the specific use of the computer and justify a request that it be a direct expense in the PE Summary of Recommendation (SOR) form. The PE Subcommittee reviewed the language proposed by the Workgroup and approved it with the revisions highlighted in red below. **The PE Subcommittee recommends the following questions are added to the PE Summary of Recommendation (SOR):**

- **Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item *computer, desktop, w-monitor,* ED021 or *notebook (Dell Latitute D600)*, ED038?**
    - **If yes, please explain how the computer is used for this service(s).**
    - **Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?**
    - **Does the computer include code specific software that is typically used to provide the service(s)?**

The Workgroup also discussed equipment item *refrigerator, vaccine, temperature monitor w-alarm*, ED043. Currently for CPT 2019 there are five CPT codes that include equipment item *refrigerator, vaccine, temperature monitor w-alarm*, ED043. The codes are vaccine administration codes 90460 and 90471-90474. The Workgroup recommended, and the PE Subcommittee agreed that the default designation for refrigerators 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.

II. 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 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. The PE Subcommittee determined that no further action will be taken at this time.

III. 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 CMS provided information on kits, packs and trays has been added as an additional reference spreadsheet to the PE spreadsheet workbook.

The PE Subcommittee discussed the following additional measures that could be taken to prevent duplication of supply items in direct practice expense recommendations:

- Utilizing the group tool in Excel.
- Eliminating kits, packs and trays and requiring specialty societies to list every supply item individually.
- Requiring a cost differential between a checklist of all individual supplies needed to provide a service and all kits, packs and trays as well as individual supplies needed to provide a service.
- Making the contents of the kits included in the PE reference materials more readily available
- Adding a question to the PE SOR to provide the detail of the supplies and kits on that document rather than on the PE spreadsheet.

The PE Subcommittee discussed the options and determined that bullet 5 is the best course of action. **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).**

In addition, AMA staff will revise and update the kits, packs and trays reference document annually.

IV. Clinical Staff Time Surveys Workgroup

The PE Subcommittee reviewed the staff note regarding practice expense surveys and the history of instances when clinical staff time surveys were conducted. The PE Subcommittee discussed that there are currently three methods employed by specialty societies to develop the direct practice expense inputs recommendation for clinical staff times:

1. Expert panel

2. Within the physician work survey, the physician is asked to estimate clinical staff time for certain clinical activities
3. The clinical staff are surveyed for time directly

The PE Subcommittee discussed that PE surveys are helpful, but it may not be immediately clear when a survey should be conducted. Although PE surveys have been more frequent in recent years, currently PE surveys are not required and can be difficult to design and administer. A PE Subcommittee member pointed out that the expert panels have been a reliable source of quality practice expense recommendations from the time that the RUC began its work. The PE Subcommittee agreed with this point. There are several reasons that a specialty society might determine that it is appropriate to conduct a practice expense survey, some of the most common are:

- CMS requests a survey in rulemaking
- CMS questions the accuracy of a PE RUC recommendation and requests data to validate
- CMS questions the accuracy of a PE RUC recommendation and the RUC determines that more data is needed to respond
- The specialty societies or the RUC determine that a survey is necessary due to high volume or high expenditure
- Services are technical component only
- The specialty societies opt to conduct a PE survey for a variety of reasons

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.

V. 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 a question about the intra-service clinical staff times for services that include expensive equipment, for example CT, MR and radiation therapy services. **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 – eg, 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.

VI. 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 recommendation was based on data obtained through a customized additional survey question in the work survey asking physicians to estimate the number of minutes required for their clinical staff to complete activities in the pre-service

period for each code. According to survey data the median clinical staff time for both services is 90 minutes. This is 30 minutes beyond the pre-service clinical staff time standard package. The 25th percentile of the survey is 60 minutes. The PE Subcommittee determined that it was appropriate to maintain the standard pre-service clinical staff time for 090-day globals for the services. However, some PE Subcommittee members questioned if the 60 minutes standard pre-service time remains adequate or if 090-day global services require more pre-service time. **The PE Subcommittee will form a Workgroup to review the standard pre-service time inputs for 090-day globals and determine if any revisions to the time components are necessary. The Workgroup will be chaired by PE Subcommittee member Doctor Neal Cohen.**

VII. Equipment Utilization Rate

The PE Subcommittee received a request from a specialty society that during other business the PE Subcommittee discuss CMS' question in rulemaking regarding any new data on the 50% equipment utilization assumption used in CMS' computation of equipment cost per minute.

In the proposed rule for 2020 CMS repeated the following about the usage factor used in their computation of medical equipment costs:

> "We currently use an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment, for which we use a 90 percent assumption as required by section 1848(b)(4)(C) of the Act. Stakeholders have often suggested that particular equipment items are used less frequently than 50 percent of the time in the typical setting and that CMS should reduce the equipment utilization rate based on these recommendations. We appreciate and share stakeholders' interest in using the most accurate assumption regarding the equipment utilization rate for particular equipment items. However, we believe that absent robust, objective, auditable data regarding the use of particular items, the 50 percent assumption is the most appropriate within the relative value system. We welcome the submission of data that would support an alternative rate."

The specialty believes that the assumption is faulty, and that equipment used in their specialty is in use far less than 50 percent of the time. The specialty society would like CMS to engage with the RUC to determine a more accurate equipment utilization assumption rate. RUC staff will draft a staff 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.

VIII. Practice Expense Recommendations for CPT 2021:

Tab	Title	PE Input Changes
4	Breast Reconstruction	No Change
5	Percutaneous Ventricular Assist Device Insertion	No PE Inputs
6	Transrectal High Intensity Focused US Prostate Ablation	No Change

Tab	Title	PE Input Changes
7	Screening CT of Thorax	Modifications
8	Medical Physics Dose Evaluation	Refer to January 2020 RUC Meeting for PE Survey
9	Remote Retinal Imaging	Modifications
10	Exercise Test for Bronchospasm	Modifications
11	Hip/Knee Arthroplasty	Modifications
12	Spirometry	Modifications
13	Molecular Pathology Interpretation	Modifications
14	External Counterpulsation	Modifications

AMA/Specialty Society RVS Update Committee **Tab 16**
Research Subcommittee
October 3, 2019

Members Present: Ezequiel Silva III, MD (Chair), Jimmy Clark, MD (Vice Chair), Dale Blasier, MD, Gregory DeMeo, MD, Peter Hollmann, MD, Omar Hussain, MD, Katie Jordan, OTD, OTR/L, Walt Larimore, MD, M. Douglas Leahy, MD, Daniel McQuillen, MD, Guy Orangio, MD, Marc Raphaelson, MD, David Slotwiner, MD, Stanley Stead, MD, Michael Sutherland, MD, Timothy Tillo, DPM, Robert Zwolak, MD

I. Minutes, June 4th, 2019 RSC Specialty Requests Conference Call and Separate Electronic Review

The Research Subcommittee report from the June 4 conference call and separate electronic review included in Tab 16 of the October 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. Instead of "clearance" the Subcommittee updated that language to "perioperative risk assessment" and instead of "emails", the Subcommittee updated that text to "internet or similar electronic communications network" which is from the CPT long descriptor from current e-visit code 99444.

II. 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. If a specialty is either the dominant provider or performs a large minority of the claims and does not indicate level 1, AMA staff will follow up with that specialty and encourage them to participate in the process. Also, when it is clear from a survey that there is widely disparate work between the different specialties performing the service, these services are identified and referred to the CPT Editorial Panel for review as appropriate. An example of this noted by a Subcommittee member was the gastrostomy tube code, where it was identified that general surgery and emergency medicine required a more granular coding structure due to large differences in their respective physician work, time and patient populations. Subcommittee members also expressed concern that creating any hard rule would be overly prescriptive and potentially burdensome to specialties.

A Subcommittee member suggested for RUC recommendations to include a notation about whether dominant specialty had elected to not participate in a survey and whether that can be used as a reason for

compelling evidence going forward. Others noted that this can be determined via other methods and is not needed for the RUC recommendation.

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. Surveying specialties often split out their data with their original submission, particularly when there will likely be questions of whether there are differences in physician work or service period times between specialties. Also, RUC reviewers have the opportunity to request for specialties to split out their data during the RUC's pre-meeting written comment process and societies regularly split out their data following these requests. The Research Subcommittee agreed that no changes were needed at this time to the current processes.

III. Requirement to Present Summary Data to RUC if Survey is Conducted *(revisiting issue from last discussion in 2017)*

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. The RUC member proposed that if a survey is conducted, then a summary of the original data would need to be submitted to the RUC. This issue was referred to the Research Subcommittee and discussed at the September 2014 meeting. The Research Subcommittee did not recommend the adoption of the proposal at that time. Instead, the Subcommittee requested for AMA staff to track the occurrences with the intent to re-evaluate the issue in two years, at the October 2016 meeting. For 2015-2016, there were 6 additional issues where surveys were conducted and the summary data was not provided. During the October 2016 meeting discussion, some Subcommittee members noted their discomfort with the ability for societies to decide to resurvey without having to provide a detailed explanation of their rationale or having to provide their current summary data. Other Subcommittee members noted that there was no apparent pattern of societies regularly requesting resurvey without providing data. AMA staff noted that, in addition to the table showing the history of how often societies requested resurvey without providing a summary of their original data, there were a similar number of instances where societies requested resurvey but did provide summary data. The Research Subcommittee decided to continue this discussion at the January 2017.

At the January 2017 meeting, the Subcommittee reviewed the updated information provided by staff and noted that this seems to be a relatively uncommon issue and that there does not seem to be any discernable pattern. Several Subcommittee members noted that the most common rationale was due to societies referring codes to CPT after issues became apparent after launching their surveys. The Subcommittee agreed that no rule was needed at this time. The Subcommittee also noted that they could revisit the issue in 2019 to continue to track this issue.

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.

IV. 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. A Subcommittee member also noted that societies could also consider breaking out the time estimates, first stating that the portion of the survey to determine eligibility only takes a few minutes and then stating how long the full survey takes.

V. Review of Potential Improvements to the RUC Survey Process *(new item)*

a. 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.**

b. 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?	Yes	
	No	

c. 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!***

d. Response Rate Percentage Field in Summary of Recommendation (SOR) document

AMA RUC Staff proposes 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.**

VI. 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 Chair noted that the Harvard study obtained estimated W/T for all pre- and post-operative services by obtaining measures of work and time for a representative sample of these services. The study did this by measuring the work and time of vignettes that described pre- and post-operative activities from hospital admissions and examinations to post-operative hospital care including ICU care and postoperative office visits. The hospital admissions data was the primary basis for the intensity assigned to pre-service evaluation.

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 has to 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.

One Subcommittee member expressed concern that it may not be appropriate to apply this to services retroactively.

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 prepare analyses on the impact of changing the intensities of the pre and post service time components.

AMA/Specialty Society RVS Update Committee **Tab 17**
Relativity Assessment Workgroup
October 3, 2019

Members: Doctors Margie Andreae (Chair), Norman Smith (Vice Chair), Jeffrey Paul Edelstein, Matthew Grierson, Gregory Harris, John Heiner, David Hitzeman, Thomas Kintanar, Timothy Laing, John Lanza, Alan Lazaroff, Nader Massarweh, Dee Adams Nikjeh, PhD, CCC-SLP, Scott Oates, Folusho Ogunfiditimi, PA-C, John Proctor and David Wilkinson.

I. CMS Other Source Codes – Medicare Utilization over 20,000 – Review Action Plans

In October 2018, the Workgroup discussed future screens and recommended lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000. **The Workgroup reviewed the action plans for the following codes and determined:**

CPT code	Recommendation
70030	Survey for January 2020
75820 75822 (f)	Survey for January 2020
76970	Refer to CPT Editorial Panel for deletion
76998	Refer to CPT Editorial Panel (May 2020) to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.
80500	Refer to CPT Editorial Panel (Sept 2020) to define this service more specifically, currently the descriptor is vague.
94250	Deleted at CPT Sept 2019 for CPT 2021
94750	Deleted at CPT Sept 2019 for CPT 2021
G0296	Review in 2 years (Oct 2021)
G6014	Remove from screen

II. High Volume Growth – Review Action Plans

Eight services were identified via the High Volume Growth screen, services with total Medicare utilization of 10,000 or more that increased by at least 100% over a span of six years. **The Workgroup reviewed the action plans for the following services and recommends:**

CPT code	Recommendation
00537	Survey for April 2020
01936	Refer to CPT Editorial Panel to create more granular codes.
17250	Review in 2 years (Oct 2021)
77014	Allow specialties to continue to work with CMS to implement the 2015 radiation treatment delivery codes. Review in 2 years (Oct 2021)
77401	Survey for direct practice expense inputs for January 2020
96920 96921 96922	Review in 2 years (Oct 2021). Therapy has changed for psoriasis and these services will continue to decrease.

III. Work Neutrality (2013) – Review Action Plan

The review of the work neutrality issue for CPT codes 64633-64636 did not occur due to time limitations at the Relativity Assessment Workgroup in September 2014. However, due to the nature of the possible incorrect coding of per nerve instead of per joint, the specialties were encouraged to immediately begin addressing this coding education and clarification. The RUC recommended that the specialty societies develop a CPT Assistant article to address this issue. The specialty societies submitted a CPT Assistant article stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before (publication date: February 2015). In January 2015, the Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. The RUC recommended that the specialty societies immediately submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint issue (for CPT 2016). The RUC requested that AMA staff compile data on how many times a service is reported on the same patient on the same day and 2014 preliminary Medicare utilization. In April 2015, the Workgroup agreed that the specialty societies have taken aggressive action to ensure correct reporting of these services. The Workgroup recommended allowing the multiple efforts to take effect and re-review the utilization data for these services in April 2017. In May 2015, the CPT Editorial Panel revised the parenthetical instructions for five codes describing paravertebral facet join nerve destruction to clarify that these codes are reported per joint, not nerve. In April 2017, the specialty society indicated, and the Workgroup agreed that recent CPT changes did not take effect until 2016 and the Medicare utilization was not available when preparing for this meeting. The Workgroup recommended that more time was necessary to determine CPT changes were effective and that the Workgroup should review these services in October 2019 when two years of Medicare utilization data are available.

In October 2019, the Workgroup thoroughly discussed the history of this family noting that although the specialty used best effort to estimate utilization and distribution of reporting these services, the original recommendations were not work neutral and compelling evidence had not been approved. The Workgroup noted that the growth in these services is appropriate as patient population requiring these services has grown. However, due to the extensive growth and original incorrect assumptions about distribution of reporting, the Workgroup determined that a new survey is required. A member questioned if the codes should be surveyed using a 000 global period, rather than the current 010-day global period. **The Workgroup recommends that CPT codes 64633-64636 be surveyed for April 2020.**

IV. New Technology/New Services – Review Action Plans

In 2005, the AMA RUC began the process of flagging services that represent new technology or new services as they were presented to the Committee. At this meeting the Workgroup continued review of CPT 2016 codes that were flagged at the October 2014 – April 2015 RUC meetings, with 3 years of available Medicare claims data (2016, 2017 and preliminary 2018 data). **The Workgroup reviewed the action plans and recommends the following:**

CPT code	Recommendation
27280	Remove from list. CPT code 27280 was surveyed with 27279 in Sept 2014. Because 27279 was considered new technology at the time of the survey, the RUC flagged both codes under new technology to review the first three years of Medicare utilization. CPT code 27279 was removed from this screen because it was surveyed at the April 2018 (CPT 2020) meeting.
31652 31653 31654	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33477	Review in 3 years (Oct 2022); pediatric procedure with some CMS utilization.

CPT code	Recommendation
43210	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
50430- 50435 50606 50693- 50695 50705 50706	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
61645 61650 61651	Remove from list. Although the RUC discussed that the subsequent hospital visit occurs, CMS has already issued their statement on 23-hr hospital stay services.
64566	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
65785	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
66174 66175	Specialty societies will review the billed together file to determine if they will revise these services to CPT Feb 2020 for bundling or if they will go straight to survey. Specialty societies will provide an action plan for the RAW in January 2020.
76881 76882	Review in 2 years (Oct 2021) after additional utilization data is available.
78265 78266	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
91200	Survey for January 2020.
93050	Review in 2 years (Oct 2021)
99497 99498	Review in 2 years (Oct 2021)

V. Reiteration of Screens – Review Data

- **Site of Service Anomaly**

  Outpatient Setting but Includes Hospital Visits

  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 agreed 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.

  Inpatient Hospital Setting but includes half discharge day management (99238)

  No new codes were identified under this scree with the criteria 2016, 2017 and 2018e Medicare utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included.

- **Harvard Valued**
  The Workgroup identified three Harvard valued services with 2018e Medicare utilization over 30,000. **The Workgroup requests action plans for CPT codes 38505, 67145 and 92065 on how to address these services at the January 2020 Relativity Assessment Workgroup meeting.**

- **High Volume Growth**
  The Workgroup identified 12 services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2013 through 2018e. **The Workgroup requests action plans for CPT codes 01916, 11047, 52287, 64615, 90785, 93228, 93229, 93621, 93656, 93890, 93892 and 95923 for review at the January 2020 Relativity Assessment Workgroup meeting.**

- **Surveyed by one specialty and now performed by a different specialty**
  The Workgroup identified two codes with 2018e Medicare utilization over 10,000 where a service was performed by one specialty but is now performed by a different specialty. **The Workgroup requests action plans for CPT code 72275 and 95921. The Workgroup also requested that the action plan for 95921 addresses CPT code 95943 which was requested to be deleted and should be considered so physicians do not inappropriately report 95921 instead if 95943 is deleted.**

- **CPT Assistant Article Analysis**
  There was only one issue identified to review the utilization data after a CPT Assistant article was published (2017), regarding reporting CPT code 76707 instead of G0389. The G code was deleted therefore the issue has been addressed.

- **Post-Operative Visits**
  In April 2019, the Workgroup requested that AMA staff rerun the Post-Operative Visits screens for 010-day global services with more than 1 office visit and 090-day global with more than 6 office visits to see if any additional codes are identified.

  010-Day Global Codes with >1 office visit based on 2018e Medicare utilization > 1,000
  The Workgroup identified five services that were either not identified or the office visits were not validated in 2014 when this screen was first run. **The Workgroup requests action plans for CPT codes 10061, 28002, 40801, 46020 and 66761 for review at the January 2020 meeting. The specialty societies should explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

  090-Day Global Codes with >6 office visits based on 2018e Medicare utilization > 1,000
  The Workgroup identified three services that were either not identified or the office visits were not validated in 2014 when this screen was first run. **The Workgroup requests action plans for CPT codes 66180, 66183 and 66185 for review at the January 2020 meeting. The specialty societies should explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

  In January 2020, the Workgroup should discuss if this screen should be considered complete after this iteration.

ZZZ Global Codes with post-operative visits

After the RUC reviewed the Evaluation and Management (E/M) office visits in April 2019, it also recommended that the increases for physician work and time, if accepted, should be incorporated into the surgical global periods for each CPT code with a global of 010-day, 090-day and MMM (maternity) codes. When AMA staff compiled the list of 010-day, 090-day and MMM services in which these changes should be applied, they noticed that several low volume codes that were converted to ZZZ global periods in 1999 still included office visits (CPT codes 67320, 67331, 67332, 67334, 67340). It appears that these office visits may not be appropriate for these services. Additionally, these services received the increase in 2007, when the E/M increases were applied to the surgical global periods.

The Workgroup requests action plans for CPT codes 67320, 67331, 67332, 67334, 67335, and 67340 for January 2020. The specialty societies should indicate whether the work RVUs from the 2007 visits increases should be removed, the services should be surveyed or how these services should be corrected.

- **Work Neutrality (CPT 2018)**

  The Workgroup identified three code families reviewed in the CPT 2018 cycle (April 2016, October 2016 and January 2017 RUC meetings) that have more than 10% increase in work RVUs from what was projected.

  The Workgroup requests action plans for January 2020, to address the increases in these services:

  1) **Continuous Glucose Monitoring (CPT codes 95250 and 95251) shows a 64% increase in work RVUs for 2018.**
  2) **INR Monitoring (CPT codes 93792 and 93793) shows a 314% increase in work RVUs for 2018.**
  3) **Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) show a 468% increase in work RVUs for 2018. This family is also on the new technology list for review at the October 2020 Relativity Assessment Workgroup meeting.**

VI. High Volume Category III Codes – Review Data (11 codes)

At the April 2019 RUC meeting under new business, Doctor Smith referred the issues of examining Category III codes with high volume to the Relativity Assessment Workgroup. The Workgroup identified seven Category III codes with 2018 estimated Medicare utilization over 1,000. **The Relativity Assessment Workgroup requests action plans in January 2020 for CPT codes 0191T, 0275T, 0376T, 0379T, 0394T, 0474T, and 0449T. Specialty societies should address whether these codes should be converted to a Category I code.**

VII. Informational Items

The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

AMA/Specialty Society RVS Update Committee **Tab 18**
Anesthesia Workgroup
October 4, 2019

Members: Doctors Verdi DiSesa (Chair), Dale Blasier (Vice Chair), Scott Collins, William Donovan, Peter Hollmann, Christopher Senkowski, James Waldorf, Thomas Weida and Robert Zwolak.

Anesthesia Workgroup 2016-2018

In 2016 and 2017 the RUC reviewed anesthesia procedures identified by CMS as potentially misvalued. The RUC noted that the anesthesia fee schedule codes had not been reviewed or validated since 2007.The RUC formed an Ad Hoc Anesthesia Workgroup to address issues regarding the process of valuing these services. The Workgroup spent time developing an understanding of the anesthesia base units and the process to value anesthesia services using time. The Workgroup determined that an alternative approach to valuing and validating anesthesia base units should be examined. The initial intent was to compare anesthesia codes to other codes in the Resource-Based Relative Value Scale (RBRVS).

In October 2017, the Workgroup reviewed a comparison of anesthesia to surgical codes. This list comprised the top 32 anesthesia codes with $20 million or more in 2016 Medicare allowed charges, which represented 75% of total 2016 estimate. The same day surgical code was obtained from same day/same patient top surgical code reported with the anesthesia service from the 2015 Medicare 5% file. The Workgroup reviewed the most frequently reported 32 anesthesia codes and compared these codes to the top surgical codes with which they are reported. The Workgroup was concerned with the range of intensities of surgical codes reported with each anesthesia code.

The Workgroup determined it must first validate the 2007 methodology to identify a set of anchor codes. AMA staff noted that 8 of the top 32 anesthesia codes have a single top surgical code that is reported at least 50% of the time. The Workgroup requested that the specialty society review the 2007 methodology and confirm or revise the methodology using the 8 codes as an example.

2018

In January 2018, the American Society of Anesthesiologists (ASA) presented the 2007 building block methodology updated with 2018 data and some new assumptions. The Workgroup determined that it would not be appropriate to use the building block method to develop recommendations for valuation of anesthesia services relative to the other codes in the RBRVS. However, the building block methodology, suitably modified, might be useful to demonstrate relativity between anesthesia services and to establish a set of reference codes that like other codes in the RBRVS may be used in a process of magnitude estimation survey of base units.

The Workgroup also discussed the pitfalls of attempting to develop a methodology for comparing anesthesia base units to physician work RVUs. After some discussion, the Workgroup determined that it would focus on defining a method to determine relativity between anesthesia services compared to other anesthesia services. Given the relatively few degrees of freedom inherent in the Congressionally-mandated system of anesthesia base units, the Workgroup thought it unnecessary to develop a technique for the precise determination of relativity between anesthesia base codes and work units of all other physician services. In contrast, the Workgroup sought a method to estimate the relative values of services represented by anesthesia base units.

In April 2018, the Anesthesia Workgroup reviewed ASA's revised five-step building block methodology. A significant limitation is logical circularity of the method. In other words, the methodology used the existing base unit value as part of the calculation of the building block value. The Workgroup worked with the specialty to develop an alternate non-base unit dependent methodology that could be used to

value a set of base unit values for a Reference Service List of codes representing services that spanned the range of anesthesia base unit values (3 - 30). The principles on which the new methodology is based are:

- The base unit is the foundation of the work value of anesthesia services, is mandated by Congress, and cannot be changed without an act of Congress
- While using conversion factors and the dollar value of anesthesia services, it is arithmetically possible to convert base units into Relative Value Units (RVUs) (and *vice versa*), this approach does not yield useful and usable data
- Because the approaches are so conceptually different, it is not meaningful to do a direct comparison of base units and RVUs
- The circular reasoning in the 2007 building block method should be eliminated by suitable modification of the building block method
- A new non-circular method to estimate base values should be developed and used to value a set of 16 codes that span the range of base unit values (3 – 30) and that can serve as an updatable Reference Service List (RSL) for the valuation of any and all of the anesthesia codes

The Workgroup met twice via conference calls over the summer of 2018. In October 2018, the Anesthesia Workgroup finalized the anesthesia building block methodology to develop what the Workgroup defines as "proxy" values to assess the relativity of anesthesia services. **The Workgroup recommends the following anesthesia building block methodology:**

Step 1: Pre-Service Evaluation
The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service may have incorrectly compared time and intensity for this step. Also, using a fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommended that ASA survey the proposed reference service codes for pre-service evaluation time and multiply by the intensity of 0.0224 to compute the proxy work value of this phase of anesthesia services.**

Step 2: Equipment, Drug and Supply Preparation (EDSP)
The Workgroup recommended that ASA develop time packages to apply to EDSP work. The Workgroup noted that these packages would eventually be part of the anesthesia base code survey process and be used in conjunction with the ASA expert panel to refine the survey results, just as the RUC analyzes survey pre-time with the pre-time packages with the review of services in the RBRVS. The Workgroup reviewed ASA's drafted time packages provided. The Workgroup agreed with the four levels of anesthesia complexity/patient complexity which are similar to other RUC pre-time packages. **The Workgroup recommended that ASA survey the reference service codes for EDSP time, review the surveyed time and adjust to reflect the time packages, and multiply by 0.0081 to determine the proxy work value of this phase of the anesthesia services. The Workgroup further recommended, as in the standard RUC process, Anesthesia will not increase time beyond the survey total for any segment of this process.**

Step 3: Induction Period Procedure
The Workgroup reviewed ASA's draft time packages for the induction period and agreed with the four levels of anesthesia/patient complexity and the detailed description of the work of the anesthesiologist for each level and for the induction period time to drill down to the individual task level. The Workgroup determined that two levels of intensity should be used: the intensity of code 31575 *Laryngoscopy, flexible; diagnostic* (IWPUT = 0.1172) should be used for the complex patient packages and the intensity

of code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (IWPUT = 0.0636) should be used for the straightforward patient packages. **The Workgroup recommended that ASA survey the proposed reference service codes for induction period time, review the surveyed time and adjust to reflect the time packages, and multiply the time by the appropriate level of intensity (straightforward patient, 0.0636 or complex patient, 0.1172).**

Step 4: Post- Induction Period Procedure Anesthesia (PIPPA)
The Workgroup discussed the PIPPA level descriptions. ASA noted that for time units beyond base units the anesthesiologist is paid the same amount per unit of time no matter the complexity of the surgical service in which the anesthesia is being administered. ASA indicated that the PIPPA helps to account for the complexity of each case. The Workgroup noted that taking the total post-induction time, divided into each quintile and then multiplied by the PIPPA quintile intensities might produce distortions in relativity for very short or very long services. The Workgroup and ASA agreed that PIPPA should be a factor, but initially did not reach a conclusion on how it would be applied. **Therefore, the Workgroup recommended surveying the proposed reference codes for post-induction anesthesia time first and determine two sets of "proxy" work values, one including and the other excluding the PIPPA contribution. After review of the results in April 2019, the Workgroup concluded that the PIPPA times should be included in the calculation of the base unit proxy values for the 16 RSL codes. This inclusion recognizes that PIPPA is the only way to assess the relative intensity of the post-induction anesthesia services furnished.** The PIPPA calculation is the median number of minutes multiplied by the percent of time in level 1 and multiplied by the level 1 intensity factor. Each of the five levels are summed. The median times and percent distributions across the five levels are directly from the survey responses. The intensity factors were determined and approved by the RUC in 2007 (level 1 = 0.031, level 2 = 0.044, level 3 = 0.055, level 4 = 0.070 and level 5 = 0.096).

Step 5: Post Anesthesia Evaluation
The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service for this component may have incorrectly compared time and intensity. Also, using the fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommended ASA survey the proposed reference service codes for post-anesthesia evaluation time and multiply by the intensity of 0.0224 to compute the proxy value of this phase of anesthesia services.**

The values from the five phases of anesthesia care were added, the sum creating a proxy work value for each of the proposed reference service codes. Assuming a linear relationship between proxy codes and anesthesia Base Units, linear regression was used to compare existing Base Units to proxy work values for the 16 RSL codes to which this new building block methodology is applied.

Anesthesia Reference Services Selected for Proposed RSL:
The Workgroup agreed on the 16 anesthesia codes that will comprise the anesthesia reference service list. These are codes 00142, 00350, 00560, 00562, 00566, 00567, 00670, 00731, 00790, 00796, 00812, 01214, 01402, 01630, 01638 and 01810. These codes are highly utilized and span the breath of anesthesia base unit values (3 - 30). The proxy relative values from the five phases of anesthesia care will be summed to create a proxy value for each of the proposed reference service codes.

On a December 3, 2018 conference call the Workgroup reviewed, revised and approved the survey instrument, survey cover memo, educational PowerPoint, vignettes, time packages document and survey summary spreadsheet.

2019
The Research Subcommittee reviewed and finalized the anesthesia survey instrument and documents at the January 2019 meeting.

In April 2019, the Anesthesia Workgroup reviewed the proxy values of the 16 anesthesia services compared to the current base units and determined that for five anesthesia services there was an arguably significant difference so that they fell off the regression line (00142, 00566, 00567, 00731 and 00790). The Workgroup also examined the 16 anesthesia codes using linear interpolation using the proxy work values to calculate base unit values. The Workgroup noted that both methods should be examined by an AMA Economist skilled in statistical analysis to help to determine the optimal statistical method for examination of the relativity of these services**.**

In June 2019, Apoorva Rama, PhD, AMA Economist, thoroughly reviewed the regression analysis and the Workgroup Chair's linear interpolation as well as conducting two additional analyses which included a sensitivity analysis of the impact of each of the proxy RVUs on the line determined by linear regression. This analysis showed that the removal in turn of any one CPT code had minimal influence on the regression line generated. *The full data analyses and report are attached*.

The economist's overall recommendation was:

- Use linear regression, not linear interpolation
- Further examine the CPT codes that are "off the line" in particular the anesthesia for CABG codes (00566 and 00567). While there may be sources of error associated with the calculation of the proxy RVUs, sensitivity analyses suggest that inaccuracies in either the base units or the proxy RVUs may be the cause for deviation from the regression line. Ultimately, it will require an expert panel to make the judgement as to whether the source of error is in the base unit value or in the construction of the proxy RVU.

In July 2019, the Workgroup confirmed that the main CPT codes of concern are 00566 *Anesthesia for direct coronary artery bypass grafting; without pump oxygenator* (base unit = 25 and proxy RVU = 17.68 and PIPPA time = 240) and 00567 *Anesthesia for direct coronary artery bypass grafting; with pump oxygenator* (base unit = 18 and proxy RVU = 19.82, PIPPA time = 273). The relative magnitudes of the base units and proxy RVUs are opposite and the time is higher for the "with pump" code. **Since having reference codes in the range of 15-30 base units is important and since experienced clinicians believed the current rank order of the base units is correct, it was agreed that CPT code 00566 and 00567 should undergo a targeted resurvey (using the proxy RVU survey) of anesthesiologists who regularly perform both services.**

In October 2019, the Workgroup reviewed the new proxy work RVU results for codes 00566 and 00567. ASA indicated that for code 00566, the rank order issue remains, while 00566 (base unit = 25) base unit value is 7 units greater than 00567 (base unit = 18), the building block value for 00566 is slightly less than the building block value for 00567. ASA also noted that 00566 is off the regression line and has low Medicare utilization (6,610 in 2018e). The Workgroup noted that including 00566, there are only six codes in the range of 20-30 base units, two of which are already on the RSL (00562 and 00796). The Workgroup determined that if they removed 00566 from the Anesthesia RSL that there are still enough codes in the higher base unit range. ASA recommended, and the Workgroup agreed to remove code 00566 from the Anesthesia RSL.

The Workgroup indicated concern with keeping code 00731 *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified* (base unit = 5) on the Anesthesia RSL as it appears off the regression line and clinically may be less complex than other anesthesia services with the same base unit. The Workgroup agreed that another anesthesia service with a base unit of 5 (code 01630) is on the RSL and will provide adequate comparison. **The Workgroup recommends removing codes 00566 and 00731 from the Anesthesia Reference Service List. The AMA economist, Apoorva Rama, PhD, examined the proportion of variance when removing codes 00566 and 00731 and determined that the r^2 changed from 0.94 to 0.95, thus strengthening the correlation. The Workgroup agreed that removing these two services would not significantly distort the regression line of anesthesia reference services. The Workgroup recommends finalizing the Anesthesia Reference Service List with 14 codes (00142, 00350, 00560, 00562, 00567, 00670, 00790, 00796, 00812, 01214, 01402, 01630, 01638 and 01810).**

Anesthesia Survey

The Workgroup reviewed the current Anesthesia Survey template and recommends the following revisions.

Question 2

How much of your **personal** time is required per patient for each of the following steps in patient care related to this procedure? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your time for the survey code on the front cover. *(Refer to definitions.)* **Do not report time provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical secretaries, receptionists, and technicians.** ~~**Indicate your time for the survey code on the front cover**~~. Do not report time or work related to separately billable services such as postoperative pain management procedures or invasive monitoring procedures. Do not report time or work of separately billable critical care services or evaluation and management services. *(Refer to definitions.)*

Question 5

Post induction anesthesia time has varying levels of physician work intensity. In this portion of the survey, you are asked to allocate the post-induction anesthesia time to five different intensity groups. The post-induction intensity levels represent activities characterized by a level of physician work intensity (mental effort, technical skill, psychological stress) similar to the example of activities listed below. Assign the appropriate percentage of post-induction time to each of the five intensity levels so the ~~**the**~~ total equals 100%. Do not include time spent on the induction procedure.

	Percentage of Time (%)
Level 1: ~~**Presenting**~~ Problems are self-limited or minor; Straightforward medical decision making and treatment Examples include but are not limited to: • *Monitoring and recording standard physiologic monitors (EKG, $ETCO_2$, SpO_2, BP, respiratory parameters) in a stable patient* • *Positioning a patient for surgery (ie, supine)*	

• *Titrating anesthetic level to achieve optimal surgical condition*	
Level 2: ~~**Presenting**~~ Problems are of low severity; Medical decision making and treatment of low complexity Examples include but are not limited to: • *Evaluating and managing transient aberrations in hemodynamic or respiratory status such as moderate tachycardia or hypotension* • *Responding to abrupt changes in surgical activity (eg, visceral traction, orthopedic cement application, abdominal insufflation)* • *Positioning an unconscious patient (ie, prone, sitting, decubitus) for surgery* • *Maintenance of cardiopulmonary bypass*	
Level 3: ~~**Presenting**~~ Problems are of moderate severity; Medical decision making and treatment of moderate complexity Examples include but are not limited to: • *Inducing intentional hypotension (eg, starting a vasodilator)* • *Evaluation and management of sustained hypertension using vasoactive agents* • *Preparing and evaluating a patient for anesthetic emergence and tracheal extubation* • *Initiation of cardiopulmonary bypass* • *Maintenance of single-lung ventilation*	
Level 4: ~~**Presenting**~~ Problems are of moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity Critically ill or critically injured patient Examples include but are not limited to: • *Evaluating and managing intraoperative myocardial ischemia, sustained hypotension, serious cardiac arrhythmias* • *Maintenance of hypotension and associated fluid, drug and transfusion requirements during cerebral aneurysm clipping* • *Initiating single lung ventilation*	
Level 5: ~~**Presenting**~~ Problems are of high severity; Medical decision making and treatment of high complexity Critically ill or critically injured patient Examples include but are not limited to: • *Managing separation from cardiopulmonary bypass* • *Managing clamping or unclamping of abdominal aorta* • *Managing massive transfusion for resuscitation of hemorrhagic shock*	
Total (must equal 100%)	

The Workgroup confirmed that for Question 7 when the survey respondent indicates the base unit, the Qualtrics survey only allows a whole number to be entered.

Summary of Recommendation (SOR) Form

The Workgroup recommends the following revisions to the Anesthesia SOR:

- Revise the SOR to display all five elements of time for the top two key reference codes - add boxes to display evaluation, equipment/supply preparation, induction period, intra-service time and post-induction period.
- Add two columns to the Post-Induction Anesthesia Time Intensity Allocation Table to display the PIPPA intensities for the top two key reference services.

The Workgroup indicated that the specialty society will be expected to note in the additional rationale section of the SOR if the building block value supports the base unit recommendation and fits on the regression line. If the recommended base unit does not fit on the regression line, ASA should provide an explanation.

Educational Materials

The Workgroup will work with ASA to develop educational materials for RUC members reviewing codes for anesthesia services.

ASA will work with the Research Subcommittee on educational materials for physicians completing the survey.

Following is a summary of the Workgroup's accomplishments and recommendations:

- Developed a deep understanding of the methods and rationales for the current method for determining and compensating for the provision of anesthesia services including the concept and application of PIPPA and the current building block method
- Recognized that while technically feasible, that there was no insight gained by converting anesthesia base units into RVUs (or vice versa)
- Determined that there is a logical flaw in the current building block method, specifically a circularity of the reasoning as the existing base unit value is used in the calculation of base units for a given service
- Recognized that there has not been a procedure for the periodic validation and updating of a Reference Service List for anesthesia services
- Developed a new building block method based on multiple time surveys and assignment of "proxy" RVUs to each of the phases of an anesthetic, including PIPPA
- 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 BBM and the generation of a regression line plotting proxy RVUs v. Base Units
- Used this regression line and the new method to validate a proposed RSL for anesthesia services
- Recommended that the new 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, Rasch analysis and other methods. Specifically, the time estimates recorded by surveyees will be used to calculate "proxy RVUs" which can be plotted on the regression line (proxy RVUs v. Base units) in order 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.

AMA/Specialty Society RVS Update Committee **Tab 19**
Health Care Professionals Advisory Committee Review Board
Friday, October 4, 2019

Members Present: Michael Bishop, MD (Chair), Dee Adams Nikjeh, PhD, CCC-SLP (Co-Chair), Timothy Tillo, DPM (Alt. Co-Chair), Charles Fitzpatrick, OD, Stephen Gillaspy, PhD, Anthony Hamm, DC, Peter Hollmann, MD, Katie Jordan, OTD, OTR/L, Folusho Ogunfiditimi, PA-C, Paul Pessis, AuD, Rick Rausch, DPT, MBA, Ezequiel Silva III, MD, Karen Smith MS, MBA, RD, LD, FADA, Doris Tomer, LCSW, BCD, Korinne Van Keuren, DNP, MS, RN

I. Introductions and CMS Update

Doctor Bishop called the meeting to order at 9:00am and turned the chair over to Dr. Nikjeh for the remainder of the meeting.

Doctor Edith Hambrick Medical Officer at CMS attended the HCPAC meeting and reported that CMS has received thousands of comments on the Proposed Rule and they are very busy reviewing all the comments and writing the Final Rule. The Final Rule will be released in roughly 3 weeks. Administrator Verma spoke on new Medicare regulatory proposals yesterday. These proposals are for study at this time and will require congressional action to be implemented.

II. Reports from HCPAC members on RUC Workgroups and Subcommittees

HCPAC Members on the following Committees and Workgroups provided information about what the group does as well as an update on the work that the group is currently engaged in.

i. Research Subcommittee
ii. Administrative Subcommittee
iii. Practice Expense Subcommittee
iv. Relativity Assessment Workgroup
v. Multi-Specialty Points of Comparison Workgroup
vi. Professional Liability Insurance Workgroup

III. HCPAC Organizations use of Evaluation and Management Codes (Informational)

The HCPAC discussed that Evaluation and Management (E/M) services are designed to capture traditional physician office visits that include exams and medical decision-making. Medicare allows some members of the Health Care Professionals Advisory Committee (HCPAC) Review Board organizations to report E/M codes. Members of other HCPAC organizations have evaluation or assessment procedure codes specifically for their use through the Medicare payment system. The HCPAC discussed that a limited number of non-MD/DO health care professionals are allowed by statute to utilize Evaluation and Management (E/M) CPT codes 99201-99499 through Medicare. The HCPAC also discussed that there was language in the Proposed Rule describing G-codes created by CMS for e-visit assessment services provided by nonphysician healthcare providers with the rationale that HCPAC organizations cannot report services that include the language "evaluation and management" in the descriptor. Clarification should appear in the Final Rule. If a specialty society believes that their services are not adequately described in CPT, the best course of action is to develop a coding proposal application. Changes to become a Medicare- approved provider of E/M services must be made through statue.

IV. HCPAC Organizations Systems for Educating on CPT and RBRVS (Discussion Item)

The HCPAC discussed that it is important for students to receive education on the "business" of their professions however it is not often taught in their training programs. The HCPAC discussed what efforts their specialties are engaged in and potential collaborative efforts.

V. Update on next review of HCPAC Multi-Specialty Points of Comparison (MPC) List

The next review and revisions of the HCPAC MPC list will be done for April 2020 HCPAC meeting. HCPAC organizations should begin to think about the codes that they would like to see added and deleted in anticipation of this review.