AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
April 27-29, 2022

Meeting Minutes

I. Welcome and Call to Order

The RUC met in-person and virtually in April 2022. Doctor Ezequiel Silva, III called the hybrid meeting to order on Thursday, April 28, 2022, at 2:00 p.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva, III, MD
Margie C. Andreae, MD
Sergio Bartakian, MD
James Blankenship, MD
Robert Dale Blasier, MD
Jim Clark, MD
Joseph Cleveland, MD
Scott Collins, MD
Daniel DeMarco, MD
Gregory DeMeo, DO
William Donovan, MD, MPH
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
John H. Proctor, MD, MBA
Marc Raphaelson, MD
Richard Rausch, DPT, MBA
Christopher Senkowski, MD
Norman Smith, MD
Timothy Swan, MD
Donna Sweet, MD
G. Edward Vates, MD
James C. Waldorf, MD
Thomas J. Weida, MD
Adam Weinstein, MD

RUC Alternates:
Amr Abouleish, MD, MBA
Jennifer Aloff, MD
Anita Arnold, MD
Gregory L. Barkley, MD
Eileen Brewer, MD
Audrey Chun, MD
Leisha Eiten, AuD
Martha Gray, MD
David C. Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Sanjay A. Samy, MD
Kurt A. Schoppe, MD
James L. Shoemaker, MD
Clarice Sinn, DO
Michael J. Sutherland, MD
Donna Sweet, MD
Mark T. Villa, MD
David Wilkinson, MD, PhD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

Doctor Silva introduced himself and welcomed everyone to the in-person RUC meeting. He explained the virtual component of the meeting and that virtual participants would be able to view the meeting proceedings in webinar format. Additionally, he reminded participants of RUC confidentiality provisions, general expectations for the meeting, and highlighted the importance of conference etiquette.

- Doctor Silva communicated the following guidelines related to confidentiality:
  - All RUC attendees must adhere to the confidentiality agreement that was attested to prior to the meeting.
  - Confidentiality extends to both materials and discussions at the meeting.
  - Recording devices are prohibited. However, this meeting is being recorded by the AMA.
  - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).

- Doctor Silva reviewed the financial disclosures:
  - RUC members completed a statement of compliance with the RUC Financial Disclosure Policy.
  - There were no stated disclosures/conflicts for this meeting.

- Doctor Silva conveyed the following information on the virtual and in-person components:
  - Virtual attendees are in listen-in only mode.
  - All meeting registrations received the Zoom link.
  - In-person attendees may follow along on the screens in the room or the shared screen on Zoom.

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
  - Perry Alexion, MD – Medical Officer
  - Michael Soracoe, PhD – Analyst
  - Gift Tee, MPH – Director, Division of Practitioner Services

- He also noted that several CMS observers were present for the virtual component of the meeting:
  - Anne Blackfield
  - Tamika Brock
  - Larry Chan
  - Arkaprava Deb, MD
  - Pamela Foxcroft Villanyi, MD
  - Liane Grayson, PhD, MPH
  - Edith Hambrick, MD
  - Morgan Kitzmiller, MHA
  - Ann Marshall
  - Karen Nakano, MD
  - Pam West

- Doctor Silva welcomed the following Contractor Medical Director:
  - Janet Lawrence, MD
  - Barry Whites, MD (virtual)
  - Richard Whitten, MD (virtual)

- Doctor Silva welcomed the following Members of the CPT Editorial Panel:
    - Timothy Swan, MD – CPT Panel Member

- Doctor Silva welcomed the following observers:
    - Sarah Wilson – Research Analyst Government of Alberta (virtual)
    - Yuliya Xiao – Manager, Government of Alberta (virtual)

- Doctor Silva announced new RUC Members:
    - Donna Sweet, MD (Primary Care Rotating Seat)
    - Adam Weinstein, MD (RPA)

- Doctor Silva announced the new RUC Alternate Members:
    - Anita Arnold, MD (ACC)
    - Martha Gray, MD (Primary Care Rotating Seat)
    - Matthew Press, MD (ACP)

- Doctor Silva held a moment of silence to remember Thomas Cooper, MD (1944-2022) who served as a RUC member for AUA from 2008-2010 and 2013-2016.

- Doctor Silva 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).

- Doctor Silva announced the RUC reviewer guidelines:
    - To enable more efficient RUC reviews, AMA staff shall review specialty Summary of Recommendation forms (SORs) for adherence to our general guidelines and expectations, such as:
        - Specialty representation
        - Survey methodology
        - Vignette
        - Sample size
        - Budget Neutrality / Compelling evidence
        - Professional Liability Insurance (PLI)

- Doctor Silva shared the following procedural issues 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.

- Doctor Silva conveyed the following procedural guidelines related to Voting:
  - Work RVU and Direct Practice Expense Inputs = 2/3 vote
  - Motions = Majority vote
  - RUC members will vote on all tabs using the single voting link provided via email.
  - You will need to have access to a computer or smart phone to submit your vote.
  - If you are unable to vote during the meeting, please notify AMA staff.
  - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
  - We vote on every work RVU, including facilitation reports.
  - If members are going to abstain from voting, please notify AMA staff so we may account for all 29 votes.
  - If specialty society presenters require time to deliberate, please notify the RUC Chair.
  - If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.

- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
  - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
  - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
  - You must enter the work RVU, physician times and reference codes to support your recommendation.

- Doctor Silva shared the process for reviewing Research Subcommittee recommendations:
  - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.
  - For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.

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 conveyed the following information regarding the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets
  - Download offline version, you will be prompted whenever there is an update available.
  - Be sure to clear cache and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database has been updated to reflect 2020 data.

- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
  - The RUC Process webinars may be accessed via the RUC Collaboration home page or click "General Resources" from the left navigation bar and then "New to the RUC" and "RUC Process Webinars & Presentations."
  - The RUC Process webinars may also be accessed directly via the YouTube link: https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2024 and 2025 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Aug 23, 2022	Sept 21-24, 2022	Chicago, IL	CPT 2024
Dec 13, 2022	Jan 11-14, 2023	Naples, FL	CPT 2024
Apr 4, 2023	Apr 26-29, 2023	San Diego, CA	CPT 2025

IV. Approval of Minutes from the January 2022 RUC Meeting

The RUC approved the January 2022 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

Timothy Swan, MD provided the following CPT Editorial Panel update on the May 2022 Panel meeting, response to the COVID-19 pandemic, and CPT Ad Hoc Workgroups:

- Panel meeting activity in response to the COVID-19 pandemic:
  - The Panel continues to create COVID vaccine codes
  - The CPT Editorial Panel has approved addition of 32 Category I codes, revised guidelines and parenthetical notes, and updated Appendix Q
  - Note: Approved April 2022:
    - A product code (91310) and administration code (0104A) to identify a Sanofi Pasteur booster dose for adults (ie, 18 years and older)
    - An administration code (0074A) to identify the Pfizer Diluent Reconstituted Tris Sucrose Booster Dose COVID-19 Vaccine 10 mcg/0.2 mL dosage (5-11 year-old patients)

- May 2022 Panel Meeting:
  - 50 Notable agenda items:
    - 8 Digital medicine related CCAs
    - 20 Category III code applications
  - Ambulatory Pediatric-to-Adult:
    - Establish codes 9X010, 9X011, 9X012, 9X013 to identify joint transition visit between sending and receiving providers/QHPs/clinical staff
  - Caregiver Training Services:
    - Establish codes 97550, 97551, 97552 to report skilled training of caregiver strategies and techniques
  - E-M Additional Cleanup for the 2023 code set:
    - Hospital Inpatient or Observation Care Services, Nursing Facility Discharge Services, Prolonged Service on Date Other Than the Face-to-Face E/M Service Without Direct Patient Contact, Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision, and Transitional Care Management Services
  - Intraoperative Cardiac Ultrasound Services:
    - Establish codes 76984, 76987, 76988, 76989 to report intraoperative cardiac ultrasound services

- CPT Ad Hoc Workgroups:
    - Tumor Genomics Neoplastic Targeted GSP Workgroup
        - Workgroup Charge: To create CPT coding solution(s) for extended/comprehensive genomic testing in tumor/neoplastic conditions, including whole genome sequencing. In the deliberation process, the workgroup will utilize information gained in the AMA's July 2021 Diagnostic Precision Medicine Coding and Payment meeting to determine the feasibility of more granular coding solutions within this space. If deemed appropriate the workgroup may additionally suggest a more granular coding solution for non-neoplastic genomics testing.
        - The workgroup is working towards having one meeting scheduled prior to the May 2022 Panel meeting. The Workgroup's goal is to submit a CCA, if deemed necessary, for the February 2023 Panel meeting
    - Unlisted Code Workgroup
        - Workgroup Charge: The Workgroup will investigate the use of unlisted codes, specifically how they are used in conjunction with existing Category I and III CPT codes during the same intervention (eg, procedure, analysis), and determine the need for CPT to provide unifying guidance on their appropriate use. If such guidance is recommended, then the Workgroup will provide a draft of such guidance to the Editorial Panel.
        - The Workgroup has met twice and is currently working on revisions to the general CPT guidelines for the use of unlisted CPT codes. The Workgroup is focusing on providing examples and expanding the possibility of using modifier with unlisted codes. The Workgroup anticipates submitting an editorial CCA for the September 2022 Panel meeting.
    - Appendix P (CPT Codes That May Be Used For Synchronous Telemedicine Services) Workgroup
        - Workgroup Charge: To develop objective criteria for the Panel to utilize for maintenance of the list of CPT codes listed in Appendix P and if deemed appropriate the Workgroup will provide suggested edits to the Appendix P introduction guidelines.
        - AMA staff have worked to collect the list of interested CPT Advisors to be on the Workgroup. The Workgroup will begin their work later this summer.

- Next Panel Meetings
    - The next Panel meeting is May 12-14, 2022, in Chicago
    - The next application submission deadline is June 15, 2022 (for September 15-17, 2022, meeting)

VI. Washington Update

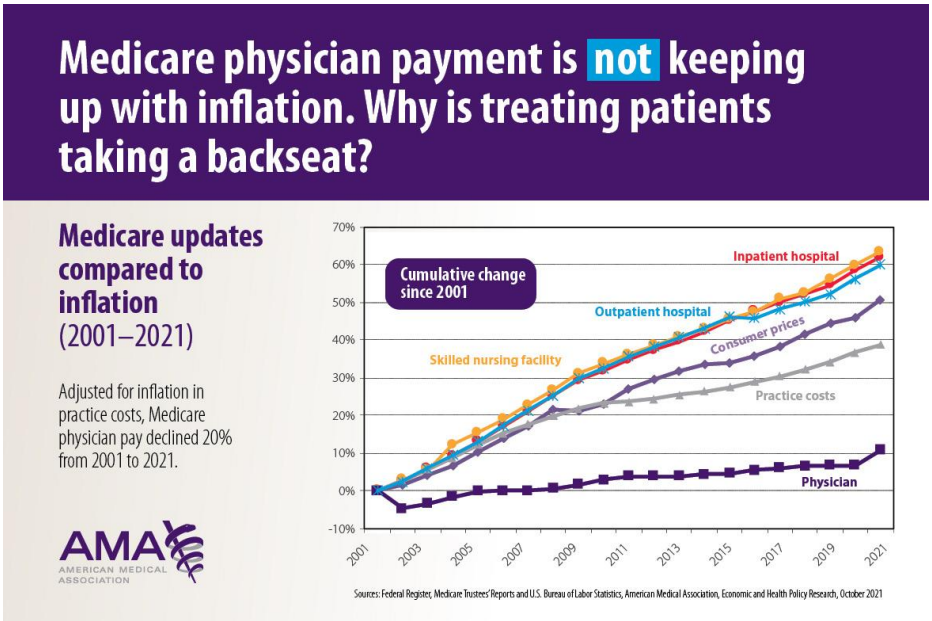
Bryan Hull, JD, MPH, Senior Attorney, Legislative Affairs, AMA, provided the Washington report focusing on the AMA response to the Medicare Physician Payment Cuts.

- 2022 Relief from Medicare Physician Payment Cuts
    - What we are facing January 1, 2023:
        - 3.7% E/M budget neutrality cuts
        - Reimposition of 2% sequester
        - 4% PAYGO sequester

- Protecting Medicare & American Farmers from Sequester Cuts Act
  - 3% E/M budget neutrality relief
  - 2% sequester phases-in 7/1
  - 4% PAYGO sequester postponed

- Anticipated Medicare Physician Payment Cuts
  - 3% Budget Neutrality cut (January)
  - 2% sequester (July)
  - 4% estimated PAYGO sequester (2023)
  - No update till 2026
    - 0.25% permanently afterwards
  - Implementation of G-2211 add on code in 2024
  - Merit-based Incentive Payment System (MIPS) penalties up to -9%

- Need for Medicare Reform
  - The Quality Payment Program (QPP) was implemented in 2017
    - We haven't had a "normal year" yet
  - No mechanism to account for increases in costs of practice
  - 4 MIPS performance categories not streamlined or meaningful as intended
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was intended to end annual "stop the cut" exercises
    - Problems due to statute itself, not physician performance
  - Physician reimbursement has not kept pace with inflation or other areas of health care
    - Asking Congress to provide a stable payment update for physicians similar to what hospitals and skilled nursing facilities already receive
    - Medicare Advantage (MA) plans are projected to see nearly an 8% payment increase



- Short-term Medicare Advocacy Requests
  - Extend the 3% temporary conversion factor (CF) increase to avoid budget neutrality (BN) cuts associated with E/M policy changes

  - Replace scheduled and anticipated pay cuts with positive, inflation-based updates
    - Asking Congress to provide in the immediate future a stable payment update for physicians similar to what hospitals and skilled nursing facilities already receive
  - Waive 4% PAYGO sequester
  - Pass the Value in Health Care Act
    - Extend the expiring 5% bonus for advanced Alternative Payment Model (APM) participation
    - Extend lower threshold of 50% for advanced APM participation (vs. 75%)
    - Extend MIPS $500 million annual pool for exceptional performers

- Political Environment
  - Compressed election year calendar
    - Highly partisan environment
  - Need to focus on healthcare policy objectives with strong bipartisan support
    - With Medicare, offsets (or going without offsets) is even more difficult in an election year
    - Laying the foundation for reforms in Congress regardless of party control
  - Working closely with Doctor Bucshon and E&C leadership on MACRA oversight efforts
  - Letter to Congress asking not to adopt MedPAC recommendations to continue Medicare physician payment freeze
  - Meeting W&M and E&C on Physician Payments

- Telehealth Flexibilities – Extension
  - Enactment of H.R. 2471
    - Urban, rural, and suburban Medicare beneficiaries will continue to retain access to telehealth services regardless of where they live
    - Patients will continue to receive virtual care wherever they can access a telecommunications system, including the home, rather than only at statutorily acceptable originating sites
    - Delays implementation of this in-person requirement for tele mental health services for 151 days after the conclusion of the public health emergency (PHE)
    - Allows for audio-only telehealth services to continue to be provided to Medicare telehealth beneficiaries for 151 days after the end of the COVID-19 PHE
    - Includes critical reporting requirements by MedPAC, Inspector General, CMS

- Additional AMA Advocacy Efforts
  - CMS Reweighting 2021 MIPS Cost Performance Category
  - Continued efforts on No Surprises Act implementation and litigation
  - Prior Authorization
  - ACA coverage –family glitch
  - Medicaid eligibility redeterminations
  - COVID provider relief funding reporting
  - COVID funding for vaccines, testing, treatment
  - Mental and behavioral health
    - Health Equity
  - Substance use disorders and treatment of pain
  - Physician workforce
  - Medical student debt
  - Maternal health

- Calendar Year 2023 Proposed Rulemaking
    - CY 2023 Hospital Inpatient Prospective Payment System (IPPS)
        - Released April 18th
        - Comments due June 17th
    - CY 2023 Physician Fee Schedule (PFS)
        - Anticipated July 2022
        - Has reached OMB for review
    - CY 2023 Hospital Outpatient Prospective Payment System (OPPS)
        - Anticipated July 2022

- Mr. Hull addressed questions from the attendees:
    - A RUC member inquired about the AMA's work on social determinants of health and health equity. Mr. Hull responded that the AMA created the Center for Health Equity (CHE) to address equity issues, which is an important activity at the AMA. AMA Advocacy Department, along with CHE and others within the AMA are addressing social determinants of health, including commenting to CMS on these issues in previous and upcoming rulemaking. These comments can be found on the AMA website.
    - A RUC member inquired about the AMA's efforts to clarify the CMS changes to split/shared visits criteria. Mr. Hull responded that the AMA has had several discussions with CMS to review this issue and will hopefully receive further clarity in upcoming rulemaking. AMA staff added that the AMA organized a sign on letter to CMS requesting further clarity in the final rule on split/shared visits and allowance of time and/or medical decision making and that CMS stated they are considering the request.

VII. Centers for Medicare & Medicaid Services Update

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the 2022 Physician Fee Schedule (PFS) Final Rule.

- CY 2022 PFS Final Rule Highlights:
    - On November 2, 2021, CMS issued a final rule that includes policy changes for Medicare payments under the PFS, and other Medicare Part B issues, effective on or after January 1, 2022. Comments on the proposed rule were due by September 13, 2021. Some of the topics covered in the Final Rule included:
        - CY 2022 PFS Ratesetting and Conversion Factor updates
        - Clinical Labor Pricing Update
        - Evaluation and Management Services
        - Implementation of Certain Consolidated Appropriations Act of 2021 (CAA) Requirements
        - Telehealth and Other Services Involving Communications Technology
        - Therapy Services
        - Vaccine Administration

- Protecting Medicare and American Farmers from Sequester Cuts Act, 2021
    - Following the release of the CY 2022 PFS Final Rule, the Protecting Medicare and American Farmers from Sequester Cuts Act, 2021, was enacted on December 9, 2021. The law included provisions that resulted in increases in PFS payment amounts effective January 1, 2022, including:

        - Provision of a 3.0% increase in MPFS payments for CY 2022. The new CY 2022 PFS conversion factor is $34.61
        - Suspension of the 2% payment adjustment (sequestration) through March 31, 2022
    - CMS recalculated the MPFS payment rates and conversion factor to reflect these changes. The revised payment rates are available in the Downloads section of the CY 2022 Physician Fee Schedule CMS-1751-F | CMS webpage.

- CY 2023 Physician Fee Schedule (PFS) Rulemaking Updates / Other Updates
    - CMS is actively working on CY 2023 PFS rulemaking
    - Other updates:
        - PHE renewed by HHS Secretary April 16, 2022

VIII. Contractor Medical Director Update

Janet I. Lawrence, MD, MS, FACP, Medicare Contractor Medical Director (CMD), provided the CMD update.

- Work Groups
    - The MACs are constantly developing ways to collaborate while maintaining the distinct needs and character of each MAC.
    - Data is collected and received from multiple sources.
    - The data collected drives new initiatives and improves the focus and goals to be achieved
    - Presently there are seven active workgroups:
        - Artificial intelligence
        - Pain management
        - Pricing
        - T Code
        - Complex Drug Administration
        - Self Administered Drug
        - Transcranial Magnetic Stimulation WG
    - The amniotic injection WG is inactive

- Amniotic and Placental Products
    - Injectable amniotic and placental products and those products for wounds are addressed differently.
    - If the product is minimally manipulated and used as in utero (wound coverings) these may be allowable. (See your MAC's website for the product codes that are allowed)
    - The evidence supporting injectable conception products (safety and efficacy) is limited and therefore these are not covered when used to manage pain or promote healing when injected.

- Local Coverage Determinations (LCD)
    - The 2016 21st Century Cures Act included changes to the LCD process, adding language to 1862(l)(5)(D) of the SSA to describe the LCD process. Section 1862(l)(5)(D), of the SSA requires each MAC that develops an LCD to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:
        - (i) Such determination in its entirety.
        - (ii) Where and when the proposed determination was first made public.

        - (iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.
        - (iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.
        - (v) An explanation of the rationale that supports such determination.

- LCD Retirement Process
    - MACs have the discretion to revise or retire their LCDs at any time.
    - If a MAC wishes to retire an LCD, all the steps of the LCD process outlined in PIM Chapter 13 must be followed.
    - This includes a minimum 45-day comment period and a minimum 45-day notice in advance of retirement.
    - MACs must ensure that they explain the reason (rationale) for retirement
    - The LCD will display until it is retired (will no longer display after retirement date once system updates)

- Medicare Coverage Articles (MCA)
    - They list information regarding benefits (Self Administered (SAD) and Complex Drug Administration Articles), or CPT, Healthcare Common Procedure Coding System (HCPCS), procedure or ICD-10 diagnosis codes.
        - The term "article" is used to describe any bulletin article, website article, educational handout or any other non-LCD document intended for public release that contains coverage/coding statements or medical review related billing or claims considerations. Medicare contractors post articles into the Medicare Coverage Database (MCD). Articles address local coverage, coding or medical review related billing and claims considerations, and may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy.
    - Article Terms
        - The term article is used to describe educational information compiled by the MACs to further explain or clarify information contained in regulatory documents (SSA, NCDs, CFRs,) (any routine footcare free standing article is tied to the NCD).
        - Articles or bulletins are used to group regulatory information in such a way that it is easier to find and understand.

- Local Coverage Articles (LCA)
    - Local Coverage Articles are a type of educational document published by the Medicare Administrative Contractors (MACs). Articles often contain coding or other guidelines that are related to a Local Coverage Determination (LCD)
    - There are different article types:
        - Billing and Coding Articles - provide guidance for the related Local Coverage Determination (LCD) and assist providers in submitting correct claims for payment.
            - Billing and Coding articles typically include CPT/HCPCS procedure codes, ICD-10-CM diagnosis codes, as well as Bill Type, Revenue, and CPT/HCPCS Modifier codes.
            - The code lists in the article help explain which services (procedures) the related LCD applies to, the diagnosis codes for which the service is covered,

        - Or which the service is not considered reasonable and necessary and therefore not covered.
    - Response to Comment (RTC) Articles - list issues raised by external stakeholders during the Proposed LCD comment period.
    - Draft Articles - written in support of a Proposed LCD. A Draft article will eventually be replaced by a Billing and Coding article once the Proposed LCD is released to a final LCD.
  - Unlike LCDs there is no formal process for the posting of articles or bulletins as they are NOT coverage documents but are clarifying or informational documents.

- Updated LCD Billing and Coding Articles
  - 2022 Medical Review Billing and Coding Articles:
    - Implantable Infusion Pumps for Chronic Pain –4/1/22
    - Influenza Diagnostic Tests –3/29/22
    - Positron Emission Tomography Scans –2/18/22
    - Pulmonary Rehabilitation Services –3/6/22
    - Outpatient Cardiac Rehabilitation –1/1/22
  - *Not all inclusive*

- References
  - 21stCentury Cures Act (https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf)
  - Medicare Program Integrity Manual Chapter 13 (https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/pim83c13.pdfz)

- Doctor Lawrence addressed questions from the attendees:
  - A RUC member inquired about the artificial intelligence (AI) workgroup and the intended goal of the workgroup. Doctor Lawrence responded that they are still trying to define their scope and come to a general consensus on a definition of AI. Doctor Silva added that the AMA has attended a few CMD AI workgroup meetings. He also confirmed that the AMA CPT Editorial Panel approved an appendix including the terms assistive, augmentative, and autonomous for the effect of differentiating services and providing consistency going forward. A RUC member added that the administrative burden of physicians is growing in tandem with increased indirect and direct practice expenses so expediting AI products that could increase efficiency would be helpful for physicians who experience this burden. Doctor Lawrence confirmed that the workgroup is working diligently to complete their charge to bring novel devices forward that provide unique and individual solutions to increase efficiency and solve other issues that physicians and health professionals experience.
  - A RUC member inquired about why the amniotic products workgroup is inactive. Doctor Lawrence responded that there are high-level discussions going on that should eventually provide clarity on the workgroup's inactive status.

IX. Relative Value Recommendations for *CPT 2024*

Total Disc Arthroplasty (Tab 4)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Kano Mayer, MD (NASS), John Ratliff, MD (AANS), Clemens Schirmer, MD, PhD (CNS) and Karin Swartz, MD (NASS)

In September 2021, the CPT Editorial Panel revised code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar* and created Category I code 22860 to describe *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure).* CPT code 22860 was created to replace Category III code 0163T *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure).* The code family is very low volume and involves a -62 modifier as there are two surgeons, an access surgeon and spine surgeon, acting as co-surgeons to perform the initial interspace and the second interspace total disc arthroplasty, as necessary. Generally, cervical disc arthroplasty is widely used and accepted over the anterior total disc arthroplasty approach that this code family describes.

The specialty societies surveyed CPT codes 22857 and 22860 for the January 2022 RUC meeting. In reviewing the survey responses for code 22857, the specialties noted, and the RUC concurred, that the collected data for the previous meeting was inaccurate. Many of the survey respondents only seemed to have accounted for the work of the orthopaedic or neurosurgeon and not also for the additional co-surgeon that routinely performs part of the intra-service work for this procedure. Therefore, the codes were resurveyed for the April 2022 RUC meeting with a targeted survey tool that was vetted and approved by the Research Subcommittee.

22857 ***Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar***
The RUC reviewed the survey results from 38 surgeons for CPT code 22857 and recommends a work RVU of 27.13 which reflects the current RVU and appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes pre-service evaluation time, 20 minutes positioning time, 15 minutes scrub/dress/wait time, 173 minutes intra-service time, 45 minutes immediate post-service time, 1-99231 and 2-99232 post-operative hospital visits, 1-99238 discharge visit, 2-99213 and 1-99214 post-operative office visits, and 537 minutes total time. The specialty societies recommended, and the RUC agreed, that pre-service package 4-FAC difficult patient/difficult procedure with 20 minutes above the pre-service evaluation time package was appropriate to better align with the survey respondents and allow for each surgeon to perform individual surgical evaluation with the patient. This service involves a -62 modifier as there are two surgeons, acting as co-surgeons throughout the entirety of the pre-service work, intra-service work, immediate post-service work, and hospital/office visits.

For this procedure, the initial arthroplasty is performed by co-surgeons (A and B). Co-surgeon A performs the initial exposure of the single (or initial) interspace taking meticulous caution to identify, retract, and protect surrounding arteries, veins, and vessels. Co-surgeon B performs the discectomy, and an appropriately sized prosthetic disc is selected based on the internal anatomy and preoperative imaging. The placement of the prosthetic disc requires significant caution as to not lacerate the iliac vessels and adjacent branches. While many patients receiving this procedure are young, the majority have significant disc degeneration, which complicates the procedure during disc exposure and placement. Following the disc placement, intraoperative fluoroscopy is performed and adjustments to the arthroplasty device are made until appropriate alignment and depth are confirmed. Co-surgeon A relaxes the retracted vessels and examines their integrity in addition to inspecting the retroperitoneal tissue for bleeding. Retroperitoneal drains are placed as necessary, and closure is performed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 22865 *Removal of total disc arthroplasty (artificial disc), anterior approach, single*

interspace; lumbar (work RVU = 31.75, 110 minutes pre-service, 210 minutes intra-service and 30 minutes immediate post-service time) and 22551 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2* (work RVU = 25.00, 98 minutes pre-service, 120 minutes intra-service and 30 minutes immediate post-service time). CPT code 22865 is valued appropriately higher given the greater intra-service time, additional hospital and office visits, and higher total time. CPT code 22551 is valued appropriately lower given the lesser intra-service time, fewer hospital and office visits, and lower total time albeit having a higher level of intensity. Overall, these key reference codes are optimal comparators as they appropriately bracket the surveyed code and demonstrate relativity of the RVU, intra-service time, and total time among similar 090-day global services. When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.0575 which is substantially lower than the IWPUT of the key reference codes selected by the survey respondents.

For additional support, the RUC compared the surveyed code to MPC codes 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU = 26.80, 68 minutes pre-service, 180 minutes intra-service and 30 minutes immediate post-service time) and 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes pre-service, 150 minutes intra-service and 40 minutes immediate post-service time). The MPC codes appropriately bracket the recommended RVU for the surveyed code and demonstrate relativity among 090-day global codes. The RUC concluded that the value of CPT code 22857 should be maintained as supported by the survey, falling between the survey median and 25th percentile. **The RUC recommends a work RVU of 27.13 for CPT code 22857.**

22860 ***Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 31 surgeons for CPT code 22860 and recommends a work RVU of 7.50 which reflects the survey median RVU and appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes intra-service time for this add-on code. This service involves a -62 modifier as there are two surgeons, acting as co-surgeons throughout the entirety of the intra-service work.

For this procedure, the second level arthroplasty is performed by co-surgeons (A and B). Once the additional vertebral level is identified and nearby vessels are meticulously retracted, the second disc interspace is properly exposed by co-surgeon A. It is important to note that exposure of the second interspace is more technically difficult than the initial interspace given the proximity to the iliac vessels, especially if the surgeons are accessing superior lumbar vertebrate levels, which is typical for this procedure. Co-surgeon B performs the discectomy, and an appropriately sized prosthetic disc is selected based on the internal anatomy and preoperative imaging. The placement of the prosthetic disc at a second interspace requires significant caution as to not lacerate the retracted iliac vessels and surrounding branches. Intraoperative fluoroscopy is performed and adjustments to the arthroplasty device are made until appropriate alignment and depth are confirmed. Co-surgeon A relaxes the retracted vessels and examines their integrity in addition to inspecting the retroperitoneal tissue for bleeding.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service and 50 minutes total time) and 22208 *Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 9.66, 120 minutes intra-service and 135 minutes total time). These key reference codes are optimal comparators as they appropriately bracket the surveyed code and demonstrate relativity of the RVU, intra-service time, and intensity of similar surgical spine add-on codes. For example, the recommended RVU for the surveyed code establishes a value slightly greater than the key reference code 22552 which is an anterior approach spine procedure that requires less time, and slightly lower RVU than the second key reference 22208 which is a posterior or posterolateral approach typically performed by a single surgeon. When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.078 which is either identical or substantially lower than the IWPUT of the two key reference codes selected by the survey respondents.

For additional support, the RUC compared the surveyed code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service time), which requires 20 minutes less intra-service time and overall is less intense and complex to perform compared to the surveyed code. Therefore, the recommended RVU of 7.50 for CPT code 22860, as supported by the survey median, maintains relativity within the family and MFS. **The RUC recommends a work RVU of 7.50 for CPT code 22860.**

New Technology
The RUC recommends that CPT code 22860 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and reassigned the 15 minutes of clinical labor time from *Other activity: coordination of care* to the CA008 *Perform regulatory mandated quality assurance activity (pre-service)* clinical activity code. This 15 minutes of clinical labor time is associated with multidisciplinary coordination of care as described in the PE SOR. The assignment to CA008 aligns with the precedent discussed in the 2019 Final Rule [CMS-1693-F] for CPT code 33440 where CMS stated that "the clinical labor associated with additional coordination between multiple specialties prior to patient arrival is more accurately described through the use of the CA008 activity code than by distributing these 15 minutes amongst the other preservice clinical labor activities." **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

<u>Skull Mounted Cranial Neurostimulator (Tab 5)</u>
John Ratliff, MD (AANS), Joshua Rosenow, MD (AANS), and Clemens Schirmer, MD, PhD (CNS)

In February 2022, the CPT Editorial Panel created three new Category I codes to describe the insertion, revision/replacement, and removal of a skull-mounted cranial neurostimulator pulse generator or receiver.

61889 ***Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)***

The RUC reviewed the survey results from 34 neurosurgeons and determined that the survey 25th percentile work RVU of 25.75 appropriately accounts for the physician work required to perform this service. The RUC recommends 60 minutes of pre-service evaluation time, 20 minutes positioning time, 15 minutes scrub/dress/wait time, 180 minutes of intra-service time, 45 minutes of immediate post-service time, 1-99233, 1-99232, 1-99239, 1-99213 and 1-99212 post-operative visits. The 20 minutes of additional pre-service evaluation time beyond the standard difficult patient/difficult procedure time package of 40 minutes is required to review extensive imaging, including imaging of the previously placed electrodes, prior scalp incisions, and prior craniotomy bone flaps that can affect the procedure planning.

These patients have almost all undergone multiple prior intracranial procedures, such as craniotomy for invasive EEG monitoring, stereo EEG electrode implantation, seizure focus resection and/or stereotactic laser ablation, including imaging of the previously placed electrodes, prior scalp incisions, and prior craniotomy bone flaps that can affect the procedure planning. These patients have typically undergone multiple prior intracranial procedures, such as craniotomy for invasive EEG monitoring, stereo EEG electrode implantation, seizure focus resection and/or stereotactic laser ablation. These are in addition to the scalp incisions made prior to this procedure for placement of the deep brain and/or cortical stimulating electrodes that are used with the skull mounted neurostimulator pulse generator. These scalp incisions and prior craniotomies need to be considered when determining the location for the skull mounted pulse generator placement to minimize wound healing difficulties and any ergonomic issues with the generator. Most of this planning work is typically done the day before the operation to identify the best site for the craniectomy and generator placement and to ensure the correct device is available at operation. Additional positioning time (over the standard 3 minutes for supine positioning) is necessary to provide access to both the previously placed electrodes (that were left under the scalp) and the site for the new skull-mounted pulse generator. This must take into account the prior scalp incisions and craniotomy flaps used for the previously placed deep brain and/or cortical stimulating electrodes as well as for any prior invasive monitoring or therapeutic intracranial epilepsy procedures. The pulse generator may be located at a separate cranial site (eg, opposite side of skull) than that which is used for placement of the electrodes, adding complexity and time to the positioning to ensure appropriate access to all required regions of the head. This includes positioning the patient in 3-pin cranial fixation as required. This major surgery is typically performed in the inpatient setting and typically involves a same-day post-operative facility visit (100% of survey respondents that noted that their typical patient requires a visit later the same day). The specialty noted, and the RUC concurred, that a 99239-discharge day visit is warranted as patients receive training on how to use the neurostimulator patient peripherals (laptop software and wand). At discharge, the patient is taught how to download data from the device to the laptop and then upload data from the laptop to the cloud server.

The RUC had an extensive discussion whether the typical patient's scalp is surgically naïve, other than the scalp incision for placement of the deep brain and/or cortical stimulating electrodes that are used with the skull mounted neurostimulator pulse generator. The electrodes are typically placed 1 or more weeks prior to the neurostimulator pulse generator placement procedure. The specialty noted, and the RUC agreed, that the current patient population has typically previously undergone multiple intracranial procedures, such as craniotomy for invasive EEG monitoring, stereo EEG electrode, implantation, seizure focus resection or stereotactic laser ablation. Although the RUC noted that the vignette that was used in the survey did not clearly indicate whether the patient was surgically naïve, the specialty noted, and the RUC concurred, that the typical patient population is not surgically naïve and the survey respondents would know this. Also, the specialty noted that the patient has also

previously undergone a surgical workup, which was explicitly included in the vignette, and that workup would typically include invasive monitoring. The neurosurgeon is often dealing with a patient population that has prior skull bone flaps around which the neurosurgeon must perform the procedure; the patient also often has one or more prior scalp incisions again around which the neurosurgeon needs to navigate.

The neurostimulator device is placed in a very specifically sized craniectomy. The device has a metallic tray which is placed in the craniectomy, and the neurosurgeon needs to contour the craniectomy so that the metallic tray fits with appropriate cosmesis to ensure appropriate scalp healing over time and minimizes the long-term risk of hardware erosion through the scalp.

To justify a work RVU of 25.75, the RUC referenced second key reference code 61312 *Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural* (work RVU= 30.17, intra-service time of 150 minutes and total time of 689 minutes) and noted that both major surgeries are intense and complex skull operations that involve a craniectomy exposing the dura. For the surveyed code, the neurosurgeon must take care to avoid violating the dura, whereas the reference code typically involves opening the dura and performing surgery on a subdural hematoma. Although the operative time is typically shorter for the reference procedure, the service typically involves a longer length of stay and more total time relative to the surveyed code. As further support, the RUC referenced MPC code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU= 26.80, intra-service time of 180 minutes and total time of 442 minutes) and MPC code 55845, *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes*, (work RVU= 25.18, intra-service time of 198 minutes and total time of 466 minutes), which appropriately bracket the recommended value for the survey code. The RUC concluded that CPT code 61889 should be valued at the 25th percentile work RVU as supported by the reference code and MPC codes. **The RUC recommends a work RVU of 25.75 for CPT code 61889.**

61891 ***Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)***
The RUC reviewed the survey results from 34 neurosurgeons and determined that the survey 25th percentile work RVU of 11.25 appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 20 minutes positioning time, 10 minutes scrub/dress/wait time, 60 minutes of intra-service time, 50 minutes of immediate post-service time, 0.5-99238 and 2-99213 post-operative office visits. Additional positioning time (over the standard 3 minutes for supine positioning) is necessary to provide access to the previously placed electrodes and the skull-mounted pulse generator. This includes positioning the patient in 3-pin cranial fixation as required. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

To justify a work RVU of 11.25, the RUC compared the surveyed code to the second key reference code 63662 *Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* (work RVU= 11.00, intra-service time of 60 minutes and total time of 243 minutes) and noted that although both services typically involve a similar amount of intra-service time, the surveyed code is slightly more complex/intense, justifying a slightly higher work RVU. The RUC noted that 60 percent of the survey respondents that selected the second key reference code indicated that the surveyed code is a somewhat or much more intense/complex service to perform. As further support, the RUC referenced MPC code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU= 12.13, intra-service time of 60 minutes and total time of 246 minutes) and MPC code 57250 *Posterior colporrhaphy, repair of*

rectocele with or without perineorrhaphy (work RVU= 10.08, intra-service time of 60 minutes and total time of 211 minutes) which appropriately bracket the recommended value for the survey code. The RUC concluded that CPT code 61891 should be valued at the 25th percentile work RVU as supported by the reference code and MPC codes. **The RUC recommends a work RVU of 11.25 for CPT code 61891.**

61892 ***Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed***

The RUC reviewed the survey results from 34 neurosurgeons and determined that the survey 25th percentile work RVU of 15.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 20 minutes positioning time, 10 minutes scrub/dress/wait time, 90 minutes of intra-service time, 50 minutes of immediate post-service time, 0.5-99238 and 2-99213 post-operative office visits. The typical patient scenario for removal of a skull-mounted cranial neurostimulator pulse generator will be for infection, erosion of hardware through the scalp, or lack of benefit. When the skull-mounted generator is removed from the previously created craniectomy, the defect needs to be corrected with a cranioplasty that requires pre-procedural planning with regards to the shape and type of material used to repair the skull defect. The RUC noted that this CPT code also bundles in the work of a cranioplasty, so the cranioplasty would not be separately reportable. Additional positioning time (over the standard 3 minutes for supine positioning) is necessary to position the patient in a manner that allows access to the previously placed electrodes and the skull-mounted pulse generator. This includes positioning the patient in 3-pin cranial fixation as required. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

To justify a work RVU of 15.00, the RUC compared the surveyed code to top key reference code 63662 *Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* (work RVU= 11.00, intra-service time of 60 minutes and total time of 243 minutes) and noted that the surveyed code involves 50% more intra-service time and 32 minutes more total time. The specialties noted, and the RUC agreed, that although both services involve the removal of a neurostimulator, the removal of the skull-mounted generator is more complex and intense because removal results in a deficit in the skull that needs to be repaired/closed. The required cranioplasty for the survey code is included and not separately reportable. As further support, the RUC also referenced MPC code 19303 *Mastectomy, simple, complete* (work RVU= 15.00, intra-service time of 90 minutes and total time of 283 minutes) and noted that both services require identical intra-service time and a very similar amount of total time. The RUC also reviewed other codes with 90 minutes of intra-service time and almost identical total time (22867, 29915, 29916, 33988, 58571) and noted that these codes provided further support for the 25th percentile work RVU. Finally, the RUC reviewed the relationship of 61892 to 61891 and noted that the difference in work RVUs between the two codes accurately accounted for the additional intraoperative time and complexity for code 61892. The RUC recognized that this service will be infrequently performed and concluded that CPT code 61892 should be valued at the 25th percentile work RVU as supported by the reference code, the MPC code, other codes with the same intraoperative time and similar total time, and in comparison to code 61892. **The RUC recommends a work RVU of 15.00 for CPT code 61892.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs, noting the standard 90-day global inputs for pre-service clinical staff time, and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 61889, 61891 and 61892 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population and utilization assumptions. At the April 2022 RUC meeting, the RUC recommendation for CPT code 61889 was based on the understanding that the current typical patient does not have a surgically naïve scalp and has previously undergone multiple intracranial procedures prior to the insertion of the skull-mounted neurostimulator.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT codes 61889, 61891 and 61892 should be labeled in the RUC database with a flag that they should not be used to validate physician work. The RUC noted that its recommendation for 61889 was based on a patient that has typically previously undergone multiple intracranial procedures, however that is not explicitly stated in the vignette itself. As 61891 and 61892 were also valued with close relativity to 61889, the RUC determined it is appropriate to place a RUC database flag on all three codes.

Spinal Neurostimulator Services (Tab 6)
Demean Freas, MD (NANS), Carlo Milani, MD (ASIPP), Gordon Morewood, MD (ASA), John Ratliff, MD (AANS), Joshua Rosenow, MD (AANS), Karin Swartz, MD (NASS), Graham Wagner, MD (SIS)

In October 2020, the RUC identified CPT code 63685 via the high volume growth screen with Medicare utilization of 10,000 or more that increased by at least 100% from 2014 through 2019. The Relativity Assessment Workgroup (RAW) requested that the specialty societies submit an action plan for each code identified for January 2021. In January 2021, the RUC recommended to refer code 63685 to CPT Assistant.

In February 2022, the CPT Editorial Panel revised four Category I codes and created three new Category I codes; the Panel also created six new Category III codes and revised four Category III codes. The revision of the four existing Category I codes included updates to the introductory guidelines, descriptors, and parentheticals for implantation, revision, and removal of spinal (63685 and 63688) and peripheral nerve (64590 and 64595) neurostimulator pulse generator or receiver devices. The three new Category I codes 64596, 64597 and 64598 are specifically for an integrated neurostimulator for the peripheral nerve and include a parenthetical referring integrated neurostimulator services for bladder dysfunction procedures to instead use a category III code, and therefore, would not be relevant to patients with bladder dysfunction. Instead, CPT category III codes 0587T and 0588T were created for the percutaneous implantation, revision, replacement, and removal of an integrated single device neurostimulation system for bladder dysfunction. **Spinal neurostimulator services CPT codes 63685, 63688, 64596, 64597, and 64598 will be surveyed for the September 2022 RUC meeting**. Neurostimulator services related to bladder dysfunction were surveyed and reviewed as a separate issue at the April 2022 RUC meeting.

Neurostimulator Services-Bladder Dysfunction (Tab 7)
Eilean Atwood, MD (ACOG), Jon Hathaway, MD (ACOG), Drew Peterson, MD, MPH (AUA), Kyle Richards, MD (AUA), Mitchell Schuster, MD (ACOG), and Thomas Turk, MD (AUA)

In February 2022, the CPT Editorial Panel created several new integrated neurostimulator Category I and Category III codes, the descriptors, guidelines and parentheticals for codes 64590 and 64595 were concurrently revised to clarify that 64590 and 64595 are only to be used for neurostimulator pulse generators or receivers that require pocket creation and include a detachable connection to a separate electrode array (non-integrated systems).

Compelling Evidence
The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for CPT codes 64590 and 64595. The RUC concurred that these services are inappropriately valued because incorrect assumptions were made in the previous valuation of the service. Information found in the Harvard study implies that the original valuation was based on neurological surgery, general surgery, and thoracic surgery data. However, these services are currently provided primarily by physicians from urology and obstetrics/gynecology. Utilization data from 1994 for both codes implies that urology and gynecology were not yet using these services and thus were not involved in the original valuation. The specialties believe the physician times used to establish the physician work RVUs were significantly underestimated, as supported by the current survey, leading to the conviction that the published relative values are inaccurate. **The RUC approved compelling evidence that the physician work for these services has changed based upon evidence that incorrect assumptions were made in the previous valuation of the service.**

64590 ***Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver***
The RUC reviewed the survey results from 69 urologists and obstetricians/gynecologists and determined that the survey 25th percentile work RVU of 5.10 appropriately accounts for the work involved in this service. Nerve stimulation is a reversible treatment for patients with bladder control problems in which conservative treatments have not worked or have not been tolerated. The RUC recommends 48 minutes pre-service time (30 minutes evaluation, 8 minutes positioning, 10 minutes scrub/dress/wait time), 40 minutes intra-service time and 15 minutes immediate post-service time, 0.5-99238 discharge visit and 1-99213 office visit as supported by the survey. Pre-service time package 3 was selected (*straightforward patient, difficult procedure*) with an increase in pre-service positioning time of 5 minutes as required for positioning the typical patient in the prone position after induction of monitored anesthesia care with sedation. The RUC discussed the survey positioning time and agreed that five minutes is appropriate because the typical patient is neurological/sacral (prone) not gastric (supine). The package pre-service evaluation time and scrub/dress/wait time were reduced by 3 and 5 minutes, respectively, to match the survey times.

The RUC compared CPT code 64590 to the top key reference service MPC code 64561 *Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed* (work RVU = 5.44, 45 minutes intra-service time and 131 minutes total time) and noted that the reference code has 5 minutes more intra-service time than the surveyed code and therefore is appropriately valued higher. The RUC also compared CPT code 64590 to the second highest key reference service CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU = 5.09, 50 minutes intra-service time and 130 minutes total time) and noted that the codes are similar in the amount of physician work and time.

For additional support, the RUC compared the surveyed code to MPC code 49440 *Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 3.93, 38 minutes intra-service time and 116 minutes total time) and noted that the intra-service times are similar, but the surveyed code has slightly more physician work and greater total time than the reference code and therefore is appropriately valued higher. The RUC further noted that the surveyed code is appropriately bracketed between these two multi-specialty points of comparison codes. The RUC concluded that CPT code 64590 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 5.10 for CPT code 64590.**

64595 ***Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array***
The RUC reviewed the survey results from 68 urologists and obstetricians/gynecologists and determined that the survey 25th percentile overestimated the physician work typically required to perform this service. The RUC established that the typical patient for this service was one wherein the generator pocket was infected and removal was required. The RUC noted several potential crosswalks with similar times and physician work relative to CPT code 64595. The RUC recommends a direct work RVU crosswalk to CPT code 38500 *Biopsy or excision of lymph node(s); open, superficial* (work RVU= 3.79, 30 minutes intra-service time and 115 minutes total time), noting that both services involve an identical amount of intra-service time and similar total time. The RUC acknowledged the strength of the survey and recommends the following survey times: 47 minutes pre-service time (29 minutes evaluation, 8 minutes positioning, 10 minutes scrub/dress/wait time), 30 minutes intra-service time, 15 minutes immediate post-service time, 0.5-99238 discharge visit and 1-99213 office visit (total time 134 minutes). As with CPT code 64590, pre-service time package 3 was selected (*straightforward patient, difficult procedure*) with an increase in pre-service positioning time of 5 minutes to account for prone positioning. The package pre-service evaluation time and scrub/dress/wait time were reduced by 4 and 5 minutes, respectively, to match the survey times.

The RUC concurred that applying CPT code 38500 as a direct crosswalk to CPT code 64595 is buttressed by several other 010-day global codes with identical intra-service time and similar total time, namely, CPT code 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU= 3.78, 30 minutes intra-service time and 122 minutes total time) and CPT code 49442 *Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 3.75, 30 minutes intra-service time and 108 minutes total time). The RUC concluded that CPT code 64595 should be valued based on a direct work RVU crosswalk to CPT code 38500 and agreed the crosswalk value slightly below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 3.79 for CPT code 64595.**

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the specialty societies that there is compelling evidence to support an increase over the aggregate current cost for clinical activities, supplies and equipment for CPT codes 64590 and 64595. The Subcommittee concurred that there is compelling evidence to justify the opportunity for an increase in the inputs based upon evidence that there have been changes in the clinical staff time and a change in supplies due to a change in technique in the way that the wound is closed. In addition, there is evidence that neither urology nor obstetrics/gynecology were involved in the PEAC review in 2002-2003 for codes 64590 and 64595, rather physiatrists (PM&R) and spinal surgeons originally presented. The PE Subcommittee voted to accept compelling evidence based on evidence that the specialty has changed as well as a change in clinical staff time and supplies due to a change in technique.

The PE Subcommittee discussed that both CPT codes 64590 and 64595 are typically reported together with another code. CPT code 64590 is reported 53.6% with higher volume CPT code 95972 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*, thus the minutes for CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* and CA010 *Obtain vital signs* were removed as they would be duplicative. The second code

64595 is reported 68.1% with CPT code 64585 *Revision or removal of peripheral neurostimulator electrode array* and thus would be subject to the multiple procedure payment reduction which would account for any duplication of services.

The PE Subcommittee made several additional modifications to the PE spreadsheet including clarifying the equipment minutes for EQ209 *programmer, neurostimulator (w-printer)* which is present for the entire 64590 procedure and removing CA037 *Conduct patient communications* since a post-operative phone call is already included in the global period. The Subcommittee switched the EQ110 *electrocautery-hyfrecator, up to 45 watts* to the EQ114 *electrosurgical generator, up to 120 watts* as it is appropriate to use the electrosurgical generator not hyfrecator. The Subcommittee agreed with the specialties that CA018 *Assist physician or other qualified healthcare professional* is now correctly 100%. Finally, the PE Subcommittee considered and approved the use of SG007 *adhesive, skin (Dermabond)* as the specific anatomical area is highly susceptible to infection but will review the issue of typical dermal adhesives. The PE Subcommittee understands that the neurostimulator pulse generator (L8679) is currently listed on the DMEPOS Fee Schedule. If the provider is a DME certified provider, then the L code would be separately paid as an L code in the office. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Assistant Referral

The PE Subcommittee discussion culminated in a request for a CPT Assistant article to clarify several issues involving the use of the EQ209 *programmer, neurostimulator (w-printer)* and to provide clear and consistent instruction to all users of the programming and insertion codes. The stimulator is used to check the impedance of the device once placed for the initial code 64590 and is present for the entire procedure. To the extent there is additional stimulation and programming, then an additional code would be reported. The article is needed to ensure that individuals are appropriately reporting the stimulation and programming with code 95972 and not just merely checking the impedance. **The RUC recommends that a CPT Assistant article be developed to clarify the appropriate use of CPT codes 64590 and 64595 as reported with other codes.**

<u>Venography Services (Tab 8)</u>

Mark Hoyer, MD (SCAI), Edward Toggart, MD, FSCAI (SCAI), Edward Tuohy, MD (ACC), and Richard F. Wright, MD (ACC)

In May 2020, the CPT Editorial Panel replaced a family of four cardiac catheterization codes with five new codes to describe cardiac catheterization for congenital cardiac defect(s). In addition, the Panel replaced two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects. In October 2020, the RUC reviewed and valued these six new 000-day global codes (93593-93598), which CMS implemented in the Medicare Fee Schedule (MFS) effective January 1, 2022.

In November 2021, the CPT Editorial Panel created six new add-on codes (93584-93588) for venography services. The services described by 93584 and 93585 were previously reported using more general codes 75827 *Venography, caval, superior, with serialography, radiological supervision and interpretation* and 75825 *Venography, caval, inferior, with serialography, radiological supervision and interpretation*, respectively; these previous codes were not solely for patients with congenital defects. The services described by codes 93585-93588 were previously reported with an unlisted code for cardiovascular services or procedures. These newly created codes represent add-on services that are sometimes performed during cardiac catheterization for congenital heart defects in the superior vena cava (SVC), the inferior vena cava (IVC), and in other congenital veins. The intention of the new codes was that they be reported with the corresponding 000 global cardiac catheterization codes.

After reviewing the survey results in preparation for the 2022 April RUC meeting, the surveying specialty societies requested, and the RUC agreed, to refer codes 93584-93588 back to CPT for further clarification within the CPT 2024 cycle. The specialty societies stated, and the RUC concurred, that the description of work and reporting of two existing CPT codes (75827 and 75825) presents a coding redundancy, which confused survey respondents and led to inaccurate estimates of physician work and time. Additionally, survey respondents were unclear on whether catheter placement/manipulation should be included in some of the codes in this family. The specialty societies stated that catheter placement/manipulation should not be considered part of the physician work for typically present anatomy of the SVC or IVC catheterization but should be considered part of the service where there is atypical anatomy. The distinctions between current coding and the newly created services are unclear and require revision by CPT to accurately explain whether the catheter placement performed for venography is part of a congenital cardiac catheterization. **The RUC recommends that existing CPT codes 93593-93598 and new add-on codes 93584-93588 be referred to the CPT Editorial Panel for revision in the 2024 CPT cycle.**

X. CMS Request/Relativity Assessment Identified Codes

Laser Treatment – Skin (Tab 9)
Alina Bridges, DO (AADA) and Alexandria Flamm, MD (AADA)

In October 2015, CPT codes 96920, 96921 and 96922 were identified via the high-volume growth screen with Medicare utilization of 10,000 or more that increased by at least 100% from 2008 through 2013. At that time, the RUC recommended that the specialty societies develop a CPT Assistant article to ensure the codes were being used correctly. The Relativity Assessment Workgroup reviews all issues referred to CPT Assistant to determine if the article addressed the RUC's concerns. In January 2022, the Workgroup reviewed these services, noting that their utilization continues to steadily increase, specifically CPT code 96920. The specialty societies indicated that they believed the growth is appropriate due to changes in treatment and medication for psoriasis. However, due to the continued growth, the Workgroup recommended, and the RUC agreed, that CPT codes 96920, 96921 and 96922 be surveyed for work and practice expense at the April 2022 RUC meeting.

In April 2022, the specialty societies indicated, and the RUC agreed, that CPT codes 96920-96922 be referred to the CPT Editorial Panel for revision. Since their definition was established by CPT in 2002, the approved indications and uses for this treatment modality have expanded beyond what is currently noted in the code descriptors. Indications for this treatment have expanded substantially beyond psoriasis to include laser treatment for other inflammatory skin disorders such as vitiligo, atopic dermatitis, alopecia areata, etc. Based on the expanded indications, the current code descriptors do not capture current practice. These procedures are performed based on the amount of active inflammation and thickness of some of the lesions themselves. Different inflammatory conditions have different clinical appearances and different depths of inflammation associated with them. Therefore, the work is different, based on the types of conditions. **The RUC recommends that CPT codes 96920-96922 be referred to the CPT Editorial Panel for review at the September 2022 CPT meeting.**

Advance Care Planning (Tab 10)
Amy Ahasic, MD (CHEST), Kathrin Nicolacakis, MD, FCCP (ATS), Michael Perskin, MD (AGS), Phillip E. Rodgers, MD, FAAHPM (AAHPM), and Elisabeth Volpert, DPN, APRN (ANA)

In January 2014, the RUC recommended that CPT codes 99497 and 99498 be referred to CPT Assistant to educate physicians on how to code these services correctly. The Relativity Assessment Workgroup reviews all issues referred to CPT Assistant to determine if the article addressed the RUC's concerns. In October 2017 and October 2019, the RUC recommended that more utilization data be collected, and the Workgroup review these services in two years. In January 2022, the Workgroup reviewed these services and noted that, although there is a low percentage of the total Medicare population reported for these services, the Medicare utilization of these services exceed well above the original projection. The Workgroup determined that the relationship of these advance care planning services in comparison to the recent changes in evaluation and management services should be examined. The RUC recommended that CPT codes 99497 and 99498 be surveyed for physician work and practice expense for the April 2022 RUC meeting.

99497 ***Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate***

The RUC reviewed the survey results from 196 physicians and determined that the survey 25th percentile work RVU of 1.50 and 5 minutes of pre-service time, 30 minutes of intra-service time and 5 minutes of post-service time accurately account for the physician work required to perform this service. The RUC noted that the specialty society decreased the pre-service and post-service times each from 10 to 5 minutes to account for any duplication when performed with an Evaluation and Management (E/M) service. The pre- and post-service work include previous discussions of advanced care planning and an assessment of the patient's likely life expectancy, review of previous records from all specialist visits, and details of their prognosis. Similarly, this follow-up with the patient and/or caregivers on the advanced care planning discussion after the visit is additional to any other follow-up.

The RUC compared 99497 to the top key reference service MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92 and 47 minutes total time) and agreed that 99497 typically requires less physician work and time to perform. The RUC also compared 99497 to 99491 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.* (work RVU = 1.50 and 33 minutes total time), which requires the same amount of physician work and similar physician time to perform.

For additional support, the RUC referenced MPC codes 95861 *Needle electromyography; 2 extremities with or without related paraspinal area* (work RVU = 1.54 and 49 minutes total time) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU =1.60 and 35 minutes total time) and determined that they support the recommended work RVU. **The RUC recommends a work RVU of 1.50 for CPT code 99497.**

99498 ***Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 184 physicians and determined that the current work RVU of 1.40, which is in between the survey 25th percentile work RVU of 1.00 and median work RVU of 1.50, appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The specialty societies indicated that this add-on service is a continuation of more than 45 minutes of discussion typically involving consensus of the patient and or multiple children/family members of the patient.

The RUC compared 99498 to the top key reference service 99425 *Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 30 minutes intra-service/total time). The RUC determined that the intensity of CPT code 99498 is much greater than that of CPT code 99425 because unlike the reference code, CPT code 99498 is performed entirely face-to-face with the patient. When CPT code 99498 is reported, it is typically a much more difficult situation that requires extra time and effort beyond that required for the base code and usually includes the presence of family members. This add-on code is more intense than the first 30 minutes of advance care planning because the physician or qualified health care professional (QHP) is not just filling out forms but is working through contentious and difficult issues and educating the family members on all diagnoses to reach planning decisions.

The RUC compared 99498 to the second top key reference service 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 0.70 and 20 minutes intra-service/total time). The RUC determined that the surveyed code requires more time, double the physician/QHP work and is more intense than CPT code 99439. Specifically, the physician work for 99439 is for supervision of clinical staff and is much less intense than the work for CPT code 99498, which is all face-to face time describing work performed directly by the physician/QHP.

For additional support, the RUC referenced MPC codes 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes intra-service/total time) and 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU =1.44 and 21 minutes total time).

Lastly, the RUC compared 99498 to other add-on E/M services. CPT code 90833 *Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (work RVU = 1.50 and 33 minutes total time), which is performed face-to-face and is slightly more intense than 99498. CPT codes 99437 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 30 minutes intra-service/total time) and 99489 *Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure*) (work RVU = 1.00 and 30 minutes intra-service/total time), both describe non-face-to-face care and CPT code 99489 describes the physician work of supervising clinical staff, which is less intense and requires less physician work to perform. The RUC determined that maintaining the work RVU of 1.40 for CPT code 99498 appropriately places this service in the proper rank order relative to other similar services. **The RUC recommends a work RVU of 1.40 for CPT code 99498.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>Transitional Care Management Services (Tab 11)</u>
Michael Perskin, MD (AGS), Korinne Van Keuren, DNP, APRN (ANA)

For CY 2021, CMS proposed and finalized increases for services they stated were analogous to the E/M office visit codes (99202-99215) increased for 2021. The list of codes CMS increased varied widely; some of these services had been previously crosswalked to an E/M office visit, used E/M office visits as a building block, included an E/M office visits as part of the service, or the service was compared to an E/M office visit as a reference point. In September 2021, the Administrative Subcommittee stated concern that the 2021 CMS valuation of these services was not based on standard RUC process – thus a survey with magnitude estimation by the physicians who perform these services, a RUC review and recommendation relative to other services, nor a CMS review and acceptance or refinement was used to establish a relative value. The Subcommittee noted that because the values for these codes did not follow the standard RUC/CMS process, using these codes as comparators or crosswalks in the RUC valuation process would disrupt the integrity of the relativity of services in the database. Basing the value of services in the Medicare Payment Schedule on services that were not established following RUC process appropriately defies the purpose of the RUC – The AMA/Specialty Society Relative Value Scale Update Committee. The Subcommittee acknowledged that the RUC accepts the CMS valuation for services as the current valuation; however, the RUC should not use specific services for comparison that the RUC believes were valued outside of RUC processes, including CMS altering values independent of a RUC recommendation. The Administrative Subcommittee recommended and the RUC agreed to flag these services as "Do not use to validate physician work" in the RUC database. The RUC agreed and placed these services

on the level of interest for all specialty societies to indicate whether they would like to survey these services or leave as "do not use to validate physician work".

The TCM services were on an LOI after the October 2021 RUC meeting and the specialties indicated they would survey for the April 2022 RUC meeting. However, at the April 2022 RUC meeting the specialty societies requested deferral to survey until the September 2022 RUC meeting. This request is based on the societies desire to know whether CMS is making any proposals that would negate the need to affirm the valuation for the TCM codes. The specialty societies also noted that they originally intended to survey the TMC services so that they would be able to use them on reference service lists when surveying other services. However, after further examination the societies indicated that the inpatient hospital visit codes may be available soon for use on reference service lists instead. Once the Proposed Rule is published this summer, the specialty societies will examine if the current services available fill the gaps for codes to populate reference service lists and whether the TCM codes need to be surveyed. **The RUC agrees to postpone the survey of the TCM services until the September 2022, RUC meeting.**

XI. Practice Expense Subcommittee (Tab 12)

Doctor Scott Manaker, Chair, provided the report of the Practice Expense (PE) Subcommittee.

At the October 2021 RUC meeting, the PE Subcommittee determined that a new PE workgroup should be created to determine whether the addition of another pre-service time package is warranted for major surgical procedures. The new, fourth workgroup convened its first meeting in December 2021 and met for additional meetings in February and March 2022. The Workgroup considered CMS' action in the CY2022 Final Rule [CMS-1751-F] for CPT codes 28820, 28825, 46020, 61736 and 61737 where the RUC recommended pre-service clinical staff times were reduced from 60 minutes to 30 minutes. CMS stated, "We continue to believe that setting and maintaining clinical labor standards provides greater consistency among codes that share the same clinical labor tasks and could improve relativity of values among codes." While acknowledging that the RUC process of handling the pre-service time for code conversions on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for their procedures, the Workgroup also recognized the value in establishing an additional 000 and 010-day global period pre-service time package as an option for those procedures in the facility-setting that require pre-service clinical staff time corresponding with a 090-day procedure. In addition, the Workgroup addressed the need for an objective way to define "major" versus "minor" procedures but agreed that attempting to define these terms was out of the scope of the PE Workgroup. Further, the Workgroup analyzed and agreed that the recently released updated BETOS classification was not an appropriate option.

The PE Subcommittee applauded the deliberations of the PE Workgroup on Pre-Service Clinical Staff Time Package for Major Surgical Procedures and concurred that the addition of a pre-service clinical staff time package is warranted for major surgical procedures that are 000 or 010-day global periods yet require greater time than provided by the standard extensive clinical staff times package. The Subcommittee agreed that a new "comprehensive" category reasonably follows "extensive use" and appropriately accounts for the comprehensive care required for the patients involved in these major surgical procedures. The new package would also encompass the global conversions from 090-day to 000 or 010-day global periods. The requirement for specialties to justify their recommended pre-service clinical staff times in the PE SOR would continue, particularly when the global periods of the codes are transitioning. **The PE Subcommittee recommends that the RUC establish an additional pre-service clinical staff time package as an option for those procedures in the facility-setting that are assigned 000 or 010-day global periods yet require pre-service clinical staff time commensurate with a 090-day procedure.**

The PE Subcommittee also considered the use of SG007 *adhesive, skin (Dermabond)* as part of the Neurostimulator Services-Bladder Dysfunction tab. **The RUC determined that the PE Subcommittee will review the issue of typical dermal adhesives at its September meeting.** The review will include a list of codes that include any sort of adhesives.

The RUC approved the Practice Expense Subcommittee Report.

XII. Administrative Subcommittee (Tab 13)

Margie Andreae, MD, Chair of the Administrative Subcommittee, provided the Administrative Subcommittee report to the RUC.

Clarify RUC Compelling Evidence Standards

Doctor Andreae indicated that at the January 2022, RUC meeting, a RUC member requested clarification on one of the compelling evidence guideline bullets regarding when an incorrect assumption in a previous value creating a flawed value. Specifically, in question was whether a previous valuation is flawed if the specialty that performs a plurality of the service was not involved in the survey of the current valuation.

The Subcommittee discussed the intent of the guidance and agreed that it was not to look for or support a change in specialty, but more of an incorrect assumption, because a specialty was not included in the previous valuation. The Subcommittee agreed that the only time a specialty would not be included in a prior valuation if they wanted to be, was if they had been excluded from a Harvard survey and the specialty did not have the opportunity to participate. Again, not at their own choosing, but were excluded, based on the process in place at the time, therefore that scenario might result in an incorrect assumption in valuation.

In contrast, in cases where a specialty was not involved in the survey of a service and the physician work for that service has now changed because this specialty performing it uses a different technique or to a different patient population, the compelling evidence to be presented would fall under the first bullet described as "Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, or physician time."

A change in a specialty over time does not necessarily mean that there automatically is a change in work. Specialties who choose not to participate in a RUC survey would not get an unfair advantage by allowing them to provide a compelling evidence argument just because they chose not to participate in a RUC survey.

In addition, in the last bullet of the compelling evidence, the Administrative Subcommittee discussed that it was important to distinguish that non-involvement by a specialty was due to the specialty being "excluded" from the process. Because the RUC level of interest process provides all specialties an opportunity to survey and no specialties are excluded from participating in a RUC survey, exclusion from a prior survey would indicate that prior survey was a Harvard survey. The Subcommittee reiterated that the last bullet of compelling evidence guidelines is about an error in the previous valuation due to incorrect assumptions at the time of valuation and not about a change in physician work or specialty over time.

The Administrative Subcommittee revised the last bullet under the evidence of incorrect assumptions made in the previous valuation of the service, to include "the current published valuation excluded a specialty that currently provides a plurality of the service."

Finally, the Subcommittee discussed that when the term "current value" is used in the **RUC Rules Regarding Presentation & Evaluation of Work Relative Values** document, it refers to the relative value published in the Federal Register for the current calendar year. To be consistent, "published" was added to "current published value" throughout the document.

The Administrative Subcommittee agreed with the above applications as to what is flawed methodology and what is a change in physician work. **To clarify these applications, the Administrative Subcommittee revised the compelling evidence standards as:**

RUC Rules Regarding Presentation & Evaluation of Work Relative Values

The RUC's policy regarding current work valuation is articulated in the *Instructions to Specialty Societies Developing Recommendations*:

The RUC operates with the initial presumption that the current published values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided to the RUC in writing on the Summary of Recommendation form.

Accordingly, the steps in the RUC decision-making process are as follows:

1. The current published value is assumed to be correct.

2. If the specialty is requesting an increase, they must present compelling evidence.

3. The RUC must vote to determine if compelling evidence has been met (majority approval required).

4. If compelling evidence has been met, the specialty proceeds to present recommended values.

5. If compelling evidence has not been met and/or the specialty requests to maintain the current published value, evidence should be presented to support current published values.

6. If evidence does not support the current published value, a RUC member may recommend a decreased value. If specialty agrees with RUC member recommendation, the RUC proceeds to vote. If the specialty declines to accept recommendation or if the recommendation does not meet 2/3 approval, the code will be referred to facilitation.

Compelling Evidence

The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

  - technique
  - knowledge/technology
  - patient population
  - site-of-service

- length of hospital stay
- physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (i.e., diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

  - a flawed mechanism or methodology used in the previous valuation by either the RUC or CMS, for example, evidence that no pediatricians were consulted in assigning pediatric values or CMS/Other source codes; and/or

  - ~~o~~ the current published valuation excluded a specialty that currently provides a plurality of the service. ~~survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.~~

CMS Codified RUC Compelling Evidence in Rulemaking
Doctor Andreae also noted that at the January 2022 RUC meeting, a Subcommittee member requested the background for when CMS codified the compelling evidence standards in rulemaking. The previous Final Rules on the Medicare Physician Payment Schedule where CMS detailed their acceptance of the RUC compelling evidence was provided in the agenda materials as informational.

The RUC approved the Administrative Subcommittee Report.

XIII. Multi-Specialty Points of Comparison Workgroup (Tab 14)

Doctor Bradley Marple, Chair, provided the report of the Multi-Specialty Points of Comparison (MPC) Workgroup.

Review of Specialty Code Recommendations
In June 2021, the MPC Workgroup recommended the identification and comprehensive review of codes on the MPC list that either have not been reviewed in the last 15 years or are codes in which CMS did not accept the RUC recommendation. AMA staff compiled a list of codes on the MPC list based on this recommendation and included codes that did not meet the suggested criteria for inclusion on the MPC list because their Medicare utilization is less than 1,000. AMA staff worked with specialty societies and received recommendations to add, maintain, or delete services from the MPC list.

The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Representatives from the specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more utilization of the code should comment on the appropriateness of addition or deletion of the service.

Ultimately, the MPC Workgroup members agreed to add 2 specialty recommended codes to the MPC list, delete 35 codes from the MPC list, and maintain 38 codes on the MPC list with justification provided by specialty societies in their recommendations.

MPC Codes – RUC-Reviewed 15+ Years Ago

In June 2021, the MPC Workgroup recommended that it identify and review codes on the MPC list that have not been reviewed in the last 15 years. There were 25 services on the MPC list that have not been RUC reviewed in the last 15 or more years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 7 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	9.23	090	2005-08	90,113
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	43.28	090	2005-08	3,163
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	39.88	090	2005-08	5,001
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	1.73	000	2006-02	20,612
70355	Orthopantogram (eg, panoramic x-ray)	0.20	XXX	2005-08	34,300
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	XXX	2005-08	5,905,780
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	2.25	ZZZ	2005-08	560,661

The MPC Workgroup recommends deleting the following 18 services from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.90	010	2005-08	24,133	Valuation based on survey data from insufficient number of respondents
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	1.45	010	2005-08	115,439	Valuation based on survey data from low number of respondents
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	1.84	010	2005-08	48,049	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	1.53	010	2005-08	30,002	Valuation based on survey data from low number of respondents
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	1.77	010	2005-08	30,312	Valuation based on survey data from low number of respondents
11443	Excision, other benign lesion including margins, except skin tag	2.34	010	2005-08	8,316	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
	(unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm					standard pre-time packages
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	2.07	010	2005-08	23,703	Valuation based on survey data from low number of respondents
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	3.11	010	2005-08	25,312	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	2.17	010	2005-08	29,582	Valuation based on survey data from low number of respondents
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	2.62	010	2005-08	89,442	Valuation based on survey data from low number of respondents
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	3.42	010	2005-08	32,484	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	3.65	000	2006-04	24,066	N/A, concurred with specialty recommendation to remove
15003	Surgical preparation	0.80	ZZZ	2006-04	43,311	N/A, concurred with

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
	or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)					specialty recommendation to remove
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	4.58	000	2006-04	32,464	N/A, concurred with specialty recommendation to remove
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	090	2005-08	1,849	Low volume; another code with same value on MPC list valued more recently
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250	N/A, concurred with specialty recommendation to remove
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation,	1.99	XXX	2006-04	3,816	Methodology to value the services would not be considered appropriate under current standards

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
	initial day					
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	1.37	XXX	2006-04	40,526	Methodology to value the services would not be considered appropriate under current standards

MPC Codes – CMS Did Not Accept RUC Recommendation

In June 2021, the MPC Workgroup identified codes in which CMS did not accept the RUC recommendation. The Workgroup noted that many of these services may be important to specialty societies, with few other services available for the MPC List. Also, many of the services were reviewed years ago and the specialty societies may have accepted the CMS decision. While several MPC Workgroup members thought that codes with RUC approved values would be better comparisons, the Workgroup decided to defer to the specialty societies. There are 34 services on the MPC list in which CMS did not accept the RUC recommended work RVU. These codes have been reviewed by the specialty societies, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 22 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.22	010	2010-10	368,976
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.01	000	2010-02	1,938,307
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	2.70	000	2010-04	456,527
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	4.10	000	2010-04	88,567
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.80	090	2007-04	11,733
36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code	2.09	ZZZ	2012-04	13,979

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	for primary procedure)				
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	1.28	000	2012-10	71,670
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	39.88	090	2013-04	12,479
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	010	2007-04	3,464
52000	Cystourethroscopy (separate procedure)	1.53	000	2016-01	897,375
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.75	000	2010-04	62,618
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, gibbons or double-j type)	2.82	000	2013-04	151,015
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	7.50	000	2013-04	11,180
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	4.00	000	2019-01	26,625
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure)	1.01	ZZZ	2019-01	101,717
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	6.55	090	2010-10	5,906
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	14.56	090	2010-10	4,687
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	13.36	090	2010-10	1,020
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	090	2014-04	1,030
85097	Bone marrow, smear interpretation	0.94	XXX	2017-04	140,727
92567	Tympanometry (impedance testing)	0.20	XXX	2007-04	922,916
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	XXX	2007-04	1

The MPC Workgroup recommends deleting the following 12 services from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	7.07	090	2007-02	2,079	N/A, concurred with specialty recommendation to remove
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	7.42	090	2007-02	1,657	N/A, concurred with specialty recommendation to remove
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	5.86	090	2007-02	1,365	N/A, concurred with specialty recommendation to remove
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, bentall)	58.79	090	2005-09	1,812	N/A, concurred with specialty recommendation to remove
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	090	2010-10	38,983	N/A, concurred with specialty recommendation to remove
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9.09	090	2011-02	10,329	N/A, concurred with specialty rec(s)
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.19	090	2010-10	7,841	CMS inappropriately assigned value uses reverse building block
60500	Parathyroidectomy or exploration of parathyroid(s);	15.60	090	2010-10	18,399	CMS inappropriately assigned value uses reverse building block
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5.60	010	2008-02	8,146	N/A, concurred with specialty recommendation to remove
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5.19	010	2008-02	29,921	N/A, concurred with specialty recommendation to remove
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull,	0.26	XXX	2015-01	9,755	N/A, concurred with specialty recommendation to

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
	cervical and sacral spine if performed (eg, scoliosis evaluation); one view					remove
92273	Electroretinography (erg), with interpretation and report; full field (ie, fferg, flash erg, ganzfeld erg)	0.69	ZZZ	2018-01	68,699	N/A, concurred with specialty recommendation to remove

MPC Codes – Medicare Utilization less than 1,000

The MPC Code *Assessment Criteria and Considerations* document states under the suggested criteria for codes to be on the MPC list that Codes with Medicare utilization of less than 1,000 should not be included on the MPC list without justification by a specialty society. Currently, there are 14 MPC codes with 2019 Medicare utilization under 1,000. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 9 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
36440	Push transfusion, blood, 2 years or younger	1.03	XXX	2016-01	1
36450	Exchange transfusion, blood; newborn	3.50	XXX	2016-01	3
36455	Exchange transfusion, blood; other than newborn	2.43	XXX	2016-01	49
36456	Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn	2.00	XXX	2016-01	1
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (ivor lewis)	57.50	090	2016-10	609
54437	Repair of traumatic corporeal tear(s)	11.50	090	2015-01	54
54438	Replantation, penis, complete amputation including urethral repair	24.50	090	2015-01	1
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	XXX	2009-04	1
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	1.92	XXX	2010-10	12

The MPC Workgroup recommends deleting the following 5 services from the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	9.89	090	2009-02	506	More recently surveyed codes with similar values are already on the MPC list (15576 and 21025)
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	7.41	090	2009-02	940	More recently surveyed code with similar values are already on the MPC list (26113)
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	6.74	090	2009-02	948	More recently surveyed code with similar values are already on the MPC list (26116)
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	5.80	010	2011-09	217	N/A, concurred with specialty recommendation to remove
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250	N/A, concurred with specialty recommendation to remove

MPC List Services Additions

The MPC Workgroup annually solicits the specialty societies for any codes that should be added to or deleted from the MPC List. There are 5 services that have been recommended for addition to the MPC list by two specialty societies**. The MPC Workgroup recommends adding the following 2 services to the MPC List:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	6.50	ZZZ	2017-01	3,632
34715	Open axillary/subclavian artery exposure	6.00	ZZZ	2017-01	206

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)				

The MPC Workgroup recommends not adding the following 3 services to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	45.00	090	2017-01	641	Low utilization
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	000	2014-01	2,321	The specialty society withdrew their request to add prior to the meeting.
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.88	000	2014-01	26,744	The specialty withdrew their request to add prior to the meeting.

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

XIV. Health Care Professionals Advisory Committee (HCPAC) (Tab 15)

Doctor Richard Rausch, Co-Chair, provided the report of the Health Care Professionals Advisory Committee (HCAPC) Review Board:

The HCPAC Review Board reviewed the following Relative Value Recommendations for CPT 2024:

Auditory Osseointegrated Device Services (Tab 15)
Deborah Carlson, PhD (ASHA) and Erin Miller, AuD (AAA)

In February 2022, the CPT Editorial Panel created two Category I codes, 92622 and 92623 to report *Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes* and *each additional 15 minutes* of work thereafter. Both codes are currently reported with an unlisted code that lacks specificity for all aspects of the activation, programming, and verification of auditory osseointegrated devices. For the April 2022 RUC meeting, both CPT codes were reviewed by the HCPAC.

92622 ***Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes***
The HCPAC reviewed the survey results from 45 audiologists for CPT code 92622 and recommends a work RVU of 1.25, which reflects the survey median RVU and appropriately accounts for the work required to perform this service. The HCPAC recommends 7 minutes of pre-evaluation time, 55 minutes intra-service time and 10 minutes immediate post-service time.

For this service, the qualified health care professional (QHP) inspects the surgical site and performs an otoscopic examination. The external sound processor is then fitted and appropriately secured to the patient's head. Most of the intra-service time is spent performing feedback calibration and making the necessary adjustments to the frequency, which is verified by in-situ measurement of bone conduction audiometric values. The sound processor is programed with any other hearing assistive technology, if indicated, and a report is prepared.

To support the recommended work RVU, the HCPAC compared the surveyed code to key reference service codes 92626 *Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour* (work RVU = 1.40, 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time) and 92603 *Diagnostic analysis of cochlear implant, age 7 years or older; with programming* (work RVU = 2.25, 20 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time). These codes are optimal comparators as both have similar intensity to the surveyed code and service period times that increase respectively as RVU increases. This demonstrates appropriate relativity within other XXX-global audiologic and hearing implant testing services. The HCPAC concluded that the value of CPT code 92622 should be 1.25 RVU, which is aligned with the survey median percentile and maintains relativity within the family and MFS. **The HCPAC recommends a work RVU of 1.25 for CPT code 92622.**

92623 ***Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)***

The HCPAC reviewed the survey results from 43 audiologists for CPT add-on code 92623 and recommends a work RVU of 0.33, which reflects the survey 25th percentile and appropriately accounts for the work required to perform this service. The HCPAC recommends 15 minutes intra-service time.

For this add-on service, the QHP continues to make necessary adjustments to the frequency response and improvement of the device for optimal performance. The sound processors performance is verified by in-situ measurements of bone conduction audiometric values. The QHP makes adjustments as necessary and programs the sound processor with other hearing assistive technology as indicated. The intensity of this service increases due to the potential young age of the patient and/or cognitive function which can increase the complexity of verifying that the processor is working properly.

To support the recommended work RVU, the HCPAC compared the surveyed code to top key reference service code 92627 *Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.33, 15 minutes intra-service and total time). CPT Code 92627 has identical intensity and intra-time as the surveyed code suggesting that the codes should be valued similarly. For additional support, the HCPAC compared the surveyed code to CPT add-on code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service and total time). This comparison code has a slightly higher intensity than the surveyed code justifying the minor difference in RVU albeit the identical intra-service time. The HCPAC concluded that the value of CPT code 92623 should be 0.33, which is aligned with the survey 25th percentile and ensures appropriate rank order among similar auditory evaluation add-on codes. **The HCPAC recommends a work RVU of 0.33 for CPT code 92623.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The HCPAC recommends the direct practice expense inputs as submitted by the specialty societies.**

The RUC filed the HCPAC report as presented.

XV. Relativity Assessment Workgroup (Tab 16)

John Proctor, MD, Chair of the Relativity Assessment Workgroup, provided the report to the RUC.

Re-review of Services – Review Action Plans

Endovascular Revascularization (37220-37235)
In January 2019, CPT code 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* was identified on the High Volume Growth screen. The specialty societies indicated and the RUC agreed to refer this entire family of services to CPT for revision to accommodate new technologies. The specialty societies worked with the CPT Editorial Panel and have submitted multiple coding change proposals. However, this issue has not been addressed via edits at CPT, therefore was placed back on the Relativity Assessment Workgroup agenda to review.

The Workgroup discussed the complexity of this issue and determined that coding clarification is still necessary. The Workgroup recommends that a joint CPT/RUC Workgroup be created to develop coding solutions for the endovascular revascularization (37220-37235) code family.

Ultrasonic guidance for placement of radiation therapy fields (G6001)
In October 2020, the RUC identified G6001 via the CMS/Other Medicare utilization over 20,000 screen. In January 2021, the RUC recommended to refer G6001 to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology). To date, a Category I code has not been created, therefore this issue was placed back on the Relativity Assessment Workgroup for review at the April 2022 Workgroup meeting.

The Workgroup agreed with the specialty society that the specialties work with CMS to develop an MLN Matters article to clarify correct coding and that the Workgroup re-review in two years (April 2024).

New Technology/New Services – Review Action Plans (39 codes/17 issues)

The Workgroup reviewed action plans for 39 codes identified via the new technology/new services screen. **The Workgroup recommends that 23 services be removed from the screen as these services did not demonstrate a diffusion in technology that impacts work or practice expense and they do not need to be re-evaluated; 15 services be re-evaluated in three years after additional utilization data is available and one service, 99484, be surveyed for the September 2022 RUC meeting; and requested again that CMS delete G0279.**

Reiteration of Screens – Review 2020 Data

Doctor Proctor noted that the following screens were re-run based on the 2020 Medicare claims data: CMS/other source, high volume growth, surveyed by one specialty and now performed by a different specialty, high volume category III codes, CPT Assistant analysis, contractor priced high volume codes and services performed together 75% or more. **The Relativity Assessment Workgroup will review 53 action plans for these services at the September 2022 meeting.**

Gender Equity Payment

In response to the January 2022 Relativity Assessment Workgroup (RAW) on gender equity payment between services performed by gynecologists and urologists a RUC member commented that the preventive medicine services codes 99381-99397 could be reviewed by the RAW for potential gender based misvaluation.

At this meeting, the presenters from ACOG indicated, and the Workgroup agreed, that there may be additional resources associated when a pelvic examination is performed. **The Workgroup agreed that this issue should be referred to the CPT Editorial Panel to consider the specialties request for additional code(s) to describe pelvic examinations. The CPT Editorial Panel may choose to consider the development of additional codes to address any identifiable gender-based inequities in existing CPT code content.**

The RUC approved the Relativity Assessment Workgroup Report.

XVI. Research Subcommittee

Doctor Chris Senkowski, MD, Chair of the Research Subcommittee, provided the report to the RUC:

The Research Subcommittee did not have a general policy meeting which coincided with the April 2022 RUC meeting. The Subcommittee had last met on February 21, 2022 to review specialty society requests pertaining to RUC surveys for the April meeting. On the February 21st call, the Research Subcommittee had reviewed and approved proposed vignettes, a reference service list, a custom survey template and a targeted survey sample methodology.

The RUC approved the Research Subcommittee Report.

XVII. New/Other Business

There were no new business items brought forward at this meeting.

The RUC adjourned at 3:55 p.m. CT on Friday, April 29, 2022.

AMA/Specialty Society RVS Update Committee **Tab 12**
Practice Expense Subcommittee
April 27, 2022

Members Present: Scott Manaker, MD, PhD, (Chair), Gregory Barkley, MD, John Blebea, MD, Michael Booker, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal Cohen, MD, Leisha Eiten, AuD, David Han, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, MBA, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Thomas Weida, MD, and Tim Swan, MD (CPT Resource).

I. Pre-Service Clinical Staff Time Package for Major Surgical Procedures Workgroup

At the October 2021 RUC meeting, the Practice Expense (PE) Subcommittee determined that a new PE workgroup should be created to determine whether the addition of another pre-service time package is warranted for major surgical procedures. There have been three PE workgroups addressing the issue of clinical staff pre-time packages in the past two years. The new, fourth workgroup convened its first meeting in December 2021 and met for additional meetings in February and March 2022.

Doctor Rick Rausch, chair of the Pre-Service Clinical Staff Time Package for Major Surgical Procedures Workgroup, summarized the Workgroup's recent deliberations:

At its March 2022 meeting, the Workgroup reviewed the February 2022 Workgroup report and considered the table of existing pre-service clinical staff time packages. The Workgroup members also reviewed the excerpts from the CMS final rules for the five recent codes where the Agency reduced the RUC recommended pre-service clinical staff time from 60 minutes to 30 minutes (CPT codes 28820, 28825, 46020, 61736 and 61737). The Workgroup agreed that the final rule language from the last two years did not provide a pattern or clear explanation for CMS' actions.

While acknowledging that previous workgroups had determined that the RUC process of handling the pre-service time for code conversions on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for their procedures, concern remained that CMS may continue to resort to the use of the standard 000 and 010-day extensive clinical staff times package despite the RUC recommendations. The Workgroup ultimately determined that an additional 000 and 010-day global period pre-service time package is needed as an option for those procedures in the facility-setting that require pre-service clinical staff time commensurate with a 090-day procedure. The new package would also clearly encompass the global conversions from 090-day to 000 or 010-day global periods.

Please see attached table of Pre-Service Clinical Staff Time Packages. The Workgroup considered various words to describe the new package and determined that "comprehensive" logically follows "extensive" and would appropriately account for the comprehensive care required for the patients involved in these procedures. The Workgroup noted that the requirement for specialties to justify their recommended pre-service clinical staff times in the PE SOR would continue, particularly when the global periods of the codes are transitioning.

In addition, the Workgroup addressed the need for an objective way to define "major" versus "minor" procedures but agreed that attempting to define these terms was out of the scope of the PE Workgroup. Further, the Workgroup analyzed and agreed that the recently released updated BETOS classification was not an appropriate option. The updated BETOS classification report proposes that a HCPCS code can be classified as a major procedure:

o If a HCPCS code is assigned an RVU greater than or equal to 9.0, it is identified as a major procedure.
o A HCPCS code is identified as a major procedure if it is assigned an RVU greater than or equal to 5.5 but less than 9.0, and if it is used in an inpatient setting greater than 15% of the time.

The PE Subcommittee applauded the deliberations of the PE Workgroup on Pre-Service Clinical Staff Time Package for Major Surgical Procedures and **recommends that the RUC establish an additional pre-service clinical staff time package as an option for those procedures in the facility-setting that are assigned 000 or 010-day global periods yet require pre-service clinical staff time commensurate with a 090-day procedure.**

II. Practice Expense Recommendations for CPT 2024:

Tab	Title	PE Input Changes	Consent Calendar
4	Total Disc Arthroplasty	No Changes	
5	Skull Mounted Cranial Neurostimulator	Standard 90-day global inputs	X
6	Spinal Neurostimulator Services	Letter/No Survey	X
7	Neurostimulator Services-Bladder Dysfunction	Modifications	
8	Venography Services	No Direct PE Inputs	X
9	Laser Treatment – Skin	Letter/No Survey	X
10	Advance Care Planning	No Changes	
11	Transitional Care Management Services	Letter/No Survey	X
15	Auditory Osseointegrated Device Services	No Changes	

Pre-Service Clinical Staff Time Packages

Specialties need to justify to the RUC in writing that a code should have clinical staff time greater than the package.

Pre-service time for 000 and 010 day codes is presumed to be zero unless the specialty provides evidence in writing to justify that any pre-service time is warranted.

For 000 and 010-day global codes, specialties need to justify to the RUC in writing that a code should have clinical staff time greater than zero.

If any pre-service time is found to be warranted, please use the time packages below as a guide.

Description of Clinical Activities	000 and 010 Day Non-Facility & Facility Use of Clinical Staff	000 and 010 Facility Minimal Use of Clinical Staff	000 and 010 Day Extensive Use of Clinical Staff Non-Facility	 Facility	000 and 010 Facility Comprehensive Use of Clinical Staff	090 Day Use of Clinical Staff Non-Facility	 Facility	090 Day Facility Use of Clinical Staff +Additional	090 Day Facility Emergent	Use of Clinical Staff for Endoscopy Non-Facility	 Facility
CA001 Complete pre-service diagnostic & referral form	0	3	5	5	5	5	5	5	5	3	3
CA002 Coordinate pre-surgery services/review test/exam results	0	3	3	10	20	10	20	20	7	3	5
CA003 Schedule space and equipment in facility	0	3	0	5	8	0	8	8	4	0	3
CA004 Provide pre-service education/obtain consent	0	3	7	7	20	10	20	20	0	0	5
CA005 Complete pre-procedure phone calls & prescription	0	3	3	3	7	10	7	7	4	3	3
Other Activities:	0	0	0	0	0	0	0	15	0	0	0
Total Time	**0**	**15**	**18**	**30**	**60**	**35**	**60**	**75**	**20**	**9**	**19**
CPT Code Examples	CPT code 17000	62323	12032	52356	33361	14060	66984	61312	34706	43239	45380
Common CPT codes for each pre-service clinical staff time package based on Medicare utilization	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Esophagogastroduodenoscopy (EGD), flexible, transoral; with biopsy, single or multiple	Colonoscopy, flexible; with biopsy, single or multiple

Pre-Service Clinical Staff Time for 000 and 010 Day Global presumed to be zero unless the specialty provides evidence to justify that any pre-service time is warranted – Approved February 2002

Pre-Service Clinical Staff Time for 090 Day Global – Approved March 2001, Affirmed February 2002, Submitted May 2003 Recommendations

Pre-Service Clinical Staff Time for 000 and 010 Day Global – Approved October 2012

Pre-Service Clinical Staff Time for Emergent 090 Day Global – Approved January 2016

AMA/Specialty Society RVS Update Committee **Tab 13**
Administrative Subcommittee
April 28, 2022

Members: Doctors Margie Andreae (Chair), James Waldorf (Vice Chair), Amr Abouleish, Kris Anderson, DC, Anita Arnold, Scott Collins, Daniel DeMarco, Kristopher Kimmell, Lance Manning, John McAllister, Guy Orangio, Matthew Sideman, Clarice Sinn, Donna Sweet and Robert Zwolak.

I. Clarify RUC Compelling Evidence Standards

At the January 2022, RUC Meeting, a RUC member inquired about the current compelling evidence guidelines. The member requested clarification on the standards and guidelines associated with the application of compelling evidence during RUC discussions. The member noted that RUC deliberations could benefit from aligning the terminology used to describe compelling evidence standards. The member requested that this issue be referred to the Administrative Subcommittee for review of the current guidelines to standardize the language and clarify the intent of compelling evidence.

Specifically, in question was whether a previous valuation is flawed if the specialty that performs a plurality of the service was not involved in the survey of the current valuation. For example, a Harvard survey or valuation may have excluded a specific specialty resulting in a flawed methodology as described in the last bullet of compelling evidence.

In contrast, in cases where a specialty was not involved in the survey of a service and the physician work for that service has now changed because this specialty performing it uses a different technique or to a different patient population, the compelling evidence to be presented would fall under the first bullet described as "Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, or physician time."

In addition, in the last bullet of the compelling evidence, the Administrative Subcommittee discussed that it was important to distinguish that non-involvement by a specialty was due to the specialty being "excluded" from the process. Because the RUC level of interest process provides all specialties an opportunity to survey and no specialties are excluded from participating in a RUC survey, exclusion from a prior survey would indicate that prior survey was a Harvard survey. The Subcommittee reiterated that the last bullet of compelling evidence guidelines is about an error in the previous valuation due to incorrect assumptions at the time of valuation and not about a change in physician work or specialty over time.

Finally, the Subcommittee discussed that when the term "current value" is used in the **RUC Rules Regarding Presentation & Evaluation of Work Relative Values** document, it refers to the current relative value published in the Federal Register. To be consistent, "published" was added to "current published value" throughout the document.

The Administrative Subcommittee agreed with the above applications as to what is flawed methodology and what is a change in physician work. **To clarify these applications, the Administrative Subcommittee revised the compelling evidence standards as:**

RUC Rules Regarding Presentation & Evaluation of Work Relative Values

The RUC's policy regarding current work valuation is articulated in the *Instructions to Specialty Societies Developing Recommendations*:

> *The RUC operates with the initial presumption that the current published values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided to the RUC in writing on the Summary of Recommendation form.*

Accordingly, the steps in the RUC decision-making process are as follows:

1. The current published value is assumed to be correct.
2. If the specialty is requesting an increase, they must present compelling evidence.
3. The RUC must vote to determine if compelling evidence has been met (majority approval required).
4. If compelling evidence has been met, the specialty proceeds to present recommended values.
5. If compelling evidence has not been met and/or the specialty requests to maintain the current published value, evidence should be presented to support current published values.
6. If evidence does not support the current published value, a RUC member may recommend a decreased value. If specialty agrees with RUC member recommendation, the RUC proceeds to vote. If the specialty declines to accept recommendation or if the recommendation does not meet 2/3 approval, the code will be referred to facilitation.

Compelling Evidence

The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
  - technique
  - knowledge/technology
  - patient population
  - site-of-service
  - length of hospital stay
  - physician time
- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.
- Evidence that technology has changed physician work (i.e., diffusion of technology).
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:
  - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;
  - a flawed mechanism or methodology used in the previous valuation by either the RUC or CMS, for example, evidence that no pediatricians were consulted in assigning pediatric values or CMS/Other source codes; and/or
  - ~~o~~ the current published valuation excluded a specialty that currently provides a plurality of the service. ~~survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.~~

II. CMS Codified RUC Compelling Evidence in Rulemaking

At the January 2022 RUC meeting, a Subcommittee member requested the background for when CMS codified the compelling evidence standards in rulemaking. The previous Final Rules on the Medicare Physician Payment Schedule where CMS detailed their acceptance of the RUC compelling evidence was provided in the agenda materials as informational.

AMA/Specialty Society RVS Update Committee **Tab 14**
Multi-Specialty Points of Comparison (MPC) Workgroup
April 28, 2022

Members Present: Bradley Marple, MD (Chair), Jim Clark, MD (Vice Chair), Amr Abouleish, MD, Jennifer Aloff, MD, Margie Andreae, MD, Anita Arnold, MD, Charles Fitzpatrick, OD, Stephen Gillaspy, PhD, Gregory Harris, MD, Michael R Kuettel, MD, PhD, M. Douglas Leahy, MD, Howard P. Levy MD, PhD, John Proctor, MD, Norm D. Smith, MD

Review of Specialty Code Recommendations
In June 2021, the MPC Workgroup recommended the identification and comprehensive review of codes on the MPC list that either have not been reviewed in the last 15 years or are codes in which CMS did not accept the RUC recommendation. AMA staff compiled a list of codes on the MPC list based on this recommendation and included codes that did not meet the suggested criteria for inclusion on the MPC list because their Medicare utilization is less than 1,000. AMA staff worked with specialty societies and received recommendations to add, maintain, or delete services from the MPC list.

The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Representatives from the specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more utilization of the code should comment on the appropriateness of addition or deletion of the service.

Ultimately, the MPC Workgroup members agreed to add 2 specialty recommended codes to the MPC list, delete 34 codes from the MPC list, and maintain 38 codes on the MPC list with justification provided by specialty societies in their recommendations.

I. MPC Codes – RUC-Reviewed 15+ Years Ago

In June 2021, the MPC Workgroup recommended that it identify and review codes on the MPC list that have not been reviewed in the last 15 years. There were 25 services on the MPC list that have not been RUC reviewed in the last 15 or more years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 7 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	9.23	090	2005-08	90,113
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	43.28	090	2005-08	3,163
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	39.88	090	2005-08	5,001

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	1.73	000	2006-02	20,612
70355	Orthopantogram (eg, panoramic x-ray)	0.20	XXX	2005-08	34,300
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	XXX	2005-08	5,905,780
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	2.25	ZZZ	2005-08	560,661

The MPC Workgroup recommends deleting the following 18 services from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.90	010	2005-08	24,133	Valuation based on survey data from insufficient number of respondents
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	1.45	010	2005-08	115,439	Valuation based on survey data from low number of respondents
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	1.84	010	2005-08	48,049	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	1.53	010	2005-08	30,002	Valuation based on survey data from low number of respondents
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	1.77	010	2005-08	30,312	Valuation based on survey data from low number of respondents
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	2.34	010	2005-08	8,316	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	2.07	010	2005-08	23,703	Valuation based on survey data from low number of respondents
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	3.11	010	2005-08	25,312	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	2.17	010	2005-08	29,582	Valuation based on survey data from low number of respondents
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	2.62	010	2005-08	89,442	Valuation based on survey data from low number of respondents
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	3.42	010	2005-08	32,484	Concern about assigned pre-service time — Pre-service time recommendation was from before the RUC had standard pre-time packages
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	3.65	000	2006-04	24,066	N/A, concurred with specialty recommendation to remove

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)	0.80	ZZZ	2006-04	43,311	N/A, concurred with specialty recommendation to remove
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	4.58	000	2006-04	32,464	N/A, concurred with specialty recommendation to remove

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	090	2005-08	1,849	Low volume; another code with same value on MPC list valued more recently
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250	N/A, concurred with specialty recommendation to remove
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	1.99	XXX	2006-04	3,816	Methodology to value the services would not be considered appropriate under current standards
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	1.37	XXX	2006-04	40,526	Methodology to value the services would not be considered appropriate under current standards

II. MPC Codes – CMS Did Not Accept RUC Recommendation

In June 2021, the MPC Workgroup identified codes in which CMS did not accept the RUC recommendation. The Workgroup noted that many of these services may be important to specialty societies, with few other services available for the MPC List. Also, many of the services were reviewed years ago and the specialty societies may have accepted the CMS decision. While several MPC Workgroup members thought that codes with RUC approved values would be better comparisons, the Workgroup decided to defer to the specialty societies. There are 34 services on the MPC list in which CMS did not accept the RUC recommended work RVU. These codes have been reviewed by the specialty societies, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 22 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.22	010	2010-10	368,976
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.01	000	2010-02	1,938,307
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	2.70	000	2010-04	456,527
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	4.10	000	2010-04	88,567
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.80	090	2007-04	11,733
36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)	2.09	ZZZ	2012-04	13,979
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	1.28	000	2012-10	71,670
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	39.88	090	2013-04	12,479
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	010	2007-04	3,464
52000	Cystourethroscopy (separate procedure)	1.53	000	2016-01	897,375
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.75	000	2010-04	62,618
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, gibbons or double-j type)	2.82	000	2013-04	151,015
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	7.50	000	2013-04	11,180
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	4.00	000	2019-01	26,625

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure)	1.01	ZZZ	2019-01	101,717
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	6.55	090	2010-10	5,906
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	14.56	090	2010-10	4,687
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	13.36	090	2010-10	1,020
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	090	2014-04	1,030
85097	Bone marrow, smear interpretation	0.94	XXX	2017-04	140,727
92567	Tympanometry (impedance testing)	0.20	XXX	2007-04	922,916
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	XXX	2007-04	1

The MPC Workgroup recommends deleting the following 12 services from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	7.07	090	2007-02	2,079	N/A, concurred with specialty recommendation to remove
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	7.42	090	2007-02	1,657	N/A, concurred with specialty recommendation to remove
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	5.86	090	2007-02	1,365	N/A, concurred with specialty recommendation to remove
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, bentall)	58.79	090	2005-09	1,812	N/A, concurred with specialty recommendation to remove
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	090	2010-10	38,983	N/A, concurred with specialty recommendation to remove
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9.09	090	2011-02	10,329	N/A, concurred with specialty rec(s)
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.19	090	2010-10	7,841	CMS inappropriately assigned value uses reverse building block
60500	Parathyroidectomy or exploration of parathyroid(s);	15.60	090	2010-10	18,399	CMS inappropriately assigned value uses reverse building block

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5.60	010	2008-02	8,146	N/A, concurred with specialty recommendation to remove
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5.19	010	2008-02	29,921	N/A, concurred with specialty recommendation to remove
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.26	XXX	2015-01	9,755	N/A, concurred with specialty recommendation to remove
92273	Electroretinography (erg), with interpretation and report; full field (ie, fferg, flash erg, ganzfeld erg)	0.69	ZZZ	2018-01	68,699	N/A, concurred with specialty recommendation to remove

III. MPC Codes – Medicare Utilization less than 1,000

The MPC Code *Assessment Criteria and Considerations* document states under the suggested criteria for codes to be on the MPC list that Codes with Medicare utilization of less than 1,000 should not be included on the MPC list without justification by a specialty society. Currently, there are 14 MPC codes with 2019 Medicare utilization under 1,000. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "delete" or "maintain," along with their supporting rationale. **The MPC Workgroup recommends maintaining the following 9 services:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
36440	Push transfusion, blood, 2 years or younger	1.03	XXX	2016-01	1
36450	Exchange transfusion, blood; newborn	3.50	XXX	2016-01	3
36455	Exchange transfusion, blood; other than newborn	2.43	XXX	2016-01	49
36456	Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn	2.00	XXX	2016-01	1
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (ivor lewis)	57.50	090	2016-10	609
54437	Repair of traumatic corporeal tear(s)	11.50	090	2015-01	54
54438	Replantation, penis, complete amputation including urethral repair	24.50	090	2015-01	1
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	XXX	2009-04	1
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	1.92	XXX	2010-10	12

The MPC Workgroup recommends deleting the following 5 services from the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	Rationale why MPC did not accept specialty recommendation
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	9.89	090	2009-02	506	More recently surveyed codes with similar values are already on the MPC list (15576 and 21025)

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	7.41	090	2009-02	940	More recently surveyed code with similar values are already on the MPC list (26113)
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	6.74	090	2009-02	948	More recently surveyed code with similar values are already on the MPC list (26116)
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	5.80	010	2011-09	217	N/A, concurred with specialty recommendation to remove
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250	N/A, concurred with specialty recommendation to remove

IV. MPC List Services Additions

The MPC Workgroup annually solicits the specialty societies for any codes that should be added to or deleted from the MPC List. There are 5 services that have been recommended for addition to the MPC list by two specialty societies**. The MPC Workgroup recommends adding the following 2 services to the MPC List:**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	6.50	ZZZ	2017-01	3,632
34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	6.00	ZZZ	2017-01	206

The MPC Workgroup recommends not adding the following 3 services to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency	MPC Workgroup Rationale for Not Accepting Original Recommendation
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	45.00	090	2017-01	641	Low utilization
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	000	2014-01	2,321	The specialty society withdrew their request to add prior to the meeting.
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.88	000	2014-01	26,744	The specialty withdrew their request to add prior to the meeting.

Advisors Present: Peter Hollmann, MD *(Chair),* Richard Rausch, DPT, MBA *(Co-Chair),* Leisha Eiten, AuD, CCA-A *(Alt. Co-Chair),* Dee Adams Nikjeh, PhD, CCC-SLP, Robert Zwolak, MD, Brooke Bisbee, DPM, Kris Anderson, DC, MS, Katie Jordan, OTD, OTR/L, Korinne Van Keuren, DNP, MS, RN, Stephen Gillaspy, PhD, Gregory Harris, MD, MPH, Charles Fitzpatrick, OD

I. Introductions and Updates

Doctor Rausch welcomed the HCPAC to the in-person meeting.

Assignments to HCPAC Review Board Alternate Advisors
Doctor Rausch and Doctor Hollmann emphasized the importance of electing an Alternate Advisor for all seated positions.

II. Relative Value Recommendations for CPT 2024

Auditory Osseointegrated Device Services
In February 2022, the CPT Editorial Panel created two Category I codes, 926X1 and 926X2 to report *Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes* and each additional 15 minutes of work thereafter. Both codes are currently reported with an unlisted code that lacks specificity for all aspects of the activation, programming, and verification of auditory osseointegrated devices. For the April 2022 RUC meeting, both CPT codes were reviewed by the HCPAC.

926X1 Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
The HCPAC reviewed the survey results from 45 audiologists for CPT code 926X1 and recommends a work RVU of 1.25 which reflects the survey median RVU and appropriately accounts for the work required to perform this service. The HCPAC recommends 7 minutes of pre-evaluation time, 55 minutes intra-service time and 10 minutes immediate post-service time.

For this service, the qualified health care professional (QHP) inspects the surgical site and performs an otoscopic examination. The external sound processor is then fitted and appropriately secured to the patient's head. The majority of the intra-service time is spent performing feedback calibration and making the necessary adjustments to the frequency which is verified by in-situ measurement of bone conduction audiometric values. The sound processor is programed with any other hearing assistive technology, if indicated, and a report is prepared.

To support the recommended work RVU, the HCPAC compared the surveyed code to key reference service codes 92626 *Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour* (work RVU = 1.40, 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time) and 92603 *Diagnostic analysis of cochlear implant, age 7 years or older; with programming* (work RVU = 2.25, 20 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time). These codes are optimal comparators as both have similar intensity to the surveyed code and times that increase respectively as RVU increases. This demonstrates appropriate relativity within other XXX-global audiologic and hearing implant testing services. The HCPAC concluded that the value of CPT code 926X1 should be

1.25, which is aligned with the survey median percentile and maintains relativity within the family and MFS. **The HCPAC recommends a work RVU of 1.25 for CPT code 926X1.**

926X2 Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)
The HCPAC reviewed the survey results from 43 audiologists for CPT add-on code 926X2 and recommends a work RVU of 0.33 which reflects the survey 25th percentile and appropriately accounts for the work required to perform this service. The HCPAC recommends 0 minutes of pre-evaluation time, 15 minutes intra-service time and 0 minutes immediate post-service time.

For this add-on service, the qualified health care professional (QHP) continues to make necessary adjustments to the frequency response and improvement of the device for optimal performance. The sound processors performance is verified by in-situ measurements of bone conduction audiometric values. The QHP makes adjustments as necessary and programs the sound processor with other hearing assistive technology as indicated. The intensity of this service increases due to the potential young age of the patient and/or cognitive function which can increase the complexity of verifying that the processor is working properly.

To support the recommended work RVU, the HCPAC compared the surveyed code to top key reference service code 92627 *Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.33, 0 minutes pre-service, 15 minutes intra-service and 0 minutes post-service time). CPT Code 92627 has identical intensity and intra-time as the surveyed code suggesting that the codes should be valued similarly. For additional support, the HCPAC compared the surveyed code to CPT add-on code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.35, 0 minutes pre-service, 15 minutes intra-service and 0 minutes post-service time). This comparison code has a slightly higher intensity than the surveyed code justifying the minor difference in RVU albeit the identical intra-service time. The HCPAC concluded that the value of CPT code 926X2 should be 0.33, which is aligned with the survey 25th percentile and ensures appropriate rank order among similar auditory evaluation add-on codes. **The HCPAC recommends a work RVU of 0.33 for CPT addon code 926X2.**

Practice Expense
The HCPAC approved the direct practice expense inputs as reviewed without modification by the Practice Expense Subcommittee.

III. Other Business

A member asked when assignments and pre-facilitations are scheduled for HCPAC items. AMA staff clarified that if there is only a single item on the agenda, it would be expected that all members would review the item and send in advance questions and pre-facilitation would not be necessary. If multiple items are on the agenda, assignments will be made and pre-facilitation will be planned, as needed.

AMA/Specialty Society RVS Update Committee **Tab 16**
Relativity Assessment Workgroup
April 29, 2022

Members: Doctors John Proctor (Chair), Matthew Grierson (Vice Chair), Jennifer Aloff, Sergio Bartakian, Audrey Chun, William Donovan, Martha Gray, Gregory Harris, John Heiner, Gwenn Jackson, Katie Jordan, OTD, Dee Adams Nikjeh, PhD, Norm Smith and David Wilkinson.

I. Re-review of Services – Review Action Plans

Endovascular Revascularization (37220-37235)
In January 2019, CPT code 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* was identified on the High Volume Growth screen. The specialty societies indicated and the RUC agreed to refer this entire family of services to CPT for revision to accommodate new technologies. The specialty societies worked with the CPT Editorial Panel and have submitted multiple coding change proposals. In September 2021, CPT Editorial Panel did not approve of the proposed coding changes suggested unbundling previous bundling efforts. Since this issue was not addressed via edits at CPT, it was placed back on the Relativity Assessment Workgroup agenda to review.

The Workgroup discussed the complexity of this issue and determined that coding clarification is still necessary. The Workgroup recommends that a joint CPT/RUC Workgroup be created to develop coding solutions for the endovascular revascularization (37220-37235) code family.

Ultrasonic guidance for placement of radiation therapy fields (G6001)
In October 2020, the RUC identified G6001 via the CMS/Other Medicare utilization over 20,000 screen. In January 2021, the RUC recommended to refer G6001 to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology). To date, a Category I code has not been created, therefore this issue was placed back on the Relativity Assessment Workgroup for review at the April 2022 Workgroup meeting.

The Workgroup agreed with the specialty society that the specialties work with CMS to develop a MLN Matters article to clarify correct coding and that the Workgroup re-review in two years (April 2024).

II. New Technology/New Services – Review Action Plans (39 codes/17 issues)

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. This April, the Relativity Assessment Workgroup will continue review of CPT 2018 codes that were flagged at the April 2016, October 2016 and January 2017 RUC meetings, with three years of available Medicare claims data (2018, 2019 and 2020). **The Workgroup reviewed the action plans and recommends the following:**

1. The service does not need to be re-evaluated, the code should be removed from the New Technology/ New Services Lists

2. The service requires additional claims data, more than the first three years. The RUC will determine on a case-by-case basis when the service should be re-reviewed through the New Technology/New Services List process

3. The service needs to be re-evaluated. The specialty society will survey the service and present recommendations at the next RUC meeting (ie, September 2022). New RVUs will be published January 1, 2024 if approved by the RUC and CMS.

Issue	CPT Code	Workgroup Recommendation
Intraoperative Radiation Therapy Applicator Procedures	19294	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Cryoablation of Pulmonary Tumors	32994	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Subcutaneous Implantable Defibrillator Procedures	33270	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
	33271	
	33272	
	33273	
	93260	
	93261	
	93644	
Transcatheter Mitral Valve Repair	33418	The Workgroup noted that these services are still evolving and should be reviewed in 3 years (April 2025).
	33419	
Artificial Heart System Procedure	33927	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
	33928	
	33929	
Treatment of Incompetent Veins	36465	Review in 3 years (April 2025); still fluctuation in utilization.
	36466	
Mechanochemical (MOCA) Vein Ablation	36473	Review in 3 years (April 2025); still fluctuation in utilization.
	36474	
Endovenous Ablation	36475	Review in 3 years (April 2025); still fluctuation in utilization.
	36476	
	36478	
	36479	
Treatment of Incompetent Veins	36482	Review in 3 years (April 2025); still fluctuation in utilization.
	36483	
Diagnostic Bone Marrow Aspiration and Bone Biopsy	38220	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
	38221	
	38222	
High Resolution Anoscopy	46601	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
	46607	
Peri-Prostatic Implantation of Biodegradable Material	55874	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Breast Tomosynthesis	77061	Request again that CMS delete G0279 since it may be reported with 77061 or 77062 and RAW review again after 3 years of claims data (April 2025).
	77062	
	77063	
	G0279	
Arterial Pressure Waveform Analysis	93050	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Negative Wound Pressure Therapy	97605	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
	97606	
	97607	
	97608	
Psychiatric Collaborative Care Management Services	99484	Survey for September 2022.

III. Reiteration of Screens – Review 2020 Data

CMS/Other Source
The Workgroup identified six codes with 2020 Medicare utilization data over 20,000. Codes 95851, G0105, G0121, G0425, G2010 and G2012. **The Workgroup requests that action plans be reviewed for these services at the September 2022 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed.**

High Volume Growth – 2015-2020
The Workgroup identified twelve codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020. The Workgroup noted that 77063 was addressed in the first agenda item and an action plan is not necessary for this screen at this time. **The Workgroup requests that the specialty societies submit an action plan for codes 11046, 64488, 65778, 75571, 78580, 88381, 90868, G0277, G0442, G0444 and G0446 for September 2022.**

Surveyed by one specialty and now performed by a different specialty
The Workgroup identified two codes, 27369 and 99457, 2020 with 2020 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 codes 27369 and 99457 for September 2022.**

Category III Codes with High Volume
The Workgroup identified six Category III codes with 2020 Medicare utilization over 1,000. The Workgroup noted that 0552T was just created in 2020 and the Workgroup should wait for another year of utilization before examining further. **The Workgroup requests action plans for codes 0042T, 0054T, 0055T, 0232T and 0507T for September 2022.**

CPT Assistant Analysis
The Workgroup identified two issues which the RUC referred to CPT Assistant and an article was published in 2019. **The Workgroup requests action plans for 95983, 95984, 95976, 95977 and 75898. The Workgroup specifically requests that the specialty societies address the following in their action plans: 1) Explain the issue and background of the code and why a CPT Assistant article was created; 2) What was the expected result; 3) Did the article address the issues identified with this service; and 4) Is a re-review in a couple years or further action necessary?**

Contractor Priced High Volume
The Workgroup identified six codes that are contractor priced with 2020 Medicare utilization over 10,000**. The Workgroup requests action plans for codes 95700, 95715, G0399, G2066 & G6017 (noting G6017 was previously identified on CMS/Other Source screen in error) for September 2022.**

Services Performed Together 75% or More
The Workgroup identified 19 code pairs for services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in 2020 Medicare claims data and/or contained at least one ZZZ global service were removed. **The Workgroup requests action plans for September 2022 to determine if specific codes bundling solutions should occur for the following:**

22554	63081
26480	25447

29828	29827
51728	51741

51728	51784
51729	51741

51729	51784
55700	76872

61624	75894
61624	75898

64415	76942
64447	76942

67028	92134
70496	70498

70547	70544
93890	93886

93890	93892
93892	93886

93892	93890

IV. Gender Equity Payment

In response to the January 2022 Relativity Assessment Workgroup (RAW) on gender equity payment between services performed by gynecologists and urologists a RUC member commented that the preventive medicine services codes 99381-99397 could be reviewed by the RAW for potential gender based misvaluation. The member stated that preventive medicine services are valued by age, not gender, and provided an example that care for a 30 year old male and 30 year old female have significant differences such as the need for gynecological care. These differences impact the time, physician work, and practice expense for a preventive visit based on the patient's gender suggesting the need for further review of gender-based variations of care. The member requested that the issue be referred to the RAW for review of potential misvaluation of preventive care codes based on gender-related patient care. This request was met with support from several other RUC members. The RUC concluded to refer this item to the RAW for further review of gender-based differences in preventive medicine services.

At this meeting, the presenters from ACOG indicated, and the Workgroup agreed, that there may be additional resources associated when a pelvic examination is performed. **The Workgroup agreed that this issue should be referred to the CPT Editorial Panel to consider the specialties request for additional code(s) to describe pelvic examinations. The CPT Editorial Panel may choose to consider the development of additional codes to address any identifiable gender-based inequities in existing CPT code content.**

V. Informational Items

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
Research Subcommittee Meeting Report

Monday, February 21, 2022

Members Present: Christopher Senkowski, MD (Chair), Alan Lazaroff, MD (Vice Chair), James Blankenship, MD, R. Dale Blasier, MD, Gregory DeMeo, DO, Jeffrey Paul Edelstein, MD, Peter Hollmann, MD, Omar Hussain, MD, M. Douglas Leahy, MD, Marc Raphaelson, MD, Sanjay Anantha Samy, MD, Kurt Schoppe, MD, David Slotwiner, MD, Edward Vates, MD, David Yankura, MD

I. Spinal Neurostimulator Services (63685, 63688, 64590, 64595, 64XX2, 64XX3, 64XX4): Proposed Vignettes

American Urological Association

In February 2022, the CPT Editorial Panel revised four Category I codes and created three new Category I codes; the Panel also created six new Category III codes and revised four Category III codes. The Panel also updated the introductory guidelines and parentheticals for implantation, revision and removal of differing neurostimulator devices.

The Research Subcommittee reviewed proposed vignettes for five of the new/revised Category I codes from the American Urological Association (AUA) and compared them against the CPT created vignettes. Following a robust discussion, the Subcommittee only approved AUA vignettes for codes 64590 and 64595, with minor revisions. It was noted that the American College of Obstetricians and Gynecologists (ACOG) will be surveying codes 64590 and 64595 as well.

The Research Subcommittee reviewed the proposed vignettes for 64590 and 64595 and agreed that they were appropriate with minor revisions. **The Research Subcommittee approved the vignettes as follows:**

> **64590** ***Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver ~~direct or inductive coupling~~, requiring pocket creation and connection between electrode array and pulse generator or receiver***
>
> **Research-approved Vignette:** A 65-year-old with overactive bladder refractory to ~~**behavior, medical, and injection**~~ **previous** therapy is referred for insertion of neurostimulator pulse generator.

> **64595** ***Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array***
>
> **Research-approved Vignette:** A 65-year-old with overactive bladder refractory to ~~**behavior, medical, and injection**~~ **previous** therapy is referred for revision/removal of neurostimulator pulse generator.

New codes 64XX2, 64XX3 and 64XX4 are specifically for an integrated neurostimulator for the peripheral nerve and include a parenthetical referring integrated neurostimulator services for bladder dysfunction procedures to instead use a category III code, and therefore, would not be relevant to patients with bladder dysfunction. Instead, CPT category III codes 0587T and 0588T were created for the percutaneous implantation, revision, replacement, and removal of an integrated single device neurostimulation system for bladder dysfunction. Following the discussion, the AUA noted that they would not be surveying 64XX2-64XX4.

The Research Subcommittee also noted in their discussion that the specialties whose members are involved in treating pain should consider surveying CPT codes 63685, 63688, 64XX2, 64XX3, and 64XX4. It was noted that prior to the call, only the American Society of Anesthesiologists had indicated their plan to survey some of these codes (though only 63685 and 63688). **The Research Subcommittee requested for AMA RUC staff to reach out to the specialty societies representing Neurosurgery, Pain Management, Anesthesiology,**

Interventional Pain Management, and Orthopedic Surgery regarding surveying code 63685, 63688, 64XX2, 64XX3 and 64XX4.

II. Auditory Osseointegrated Device Services (926X1, 926X2): Proposed Reference Service List

American Academy of Audiology
American Speech Language Hearing Association

The Research Subcommittee reviewed the proposed physician work reference service list (RSL) for two new Auditory Osseointegrated Device Services codes, 926X1 and 926X2. The Subcommittee noted that in general there was nothing that would preclude any of the proposed codes on the RSL, though expressed some concern that several of the codes had not been reviewed in over 10 years. Several Subcommittee members also specifically noted that the societies should try to fill the RVU gap between 0.75 and 1.15. In general, the Subcommittee noted that the societies should endeavor to fill large RVU gaps and replace older codes with more recently reviewed codes, where possible.

In advance of the call, one of the reviewers provided a list of codes for the societies to consider for either replacing older codes with similar values or to use to fill in RVU gaps. These suggested codes were: 92584, 92507, 92652, 92607, 92552, and 92521. As an example, a Subcommittee member suggested that code 92602 could be replaced with code 92507 as both services have an identical work value, though 92507 was reviewed more recently. Another reviewer suggested for the societies to also consider 92550.

The societies noted their intent to survey both the XXX global code 926X1 and ZZZ global 926X2 together on the same RSL and that they included both XXX global and ZZZ global codes on the RSL for that reason. Several Subcommittee members noted that this would be appropriate and has precedent.

III. Total Disc Arthroplasty (22857, 228XX): Proposed Custom Survey Template and Targeted Survey Methodology

American Association of Neurological Surgeons
American Academy of Orthopaedic Surgeons
Congress of Neurological Surgeons
International Society for the Advancement of Spine Surgery
North American Spine Society

In September 2021, the CPT Editorial Panel revised total disk arthroplasty CPT code 22857, which is for a single lumbar interspace and created Category I code 228XX which will be for total disk arthroplasty in a second lumbar interspace.

The specialty societies surveyed codes 228XX and 22857 for the January 2022 RUC meeting. In reviewing the survey responses for code 22857, the specialties noted, and the RUC concurred that the collected data was inaccurate for several suspected reasons. The survey results indicated a median intra-service (i.e., skin-to-skin) time of 120 minutes which immediately suggested to the specialty societies, and RUC members familiar with this service, that the survey results were inaccurate. It is likely that some of the survey respondents were unfamiliar with the procedure as it is very low volume and generally takes much longer than 120 minutes to perform the intra-service work. The RUC concluded that the survey respondents only accounted for the work of the orthopaedic or neurosurgeon and did not account for the additional co-surgeon that routinely performs part of the intra-service work for this procedure. Those familiar with this procedure further indicated that respondents likely did not account for the time spent performing the approach and closure, which is typically performed by a second surgeon. Furthermore, the standard survey tool used for this survey did not include specific instructions regarding the skin-to-skin related work by each surgeon, and this likely contributed to respondents inaccurate reporting of skin-to-skin time. Therefore, after thorough review, the specialty societies indicated, and the RUC agreed, that the survey results for both CPT codes 22857 and 228XX were erroneous and that the codes should be resurveyed for the April 2022 RUC meeting with a targeted survey tool that has

been reviewed and approved by the Research Subcommittee. At the January meeting, the RUC recommended an interim work RVU for CPT code 22857 and contractor pricing for CPT code 228XX. The specialty society were requested to resurvey for the April 2022 RUC meeting and work with the RUC's Research Subcommittee to draft a targeted survey.

On the February Research call, the specialties presented a proposed custom survey template. The specialties noted that the proposed revisions are related to clarifying the skin-to-skin definition and to clearly state that intra-service time estimates should include total time of both providers. They noted that their proposed custom language is similar to the E/M surveys that clearly indicated total time should be both face-to-face and non-face-to-face time of both the physician and QHP – even though only one of the providers would be responding to the survey.

The Research Subcommittee approved the custom survey for question 2 introductory text and question 2A as follows; the rest of the survey would remain as the standard 090-day template as was proposed by the specialty:

SURGERY 090 Global Period

Pre-service period

The pre-service period includes physician services provided from the day before the operativeprocedure until the time of the operative procedure and may include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioningthe patient and other "non-skin-to-skin" work in the OR.

The following services are **not included**:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with mod-57).
- Distinct evaluation and management services provided in addition to the procedure (reported with mod-25).
- Mandated services (reported with modifier -32).
- Moderate (conscious) sedation services (reported with CPT codes 99151-99157)

Intra-service period

For this survey, the intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure. "Skin-to-Skin" time specifically includes the total time for the approach, the definitive procedure, and the closure even if different aspects of theprocedure are performed by more than one surgeon.

Post-service period

The post-service period includes services provided on the day of the procedure and

within 90days and may include the following:

- **Day of Procedure:** Post-operative care on day of the procedure is divided into "Immediate Post-Service Time" and any subsequent visit on the day of the operative procedure. [*Immediate Post-Service Time* includes non "skin-to-skin" work in the OR after the procedure, patient stabilization in the recovery room or special unit, and communicating with the patient and other professionals (including written and telephone reports and orders).]

- **Other follow-up care before the patient is discharged:** Post-operative visits in ICU, otherin-hospital visits, and discharge day management services.

- **Office visits** within the assigned global period of 90 days.

The following services are **not included**:

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with mod -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)

SURGERY ZZZ Global Period

Intra-service period

For this survey, the intra-service time is only ~~includes~~ the additional time for additional exposure, when performed, and the definitive procedure for the second interspace totaldisc arthroplasty.

QUESTION 2a: **How much ~~of your own time~~ total time** is required per patient treated foreach of the following steps in patient care related to each survey code? It is important to be asprecise 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.

If necessary, please refer to the pre-service, intra-service and post-service period definitions onthe preceding page.

Do not include time for work related to another service, procedure, or evaluation and management code that is separately reportable.

IMPORTANT: When estimating intra-service time for 22857, please consider the total skin-to-skin work—specifically the approach, the definitive procedure, and closure—even if different aspects of the procedure are performed by more than one surgeon. The intra-service time for228XX includes only the additional time for additional exposure, when performed, and the definitive procedure for the second interspace total

disc arthroplasty.

	22857	+228XX
Day Before Procedure		
PRE-service evaluation time (minutes)		N/A
Day of Procedure		
PRE-service evaluation time (minutes)		N/A
PRE-service positioning time (minutes)		N/A
PRE-service scrub, dress, wait time (minutes)		N/A
INTRA-service time (minutes)		
POST-service time (minutes)*		N/A

** Post-operative care on day of the procedure, includes "non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure.*

The societies also requested approval to use a targeted survey using a vendor list of trained surgeons, along with a random survey of society members. **The Research Subcommittee approved the request to use a targeted survey in addition to a random sample.** The Specialties should present their survey summary data both together and with the targeted sample and random sample split out separately on the summary spreadsheet.

AMA/Specialty Society RVS Update Committee **Tab 07**
Neurostimulator Services-Bladder Dysfunction (64590, 64595)
Facilitation Committee #2

Members Present: James Blankenship, MD (Chair), Jim Clark, MD, Jeffrey Edelstein, MD, Stephen Gillaspy, PhD, Peter Hollmann, MD, Bradley Marple, MD, Marc Raphaelson, MD, Donna Sweet, MD, James Waldorf, MD, Thomas Weida, MD, Richard Weiss, MD

64595 ***Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array***
The facilitation committee reviewed the survey results for CPT code 64595 and determined that the survey 25th percentile somewhat overestimated the physician work typically required to perform this service. The facilitation committee noted several potential crosswalks with similar times and physician work relative to the survey code. After thorough discussion, the committee recommends a direct work RVU crosswalk to CPT code 38500 *Biopsy or excision of lymph node(s); open, superficial* (work RVU= 3.79, 30 minutes intra-service time and 115 minutes total time), noting that both services involve an identical amount of intra-service time and similar total time. The facilitation committee acknowledged the strength of the survey and recommends the following survey times: 47 minutes pre-service time (29 minutes evaluation, 8 minutes positioning, 10 minutes scrub/dress/wait time), 30 minutes intra-service time, 15 minutes immediate post-service time, ½ day 99238 discharge and 1 99213 office visits (total time 134 minutes).

The facilitation committee concurred that CPT code 38500 as a direct crosswalk to CPT code 64595 is buttressed by several other 10-day global codes with identical intra-service time and similar total time, namely, CPT code 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU= 3.78, 30 minutes intra-service time and 122 minutes total time) and CPT code 49442 *Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 3.75, 30 minutes intra-service time and 108 minutes total time). The facilitation committee concluded that CPT code 64595 should be valued based on a direct work RVU crosswalk to CPT code 38500, concurring that the crosswalk value slightly below the survey 25th percentile was appropriate. **The facilitation committee recommends a work RVU of 3.79 for CPT code 64595.**

Practice Expense
The Practice Expense Subcommittee made several modifications to the PE spreadsheet including clarifying the equipment minutes for EQ209 *programmer, neurostimulator (w-printer)* and removing CA037 *Conduct patient communications* as a post-operative phone call is already included in the global period. An additional point was raised by the PE Chair during the Facilitation Committee meeting regarding the billed together codes. The Chair noted that CPT code 64590 is billed together 53.6% with higher volume CPT code 95972 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*, thus the minutes for CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* and CA010 *Obtain vital signs* should be removed as they would be duplicative. The inputs for CPT code 64595 were not further revised. **The facilitation committee recommends the direct practice expense inputs as modified by the PE Subcommittee.**

Two Amendments:

During the discussion, the RUC considered dermal adhesives and noted the limited…. PE Subcommittee will review them.

The RUC recommends that a CPT Assistant article be developed to