AMA/Specialty Society RVS Update Committee
Hilton San Diego Bayfront, San Diego, CA
April 26-29, 2023

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person and virtually in April 2023. Doctor Ezequiel Silva, III, called the hybrid meeting to order on Thursday, April 27, 2023, at 3:00 p.m. PT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva, III, MD
Amr Abouleish, MD, MBA
Margie C. Andreae, MD
Amy Aronsky, DO
James Blankenship, MD, MHCM
Robert Dale Blasier, MD
Audrey Chun, MD
Scott Collins, MD
Gregory DeMeo, DO
William Donovan, MD, MPH
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
David Han, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
Omar Hussain, DO
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
Marc Raphaelson, MD
Richard Rausch, DPT, MBA
Kyle Richards, MD
Sanjay Samy, MD
Christopher Senkowski, MD
Donna Sweet, MD
G. Edward Vates, MD
James C. Waldorf, MD
Thomas J. Weida, MD
Adam Weinstein, MD
David Wilkinson, MD, PhD

RUC Alternates:
Jennifer Aloff, MD
Chester Amedia, MD
Anita Arnold, DO
Gregory L. Barkley, MD
Eileen Brewer, MD
Neal Cohen, MD
Neeraj Desai, MD
Leisha Eiten, AuD
William Gee, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Stephen Lahey, MD
Len Lichtenfeld, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Swati Mehrotra, MD
Michael Perskin, MD
James L. Shoemaker, MD
Matthew Sideman, MD
Clarice Sinn, DO
Michael J. Sutherland, MD
Mark Villa, MD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

Ezequiel Silva, III, MD, Chair of the AMA/Specialty Society RVS Update Committee (RUC), introduced himself and welcomed everyone to the in-person RUC meeting.

- 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 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.
  - The full lobbying policy can be found on the 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 registrants 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 Chair of the AMA Board of Trustees:
  - Sandra Adamson Fryhofer, MD

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff (in-person):
  - Ayush Arora
  - Morgan Kitzmiller, MHA
  - Michael Soracoe, PhD
  - Gift Tee

- Doctor Silva welcomed the CMS virtual attendees:
    - Perry Alexion, MD
    - Tamika Brock
    - Larry Chan
    - Edith Hambrick, MD
    - Sarah Leipnik
    - Kathleen Kersell
    - Scott Lawrence
    - Ann Marshall
    - Mikayla Murphy
    - Julie Adams Rauch
    - Patrick Sartini
    - Pamela Foxcroft Villanyi, MD
    - Pamela West

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

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

- Doctor Silva announced the new RUC Members:
    - David Han, MD (SVS)
    - Omar Hussain, DO (ATS/CHEST)
    - Sanjay Samy, MD (STS)

- Doctor Silva announced the new RUC Alternate Members:
    - Chester Amedia, MD (RPA)
    - Neeraj Desai, MD (ATS)/CHEST)
    - Stephen Lahey, MD (STS)
    - Leonard J. Lichtenfeld, MD (ACP)
    - Matthew Sideman, MD (SVS)

- Doctor Silva announced the following virtual observers:
    - Michael Adamson, Senior Director, Tariff –Ontario Medical Association
    - Mitchell Steffler, Manager, Tariff –Ontario Medical Association
    - Jennifer Wilock, Manager, Tariff –Ontario Medical Association
    - Nisha John, MPH –Policy Analyst, Alberta Health
    - Mark Klaver, BSc, MBA –Manager, Insured Services Delivery Unit, Alberta Health

- Doctor Silva announced a departing AMA Staff member and thanked her for 33 years of service:
    - Ruby Overton-Bridges, Staff Assistant IV

- 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 the general guidelines and expectations, such as:
        - Specialty representation
        - Survey methodology

  - Vignette
  - Sample size
  - Budget Neutrality / Compelling evidence
  - Professional Liability Insurance (PLI)
  - Moderate Sedation

- 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.
  - Tab 6 Telemedicine E/M Services –All RUC members and alternates may participate in the discussion.

- Doctor Silva conveyed the following procedural guidelines related to Voting for the RUC:
  - 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 smartphone 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 website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.
  - If members are going to abstain from voting, please notify AMA staff so that all 29 votes can be accounted for.
  - 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.

- Doctor Silva shared updates related to RUC Subcommittee and Workgroups:
  - Every two years the Subcommittees and Workgroups are restructured.
  - These were updated in February for 2023-2025.
  - All members should have received an email from the AMA staff in charge welcoming them to the Subcommittee or Workgroup.

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 Physician Practice Information (PPI) Survey Update:
  - Mathematica and the AMA are near completion of internal pre-testing of the online PPI Survey.
  - An introductory packet of information to the potential survey respondents will include a letter showing the support of 173 organizations. This letter is intended to incentivize practices and health systems to complete the survey.
  - In May, 10 practices will pre-test the survey. Interviews with the 10 practices will occur in early June.
  - The AMA will share a communication with all specialty societies in early May, so each society may communicate the importance of the survey to their membership.
  - The launch of the survey will be in late June/July.

- Ms. Smith reviewed 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 reflects 2021 data.
  - 2023 Medicare RBRVS – The Physicians' Guide is available as an e-publication.

- 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 29, 2023	Sep 27-30, 2023	Chicago, IL	CPT 2025
Dec 12, 2023	Jan 17-20, 2024	San Diego, CA	CPT 2025
Apr 2, 2024	Apr 24-27, 2024	Chicago, IL	CPT 2026

IV. Approval of Minutes from the January 2023 RUC Meeting

The RUC approved the January 2023 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

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

- New CPT Editorial Panel Leadership and Panel Members
  - New Panel Chair -Christopher L. Jagmin, MD
  - New Panel Vice-Chair -Barbara S. Levy, MD
  - Joseph Cheng, MD, Panel Member
    - Specialty: Neurosurgery
    - Panel Seat: National Medical Specialty
  - Padma Gulur, MD, Panel Member
    - Specialty: Anesthesiology
    - Panel Seat: National Medical Specialty
  - Gregory Przybylski, MD, Panel Member
    - Specialty: Neurological Surgery
    - Panel Seat: America's Health Insurance Plans (AHIP)
  - The CPT Editorial Panel consists of 21 members.

- Panel meeting activity in response to COVID-19 pandemic:
  - Update on Panel's Response to SARS-CoV-2 Vaccine
    - Covid Vaccine: To date, 59 CPT Category I codes have been created to describe manufacturer specific Covid vaccine codes.
    - The latest release on March 17, 2023, included new code (0174A). This code is intended for a Pfizer vaccine for children 6 months to 4 years as a bivalent booster after three doses of existing COVID vaccine product code (91308).

- May 2023 CPT Editorial Panel meeting:
  - 43 items of business
  - Notable agenda items
    - 8 Digital Medicine related coding change applications (CCAs)
    - 15 Category III code applications
    - 3 RUC referrals to CPT
    - Appendix S AI Taxonomy Revisions - Revise Appendix S-AI Taxonomy to include new examples recently included in the CPT code set that are assistive and augmentative services.
    - CCA Revisions Related to Digital Medicine/AI -Request to add questions regarding AI to the CPT Code Change Application
    - Hand Repair Service Bundling - Establish code 25448 to report suspension with interposition when performed; and revise code 25447 by removing the term "interposition" and adding the phrase "interposition (eg, tendon)" (Referred by the RUC to CPT).
    - HIPEC Guideline Revisions - Establish introductory guidelines that describe work that is included in the HIPEC procedures (Referred by the RUC to CPT).
    - Transcranial Doppler - Establish add-on codes to report procedures performed with complete transcranial Doppler study of intracranial arteries: vasoreactivity study (93896), emboli detection without intravenous microbubble injection (93897), and venous-arterial shunt detection with intravenous microbubble

injection (93898); revise code 93893 to describe venous-arterial shunt detection; and delete code 93890 (Referred by the RUC to CPT).
    - Intra-Abdominal Tumor Excision or Destruction-Request to establish codes 49186-49190 (open procedure) to describe excision or destruction based on the sum of the maximum dimension of all peritoneal, mesenteric, and/or retroperitoneal primary or secondary intra-abdominal tumor(s), cyst(s) or endometrioma(s). And delete codes 49203, 49204, 49205.
    - Respiratory Syncytial Virus –Reviewing two requests for:
        - mRNA RSV Vaccine
        - Immune globulin (i.e., Nirsevimab)
    - Also discussing early release policy for vaccines and immune globulins (IG), allowing for the inclusion of IGs in the existing early release policy (i.e., releasing product CPT codes prior to FDA approval.

- CPT Ad Hoc Workgroups:
    - Tumor Genomics Neoplastic Targeted GSP Workgroup
        - Co-Chairs: Lawrence Simon, MD and Aaron Bossler, MD
        - 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 submitted a CCA for consideration at the February 2023 Panel meeting, which was approved for the 2024 code set.
        - The Workgroup continues to develop genomics coding and sought input from the MPAG last week.

- Upcoming Editorial Panel Meeting: May 2023
    - The next Panel meeting is May 4-6, 2023 (Thursday-Saturday) – Chicago, IL
    - The next application submission deadline is June 14, 2023 (for September 21-23, 2023, meeting).

VI. 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 2023 Medicare Physician Payment Schedule (MFS) Final Rule.

- CMS 2023 Final Rule Highlights
    - On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023. Comments on the proposed rule were due by September 6, 2022.
    - Some Final Rule topics included:
        - CY 2023 PFS Ratesetting and Conversion Factor (CF) Updates
        - Geographic Practice Cost Indices (GPCI) and Malpractice (MP) Data Update
        - Updated Medicare Economic Index (MEI) for CY 2023

- Evaluation and Management (E/M) Services
- Telehealth and Other Services Involving Communications Technology
- Dental and Oral Health Services
- Behavioral Health Services
- Payment for Chronic Pain Management and Treatment Services
- Direct Access to Audiologist Services
- Payment for Skin Substitute Products
- Updates to Coverage Policies for Colorectal Cancer Screening

- Consolidated Appropriations Act, 2023
  - Following the release of the CY 2023 PFS Final Rule, the Consolidated Appropriations Act, 2023 (P.L. 117-328) was enacted on December 29, 2022. The law included several provisions that impacted Medicare payments for physicians and other health professionals, including a provision that increases the payment amounts for services paid under the PFS in calendar years 2023 and 2024 by 2.5 percent and 1.25 percent, respectively. The increases in fee schedules are exempt from budget neutrality requirements and would not factor into any determinations of fee schedule amounts in future years.
    - The temporary 2.5 percent payment increase in PFS payments for CY 2023 resulted in a revised CY 2023 PFS conversion factor of $33.89, a decrease of $0.72 from the CY 2022 PFS conversion factor of $34.61.
  - CMS recalculated the PFS payment rates and conversion factor to reflect these changes. The revised payment rates are available in the Downloads section of the CY 2023 Physician Fee Schedule CMS-1770-F | CMS webpage.

- CY 2024 PFS Rulemaking Updates & Other Updates
  - CMS is actively working on CY 2024 PFS rulemaking.
  - Other updates:
    - The Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, to expire at the end of the day on May 11, 2023.
      - Please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages.
      - CMS is continually working to update these pages to help all understand the effects of ending the PHE. The Medicare Administrative Contractors are the best source of information to apply individual circumstances to doing business with Medicare.

VII. Contractor Medical Director Update

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

- Potentially Misvalued Codes
  - Complex IV Administration
    - This was formerly known as chemotherapy administration.

        - This group of codes initially described the intravenous administration of medications that required significant additional processing, frequent monitoring during administration and/or special equipment necessary for their safe administration.
        - Initially used for chemotherapeutic agents since this class of drugs most often required the additional work or equipment.
        - As some of the drugs became used less frequently and newer classes of drugs were used for both oncologic indications as well as for other non-oncologic indications the lines became less distinct.
        - The codes began to be used for the administration of drugs that did not require the special "handling or equipment" or additional work during administration.
        - Some of the new classes of drugs had members that did require additional work during administration while biosimilars or other members of the group did not.
        - The codes are now used for medications that do not require special handling during their administration.
    - Dental Bone Graft Codes
        - Two potentially misvalued codes have been identified by the CMDs:
            - 21210 *Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)*
            - 21215 *Graft, bone; mandible (includes obtaining graft)*
        - Graft for purposes of the codes, refers to an autograft obtained at the time of the procedure.
        - When these codes are billed, often the graft is merely a liquid bone matrix poured around a socket area or other dental site.

- Dental Services
    - With the expansion of dental coverage, a number of situations have been and are being identified that require more clarity.
    - What is clear is that dental services that are inextricably linked to heart valve surgeries and transplants are covered.
    - What is not so clear, is when these services become inextricably linked.

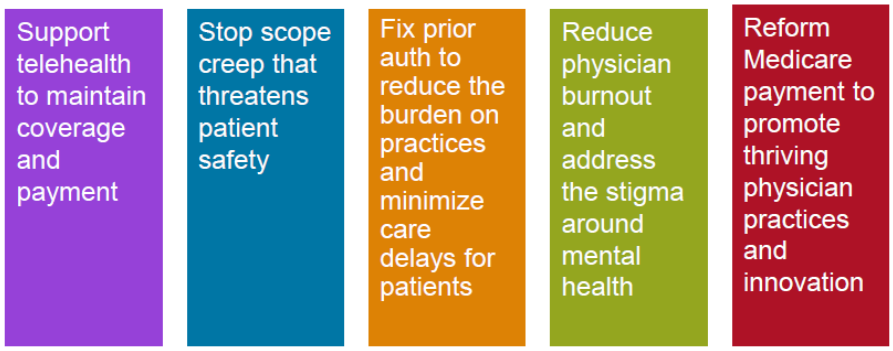
- Artificial Intelligence
    - New technology is always hitting the market and the Contractors receive the claims for review.
    - These technologies are considered screening, and with limited exception, screening is not a benefit for those that can be covered.
    - Documentation on how the new technology will be used in the management of the patient is helpful.

- Doctor Lawrence addressed questions from the attendees:
    - An AMA Staff member stated that dentists and oral surgeons seem to be in agreement with the interpretation of the CMDs that the graft in 21210 and 21215 should be autologous. Regarding the concern of misvaluation, the first step would be for the performing societies to submit a coding change application to the CPT Editorial Panel to address the autologous component of the codes since it is not explicitly defined in the CPT descriptor. Doctor Lawrence confirmed that this is the expectation to reach clarity, prevent improper coding, and allow for appropriate compensation.
    - A RUC member inquired about the complex chemotherapy infusion drugs and suggested the current CPT descriptors may be outdated as the field has evolved since their creation.

The member suggested that the infusion codes should be reviewed in the near future as a family. Doctor Lawrence agreed with this suggested approach.

VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on the AMA response to the Medicare Physician Payment, Telehealth, and Prior Authorization.

- AMA Recovery Plan for America's Physicians
  - 

  - https://www.ama-assn.org/amaone/ama-recovery-plan-america-s-physicians

- Medicare Physician Payment
  - MedPAC Report to Congress: Tie Physician Payment to Medicare Economic Index (MEI)
    - MedPAC recognized that physician pay has not kept up with the cost of practicing medicine.
    - The AMA and 134 other health organizations wrote congressional leaders, telling them that a full inflation-based update is the principal legislative solution to the ongoing problems plaguing the Medicare Physician Payment Schedule (MFS).
  - Medicare Trustees Join Chorus Calling for Medicare Physician Payment Changes
    - The trustees "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the payment system.
    - The report also points out that the current physician payment updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases.
    - "MedPAC and the Trustees have provided lawmakers with a legislative agenda for this year. Congress should adopt a 2024 Medicare payment update that recognizes the full inflationary growth in health care costs," said AMA President, Dr. Resneck in a statement, "To ignore this would be malpractice."
  - H.R. 2474 Strengthening Medicare for Patients and Providers Act
    - H.R. 2474 would provide an annual Medicare physician payment update tied to inflation, as measured by MEI.
    - Introduced by a bipartisan coalition of doctors in Congress.
      - Representatives Larry Bucshon, M.D. (R-Ind.), Raul Ruiz, M.D. (D-Calif.), Mariannette Miller-Meeks, M.D. (R-Iowa), and Ami Bera, M.D. (D-Calif.).
    - AMA and 119 state medical and national specialty societies sent a letter of support to Congress.

        - Bill expected to score in the hundreds of billions of dollars.
        - First step in a long journey.
    - Merit-based Incentive Payment System (MIPS)
        - In response to advocacy from the AMA and organized medicine, CMS will continue to allow physicians and group practices to apply for a MIPS Extreme and Uncontrollable Circumstances hardship exception to avoid up to a -9% MIPS penalty in 2025 based on 2023 performance.
        - Interested physicians and groups must actively request reweighting of one or more MIPS performance categories due to the COVID-19 PHE. Requesting reweighting of all four MIPS performance categories will avoid a MIPS penalty in 2025.
        - CMS expects to release the hardship exception application in spring 2023.

- Telehealth
    - Telehealth after the PHE ends
        - The COVID-19 PHE is set to end on May 11, 2023.
        - AMA and organized medicine strongly advocated to extend the telehealth flexibilities in place and Congress extended the following flexibilities through the end of 2024:
            - Waived the geographic and originating site restrictions.
            - Delayed the in-person requirement on Medicare tele-mental health services.
            - Continued Medicare coverage and payment for audio-only services.
            - Extended the acute hospital at home model.
        - CMS has extended several telehealth policies through 2023, including:
            - Category 3 telehealth services covered.
            - Nonfacility payment rates for telehealth services (physician offices are defined by Medicare as "nonfacility" setting, so this means telehealth payments will remain the same as in-person through 2023).
            - Direct supervision may be provided virtually.
            - Services that were slated to be on the Medicare Telehealth List until 151 days after the PHE, including the three CPT codes for telephone visits.
        - Future policies expected to be discussed in 2024 MFS Proposed Rule.

- Prior Authorization (PA)
    - Medicare Advantage (MA) and Part D Final Rule
        - With AMA's initial read, it appears that many of the provisions that the AMA advocated in support of in February (and for years before that) have been finalized, including:
            - MA must follow Original Medicare coverage guidelines when making medical necessity determinations.
            - When Original Medicare coverage guidelines are not fully established, plans may create coverage criteria based on widely used guidelines and clinical literature. This information must be made publicly available.
            - PA approvals must remain valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating physician's recommendation.
            - Plans must establish a minimum 90-day transition period when an enrollee who is currently undergoing treatment joins a new MA plan.

- These changes will take effect on January 1, 2024.

- No Surprises Act (NSA)
  - NSA
    - The AMA supports the NSA's goal of protecting patients from surprise medical billing.
    - The AMA has raised multiple concerns about how the statute has been implemented:
      - Increased fees – Drastically increased administrative fee (from $50 to $350) and Independent Dispute Resolution (IDR) entity fees for individual and batched claims.
        - Creates a barrier for small, safety net, and rural practices to participate in the process.
      - Lack of payer enforcement – Payers are using "ghost rates" to artificially deflate rates, not complying with the IDR process requirements, and often not paying following a final payment determination.
      - Claims backlog – The IDR process is swamped with ineligible claims, which represent 69% of total claims according to a preliminary report. Most of these are due to lack of clarity over federal vs. state authority; missing information (e.g., QPA); and incorrect batching.
  - AMA NSA Recommendations
    - In a January 2023 letter to HHS, the AMA recommended:
      - Charge penalties for filing meritless claims, not meeting requirements, and not paying on time. The penalties could be used to reduce the fees and disincentivize meritless claims filing.
      - Require payers to show their math and share data when it comes to calculating the Qualifying Payment Amount (QPA).
      - Rescind or postpone fee increase while questions and unintended consequences are analyzed, particularly on small, rural, and safety net practices.
      - Codify that IDR entities are not required to consider any supporting information over other information when making payment determinations.
    - AMA continues to engage with the Administration, Congress, and the courts to address the problems with implementation of the NSA.

- Ms. Hananoki addressed questions from the attendees:
  - A RUC member requested insight on the approaching debt limit discussions in Congress. Ms. Hananoki stated that she primarily works with the Executive Branch and is not privy to the day-to-day work with Congress. Although, she did offer a reminder that it is important to relay a concise message to your members of Congress, especially if it is related to a request that comes with a high CBO score.
  - A RUC member inquired about how the MEI House bill is scored. Ms. Hananoki stated that the AMA Economists estimated that the bill would score $100 billion over 10 years. AMA Advocacy staff have been under the impression that the score may be higher than the estimation given that rates are based on Medicare fee-for-service passed through to Medicare Advantage plans. That said, the AMA will not know until the actual score from the CBO is received and AMA staff can discuss this in further detail at the September RUC meeting, if more information is made available by then. AMA staff added that an

AMA economist may also be able to expand on the CBO score during their annual September presentation on Medicare utilization data.

- A RUC member inquired about the chance that the MEI House bill is passed, and if providers could still see a cut in the conversion factor. Ms. Hananoki responded that this is the first step in a long journey and the first roadblock is going to be the price tag of the MEI bill. The debt ceiling is taking the focus right now. Further, an additional roadblock will be another potential cut to the conversion factor at the end of this year. It is known that the conversion factor is already scheduled to be cut under the 2023 CAA since Congress has phased in the 4.5% cut that will take effect this year. It is important to note that there is an uphill battle to educate members of Congress about provider needs and that the AMA is working closely with specialty societies to determine how to address this issue. Ms. Hananoki reminded RUC participants to utilize the recent MedPAC report and Medicare trustees report when speaking with policymakers and to explain how the cuts are impacting your practices and your patients.
- A RUC member requested insight on the AMA position related to the increasingly difficult liability market for specialties, especially obstetrics and gynecology, vascular surgery, and neurosurgery, etc. Ms. Hananoki and other AMA staff responded that AMA economists recently published a paper regarding medical liability claim frequency among U.S. physicians.
- A RUC participant congratulated the AMA on H.R. 2474 and requested that stakeholders continue to work together to prevent further cuts to physician reimbursement. Another participant shared data from their practice on the rising inflationary costs and difficulty to sustain practice.

IX. Relative Value Recommendations for CPT 2025

Iris Procedures (Tab 4)
Samuel Masket, MD (AAO), Ankoor Shah, MD (AAO), John Thompson, MD (AAO/ASRS)

At the February 2023 CPT Editorial Panel meeting, three Category III codes, 0616T, 0617T and 0618T, were replaced by a single Category I code 66683. The three former Category III codes each described a separate clinical scenario for intraocular lens implant (IOL) insertion, and the creation of 66683 simplifies reporting for this family of iris procedure codes. Two other IOL services, CPT codes 66680 and 66682, are in the same family of 090-day global iris repair codes as 66683. All three codes were reviewed and surveyed for the April 2023 RUC meeting.

Compelling Evidence
The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for CPT codes 66680 and 66682 based on a change in operative technique and increased physician surgical time. In their summary of recommendation, the specialty society articulated the evolution of operative technique in detail. The use of micromanipulators, iris retractors, double-armed long-polypropylene sutures, and utilization of a docking needle with a lumen is now typical for these procedures, which assists in conducting a more detailed dissection of the iris from the surrounding tissues, unfurling it to identify the peripheral avulsed edge, and engaging that edge to obtain a more anatomically correct re-apposition of the iris tissue in the anterior chamber angle. **The RUC agrees with the compelling evidence presented that the physician work for these services has changed due to a change in operative technique and increased physician surgical time.**

66680 ***Repair of iris, ciliary body (as for iridodialysis)***
The RUC reviewed the survey results from 35 ophthalmologists and determined that the survey 25th percentile work RVU of 10.25 appropriately accounts for the physician work required to perform CPT code 66680. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 6 minutes pre-service scrub/dress/wait time, 45 minutes intra-service time, 10 minutes immediate post-service time, 0.5-99238 and 3-99213 post-service visits, which equals 182 minutes of total time. The RUC confirmed that three postoperative visits are typical and include visual acuity and intraocular pressure checks, gonioscopy to assess the status of the anterior chamber angle, and examination of the peripheral retina for breaks.

To support a work RVU value of 10.25, the RUC compared the surveyed code to the top two key reference services CPT codes 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* (work RVU = 10.25, 30 minutes intra-service time, and 175 minutes total time) and 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20, 45 minutes intra-service time, and 257 minutes total time). The RUC determined the surveyed code was comparable to the top key reference service as both require identical physician work and similar time; moreover, the RUC noted that the second key reference service is an accurate comparator to the surveyed code because both require the same intensity and complexity to perform.

For additional support, the RUC referenced MPC code 57250 *Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy* (work RVU = 10.08, 60 minutes intra-service time, and 211 minutes total time) and CPT code 67316 *Strabismus surgery, recession, or resection procedure; 2 or more vertical muscles (excluding superior oblique)* (work RVU = 10.31, 45 minutes intra-service time, and 164 minutes total time). The RUC noted that together these two codes appropriately bracket the survey 25th percentile work RVU, wherein CPT code 67316 has identical intra-service time, though slightly shorter total time, when compared to the surveyed code. **The RUC recommends a work RVU of 10.25 for CPT code 66680.**

66682 ***Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)***
The RUC reviewed the survey results from 34 ophthalmologists and determined that the survey 25th percentile work RVU of 10.87 appropriately accounts for the physician work required to perform CPT code 66682. The RUC recommends 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 7 minutes scrub/dress/wait time, 45 minutes intra-service time, 10 minutes immediate post-service time, 0.5-99238, 3-99213 and 1-99212 post-service visits, which equals 202 minutes of total time. The RUC confirmed that four postoperative visits are typical and include visual acuity and intraocular pressure checks and slit lamp examinations. Three of the visits include dilated examinations of the macula for cystoid edema and the peripheral retina for breaks; an additional visit is typical for continued treatment of inflammation from iris manipulation.

To support a work RVU value of 10.87, the RUC compared the surveyed code to the to the top key reference services 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without*

endoscopic cyclophotocoagulation (work RVU = 10.25, 30 minutes intra-service time, and 175 minutes total time) and 66170 *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (work RVU = 13.94, 45 minutes intra-service time, and 278 minutes total time). The RUC determined the surveyed code was comparable to the top key reference service as they both require similar physician work and time to perform; moreover, the RUC noted that the second key reference services is an accurate comparator to the surveyed code because both require the same intensity and complexity to perform.

For additional support, the RUC referenced MPC code 54437 *Repair of traumatic corporeal tear(s)* (work RVU = 11.50, 60 minutes intra-service time, and 264 minutes total time) and noted that the intra-service and total time is greater, therefore the reference code is valued higher. The RUC also compared the surveyed code to CPT code 67316 *Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)* (work RVU = 10.31, 45 minutes intra-service time and 164 minutes total time) and noted the identical intra-service time. Furthermore, the 25th percentile work RVU for the surveyed code maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 10.87 for CPT code 66682.**

66683 ***Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed***

The RUC reviewed the survey results from 31 ophthalmologists and determined that the survey 25th percentile work RVU of 12.80 appropriately accounts for the physician work required to perform CPT code 66683. The RUC recommends 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 7 minutes scrub/dress/wait time, 60 minutes intra-service time, 10 minutes immediate post-service time, 0.5-99238 and 4-99213 post-service visits, which equals 224 minutes of total time. The RUC confirmed that four postoperative visits are typical, and include visual acuity and intraocular pressure checks, slit lamp examinations, gonioscopy to assess the status of the anterior chamber angle, and examination of the peripheral retina for breaks.

To support a work RVU value of 12.80, the RUC compared the surveyed code to the top key reference services 66170 *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (work RVU = 13.94, 45 minutes intra-service time, and 278 minutes total time) and 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* (work RVU = 10.25, 30 minutes intra-service time, and 175 minutes total time). The RUC determined the surveyed code was comparable to the top key reference service in terms of measured complexity and intensity, as well as intra-service and total time; moreover, the RUC noted that the survey 25th percentile work RVU maintains rank order with the other services in this code family.

For additional support, the RUC referenced MPC code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 12.13, 60 minutes intra-service time, and 246 minutes total time) and CPT code 67039 *Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation* (work RVU = 13.20, 60 minutes intra-service time and 260 minutes total time). The RUC determined the surveyed code was equivalent to MPC code 57288 and CPT code 67039 in terms of intra-service time and noted that the referenced services bracket the survey 25th percentile work RVU. **The RUC recommends a work RVU of 12.80 for CPT code 66683.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology
CPT code 66683 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.

Optical Coherence Tomography (Tab 5)
Charles Fitzpatrick, OD (AOA), Ravi Parikh, MD (AAO), Ankoor Shah, MD (AAO), John Thompson, MD (ASRS)

At the February 2023 CPT Editorial Panel meeting, CPT code 92137 was created in response to new technology which allows imaging of the retina using optical coherence tomography (OCT) with and without non-dye OCT angiography (OCT-A). This new Category I code describes a combined imaging procedure, which was previously reported with CPT code 92134, OCT of the retina. Two other OCT services, 92132 and 92133, are in the same family of XXX global OCT codes as 92137 and 92134. All four codes were reviewed and surveyed for the April 2023 RUC meeting.

The survey was sent to a random sample of ophthalmologists and optometrists from the three participating specialty societies. In reviewing the 75 survey responses for CPT code 92137, it was apparent to the specialty societies that the survey instructions were unclear as the collected survey data reflected intra-service time estimates that were far below the physician work specified in the CPT descriptor for 92137. The specialty societies believed that a significant number of survey respondents failed to understand that 92137 is a combined study of both standard OCT images (described by 92134) and OCT angiography images. The survey 25th percentile intra-service time for CPT code 92134 was 5 minutes, comparable to the analysis of only the standard OCT images of the retina without angiography. Therefore, the specialty societies believed that the survey median intra-service time of 6 minutes for CPT code 92137 is an underestimation. The intra-service work associated with CPT code 92137 involves the same analysis of the standard OCT images as CPT code 92134, but it also includes the OCT angiography component, which is a comprehensive evaluation of the retinal and choroidal vasculature in the posterior segment for evidence of ischemia, microaneurysms and neovascularization. The specialty societies suspected that survey respondents may have only accounted for the OCT angiography component alone and did not appropriately account for the time required to complete the combined study of all the OCT images that are reviewed as part of the physician work within the intra-service time of CPT code 92137. Being that the median survey intra-service time estimates were identical for CPT codes 92134 and 92137, the specialty societies determined that 10 minutes (twice the intra time of 92134) of intra-service time was an appropriate estimation to complete the combined study OCT image comparisons.

The RUC agreed with the specialty societies that many of the survey respondents may not have fully understood the differences in intra-service time between CPT codes 92134 and 92137. To ensure accurate survey results, the specialty societies, and the RUC agreed, that all four services in the OCT code family should be resurveyed for the September 2023 RUC meeting with a targeted survey instrument that has been reviewed and approved by the Research Subcommittee.

The RUC recommends an interim work RVU of 0.31 for CPT code 92137, which is a direct work RVU crosswalk to CPT code 73523 *Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views* (work RVU = 0.31). The RUC recommends reaffirmation of CPT codes 92132, 92133 and 92134 at their current values as an interim recommendation. **The RUC**

recommends an interim work RVU of 0.26 for CPT code 92132, an interim work RVU of 0.29 for CPT code 92133, an interim work RVU of 0.30 for CPT code 93234, and an interim work RVU of 0.31 for CPT code 92137. The specialty societies will resurvey CPT codes 92132, 92133, 92134 and 92137 for the September 2023 RUC meeting in coordination with the Research Subcommittee.

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for the four OCT services in this family and made one modification. An adjustment was made to move the one minute of clinical staff time from CA004 *Provide pre-service education/obtain consent* to CA011 *Provide education/obtain consent* which is the appropriate service period as the patient moves from the screening lane for their first service to the diagnostic room for the OCT service. The PE Subcommittee verified that the typical service for all four OCT services in this family is bilateral even though the CPT descriptors include both unilateral and bilateral. The Subcommittee also reviewed the new equipment item *tomographic device, optical coherence angiography (OCTA)* for CPT code 92137 and determined that the default formula was appropriate for calculating the equipment minutes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee. The RUC noted that the resurvey of physician work for September 2023 would not impact these practice expense recommendations.**

New Technology
CPT code 92137 will be placed on the New Technology list to be reviewed in three years to ensure correct valuation, patient population, and utilization assumptions.

<u>Telemedicine Evaluation and Management Services (Tab 6)</u>
Amy Ahasic, MD (ATS/CHEST), Suzanne Berman, MD (AAP), Lisa Price, MD (AGS), Stephen Sentovich, MD (ASCRS), Ed Touhy, MD (ACC), Richard Wright, MD (ACC), Korinne Van Keuren, DNP (ANA)

Facilitation Committee #1

During the COVID-19 public health emergency, there was a need to immediately provide office visits via telemedicine. For Medicare, the office visits, codes 99202-99215, were reported with a -95 modifier *Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System* to indicate the encounter was performed via telemedicine. Additionally, telephone codes 99441-99443 were reported for both new and established patients at the same Medicare payment rate as analogous in-person office visits.

In June 2022, the joint CPT/RUC Telemedicine Office Visits Workgroup was formed to assess available data and decide the appropriate next steps to determine accurate coding and valuation, as needed, for E/M office visits performed via audio-visual and audio only modalities. The Workgroup utilized the following guiding principles:

- Allow enhanced patient access and improve care by use of clear service descriptions and use of a resource-based valuation methodology
- Administratively simple
- Reduce the need for audits
- Provide a single recognized source of coding for telemedicine and audio-only office visits
- There is no direct goal for payment redistribution between specialties

The Workgroup gathered feedback via survey from 70 specialty societies on office visits performed via telemedicine to determine the next steps. Most respondents indicated they use clinical staff in the provision of telemedicine services. Another survey was also conducted to gather information about services provided via audio-only. This information allowed the Workgroup to determine that audio-video and audio-only telemedicine services should be developed. The Workgroup submitted a CPT Code Change Application (CCA) for the February 2023 CPT meeting.

In February 2023, the CPT Editorial Panel added a new Evaluation and Management (E/M) subsection for Telemedicine Services (audio/visual, audio only, virtual check-in). The Panel added 17 codes for reporting telemedicine E/M services as well as new guidelines and notes throughout the new Telemedicine Services subsection. The Panel also deleted three codes (99441-99443) to report telephone E/M services and the related guidelines.

Sixteen telemedicine E/M codes are comprised of eight codes for synchronous audio-video (AV) services and eight codes for synchronous audio-only (audio-only) services. Each of these code sets contains four codes for new patients and four codes for established patients. These codes may be reported based on the level of medical decision making (MDM) or total time on the date of the encounter, the same as reporting for the in-person office visit codes. For each set of four codes, there is a code that may be reported for a straightforward, low, moderate and high level of MDM. These codes are patterned after the in-person office visit codes, but there is no code that mirrors 99211 because all the telemedicine codes require the physician or qualified healthcare provider (QHP) to be meeting with the patient (99211 does not require the presence of a physician).

In addition, the CPT Editorial Panel established a code for a brief virtual check-in encounter that is intended to evaluate whether a more extensive visit is required. The code descriptor is identical to that of existing HCPCS code G2012 and is intended to replace that code. The code does not require video technology and is expected to be patient initiated. It must involve 5-10 minutes of medical discussion, not longer. It may not be reported if it originates from a related E/M service furnished within the previous 7 days or if it leads to another E/M or procedure within the next 24 hours or soonest available appointment. However, if the virtual check-in leads to an E/M in the next 24 hours, and if that E/M is reported based on time, then time from the virtual check-in may be added to the time of the resulting E/M to determine the total time on the date of encounter for the resulting E/M.

Survey

The telemedicine E/M services were surveyed by 27 specialty societies whose physicians and QHPs perform these services. The survey results showed no distinctions across all the specialties surveyed. The RUC noted that the 25th percentile and median work RVUs reported in the survey were identical for the audio-video telemedicine services and for some of the audio-only services, indicating a high degree of consistency in the responses.

For the survey instrument used, the physician time was not included in the new telemedicine E/M services descriptors or the E/M services displayed on the reference service list (RSL). **These recommendations are interim and a new survey will be conducted for September 2023 that will include the minimum required times in the code descriptors as approved by the CPT Editorial Panel. Also, additional specialties who perform these services are expected to participate.**

Overall, the survey showed that the straightforward and low level of medical decision making across all modalities and types of patients for telemedicine E/M services were equivalent to the in-person office visits. This interim recommendation based on this particular survey reflects that there may be a difference in the moderate and high level of medical decision-making services, which showed less time for audio-video and even less time for the audio-only compared to the in-person office visits.

Physical Exam

The history and physical examination are no longer a required component of service in selection of the level of E/M services. The E/M code level selection is based on the complexity of the problem or problems being addressed, the data points that are considered when making decisions and the risk of the treatment decisions. Most of what a physician or QHP does in terms of chronic management of disease can be accomplished without the traditional physical examination. However, a medically necessary physical exam is often performed remotely, and the same medical decision making is extant on that visit. Some examples of a physical exam performed via telemedicine may be assessing the patient's appearance, gauging if the patient is in any distress, appearance of the patient's skin (pale or well-perfused), clarity of patient's speech, determining if the patient is having trouble breathing, assessing if patient is confused, hearing the patient's cough and viewing the patient's social/living situation. Additionally, a more focused physical exam in which the patient can assist the physician or QHP could be palpation or percussion of certain parts of the body, ranging painful joints, focusing in on any relevant part of the body (e.g., skin lesions, conjunctiva, the back of the throat) and aiding with a neurological exam (e.g. finger to nose testing, or having a family member test the skin sensation of certain body parts).

Audio-Video – New Patient

98000 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***

The RUC reviewed the survey results from 84 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.93 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99202 as both require the same work and similar intensity and complexity to perform even though the surveyed code requires 5 more minutes of time.

For additional support, the RUC referenced MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and noted both services have similar time and intensity. **The RUC recommends an interim work RVU of 0.93 for CPT code 98000.**

98001 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 98 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 1.60 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99203, as both require the same work and time.

For additional support, the RUC referenced MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82, 25 minutes intra-service time and 40 minutes total time) which requires similar work and time to perform. **The RUC recommends an interim work RVU of 1.60 for CPT code 98001.**

98002 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 135 physicians and qualified health care professionals and determined a work RVU of 2.20 appropriately accounts for the work required to perform this service. The RUC recommends 44 minutes total time. The RUC recommends a direct work RVU crosswalk to CPT code 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 2.60 since the intra-service time was 10 minutes less than the top key reference MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time).

For additional support, the RUC referenced MPC codes 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11, 40 minutes intra-service time and 60 minutes total time) and 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service and 35 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 2.20 for CPT code 98002.**

98003 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)***
The RUC reviewed the survey results from 117 physicians and qualified health care professionals and determined that a work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes total time. The RUC recommends a direct work RVU crosswalk to CPT code 95719 *Electroencephalogram (EEG), continuous recording, physician or*

other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video (work RVU = 3.00 and 40 minutes intra-service time and 60 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 2.60 since the intra-service time was 19 minutes less than the top key reference MPC code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.* (work RVU = 3.50 and 88 minutes total time).

For additional support, the RUC referenced MPC codes 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 2.87, 30 minutes intra-service time and 70 minutes total time) and 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU =3.20, 21 minutes intra-service time and 58 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 3.00 for CPT code 98003.**

Audio-Video – Established Patient

98004 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.***
The RUC reviewed the survey results from 151 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time). The RUC determined that the surveyed code was equivalent to the top key reference code 99212 as both require the same work and similar time, 17 and 16 minutes total time, respectively.

For additional support, the RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 0.70 for CPT code 98004.**

98005 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***

The RUC reviewed the survey results from 189 physicians and qualified health care professionals and determined that a work RVU of 1.22 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes total time. The RUC recommends a direct work RVU crosswalk to CPT codes 72126 *Computed tomography, cervical spine; with contrast material* (work RVU = 1.22 and 25 minutes total time), 72129 *Computed tomography, thoracic spine; with contrast material* (work RVU = 1.22 and 25 minutes total time) and 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU 1.22 and 26 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 1.30 since the intra-service time was 5 minutes less than the top key reference MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time).

For additional support, the RUC referenced MPC codes 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and 70491 *Computed tomography, soft tissue neck; with contrast material(s)* (work RVU = 1.38, 17 minutes intra-service time and 27 minutes total time). **The RUC recommends an interim work RVU of 1.22 for CPT code 98005.**

98006 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 207 physicians and qualified health care professionals and determined that a work RVU of 1.74 appropriately accounts for the work required to perform this service. The RUC recommends 32 minutes total time. The RUC recommends a direct work RVU crosswalk to MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 1.92 since the intra-service time was 9 minutes less than the top key reference 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time).

For additional support, the RUC referenced MPC code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75, 20 minutes intra-service time and 40 minutes total time) which requires similar physician work and time. **The RUC recommends an interim work RVU of 1.74 for CPT code 98006.**

98007 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.***

The RUC reviewed the survey results from 171 physicians and qualified health care professionals and determined that a work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC recommends 50 minutes total time. The RUC recommends a direct work RVU crosswalk to CPT code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (*work RVU = 2.40, 30 minutes intra-service time and 50 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 2.80 since the intra-service time was 15 minutes less than the top key reference MPC code 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (work RVU = 2.80 and 70 minutes total time).

For additional support, the RUC referenced MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time). **The RUC recommends an interim work RVU of 2.40 for CPT code 98007.**

Audio-Only – New Patient

98008 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***
The RUC reviewed the survey results from 65 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.93 appropriately accounts for the work required to perform this service. The RUC recommends 24 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99202 as both require similar intensity and complexity and time to perform.

For additional support, the RUC referenced MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time), which requires similar physician work and time to perform. **The RUC recommends an interim work RVU of 0.93 for CPT code 98008.**

98009 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 70 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.57 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99203 as both require similar work even though the surveyed code requires 5 minutes less time.

For additional support, the RUC referenced MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time), which requires similar physician work and time to perform. **The RUC recommends an interim work RVU of 1.57 for CPT code 98009.**

98010 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 79 physicians and qualified health care professionals and determined that a work RVU of 2.01 appropriately accounts for the work required to perform this service. The RUC recommends 39 minutes total time. The RUC recommends a direct work RVU crosswalk to MPC code 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions (*work RVU = 2.01, 30 minutes intra-service time and 40 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 2.18 since the intra-service time was 12 minutes less than the top key reference MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time).

For additional support, the RUC referenced MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time). **The RUC recommends an interim work RVU of 2.01 for CPT code 98010.**

98011 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)***
The RUC reviewed the survey results from 69 physicians and qualified health care professionals and determined that a work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 55 minutes total time. The RUC recommends a direct work RVU crosswalk to second top key reference MPC code 99204 *Office or other outpatient visit for the*

evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (work RVU = 2.60 and 60 minutes total time). The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 3.00 since the work and time of the survey code is similar to code 99204.

For additional support, the RUC referenced MPC code 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 2.87, 30 minutes intra-service time and 70 minutes total time). **The RUC recommends an interim work RVU of 2.60 for CPT code 98011.**

Audio-Only – Established Patient

98012 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.***
The RUC reviewed the survey results from 141 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 19 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99212 as both require the same work and similar time.

For additional support, the RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 0.70 for CPT code 98012.**

98013 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***
The RUC reviewed the survey results from 158 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.20 appropriately accounts for the work required to perform this service. The RUC recommends 26 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*

(work RVU = 1.30 and 30 minutes total time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time). The RUC determined the surveyed code was comparable to the top key reference code 99213 as both require similar work and time.

For additional support, the RUC referenced MPC codes 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35, 20 minutes intra-service time and 30 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 1.20 for CPT code 98013.**

98014 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 144 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC recommends 34 minutes total time.

The RUC compared the surveyed code 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time). The RUC determined the surveyed code is appropriately less than code 99214 because it requires less work and time to perform.

For additional support, the RUC referenced MPC codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time) and 99460 *Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant* (work RVU = 1.92, 30 minutes intra-service time and 50 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 1.80 for CPT code 98014.**

98015 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)***
The RUC reviewed the survey results from 120 physicians and qualified health care professionals and determined that a work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC recommends 47 minutes total time. The RUC recommends a direct work RVU crosswalk to CPT code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU = 2.40, 30 minutes intra-service time and 50 minutes total time). The RUC determined a crosswalk of 2.40 was more appropriate than the survey 25th percentile work RVU of 2.49 because it places this service in the proper rank order based on the intensity and complexity and time to perform this service.

For additional support, the RUC referenced MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time). **The RUC recommends an interim work RVU of 2.40 for CPT code 98015.**

Virtual Check-In

98016 ***Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion***
The RUC reviewed the survey results from 112 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 0.29 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes pre-service time, 10 minutes intra-service time and 2 minutes post-service time.

The RUC compared the surveyed code to the key reference service MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and determined that the surveyed code may require a similar amount of time to perform, but it is much less intense and complex, thus valued lower.

For additional support, the RUC referenced MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 3 minutes intra-service time and 6 minutes total time) and 97530 *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44, 15 minutes intra-service time and 19 minutes total time) which appropriately bracket the surveyed code. **The RUC recommends an interim work RVU of 0.29 for CPT code 98016.**

CPT Descriptor Time
The RUC recommends the following times for the CPT descriptors based on the same time in the office visit descriptors. The time in the CPT descriptors is rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code		Time on the Date of Encounter Recommendation to CPT
98000	Audio-video, new patient, straightforward MDM	**15**
98001	Audio-video, new patient, low MDM	**30**
98002	Audio-video, new patient, moderate MDM	**45**
98003	Audio-video, new patient, high MDM	**60**
98004	Audio-video, established patient, straightforward MDM	**10**
98005	Audio-video, established patient, low MDM	**20**
98006	Audio-video, establishes patient, moderate MDM	**30**
98007	Audio-video, established patient, high MDM	**40**

98008	Audio-only, new patient, straightforward MDM	**15**
98009	Audio-only, new patient, low MDM	**30**
98010	Audio-only, new patient, moderate MDM	**45**
98011	Audio-only, new patient, high MDM	**60**
98012	Audio-only, established patient, straightforward MDM	**10 must be exceeded**
98013	Audio-only, established patient, low MDM	**20**
98014	Audio-only, establishes patient, moderate MDM	**30**
98015	Audio-only, established patient, high MDM	**40**

Practice Expense
The specialty societies surveyed the clinical activities for the telemedicine E/M services and received 182 responses in which 60% of the respondents indicated that the use of clinical staff in the provision of telemedicine E/M services was typical (>50%). The survey directed survey respondents to indicate typical clinical time by CPT code and by clinical activity. The survey included the clinical activities currently included in the direct PE inputs for 99202-99215 as well as an opportunity to write in time and specify additional activities for pre-service period, service period and post-service period. For the survey responses that included clinical staff time, the clinical activity medians were computed and then summed to calculate total time.

The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification.

The specialty societies detailed their methodology for making some changes to specific clinical activity codes to adapt them for telemedicine. The specialty societies indicated that only specific clinical activities are applicable and edited CA009 *Greet patient, provide gowning, Ensure appropriate medical records are available*, by deleting "greet patient, provide gowning" and CA013 *Prepare room, equipment and supplies Prepare patient for the visit (i.e., check audio and/or visual),* by deleting "prepare room, equipment and supplies" and adding "prepare patient for the visit (i.e., check audio and/or visual)." The specialty societies explained how they solicited both individual time in each of the clinical activities and total time. The specialty societies also assiduously reviewed each code using the medians for relevant clinical activities and making minor adjustments, so the amount of time for the clinical staff increased appropriately along with the complexity of the medical decision making. In addition, the PE Subcommittee recommends to CMS that a camera and microphone should be considered typical in the computer contained in the indirect overhead expense. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies. The RUC noted that the resurvey of physician work for September 2023 would not impact these practice expense recommendations and affirmation of these practice expense recommendations is expected.**

HCPCS Codes
The RUC recommends deletion of G2012 *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion* as this service may be reported using CPT code 98016 in 2025. The RUC also recommends deletion of G2252 *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified*

health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion as this service may be reported using CPT codes 98008 or 98012. **The RUC recommends that CMS delete G2012 and G2252.**

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

X. CMS Request/Relativity Assessment Identified Codes

Skin Adhesives (PE Only) (Tab 7)
B. Bryan Graham, DO (ACEP), Jon Hathaway, MD (ACOG), Jonathan Kiechle, MD (AUA), Thomas Turk, MD (AUA)

In April 2022, the RUC approved the use of SG007 *adhesive, skin (Dermabond)* for CPT code 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* and 64595 *Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array*, although there was much discussion regarding whether its use is typical. Subsequently, a Practice Expense (PE) Subcommittee workgroup was created and a virtual meeting convened in October 2022 to review the issue of skin adhesives. In January 2023, the RUC considered the report of the PE Skin Adhesives Workgroup and agreed that there are multiple skin adhesive products at different price points that work similar to Dermabond. The RUC adopted the following four recommendations of the PE Workgroup:

1. The PE Subcommittee review the six codes on the Medicare Payment Schedule with Dermabond (64590, 64595, G0168, G0516, G0517, G0518) to identify justification for its use versus the generic version and present its findings to the RUC for approval. As part of this review, the specialty should submit a letter to the RUC regarding any corrections to the vignettes for CPT codes 64590 and 64595.
2. The PE Subcommittee request that the RUC recommend to CMS that Dermabond be replaced with its generic cyanoacrylate skin adhesive alternative on the CMS Direct PE Inputs Medical Supplies Listing.
3. The PE Subcommittee request that the RUC recommend to CMS that new medical supply item codes be created to encompass the generic formulations of cyanoacrylate skin adhesive in multidose form and single use sterile application.
4. The PE Subcommittee request that the RUC recommend to CMS that generic alternatives be used in place of brand names on the CMS Direct PE Inputs Medical Supplies Listing.

Per the first recommendation, the PE Subcommittee reviewed the six codes on the Medicare Payment Schedule with SG007 *adhesive, skin (Dermabond)* (64590, 64595, G0168, G0516, G0517, G0518) at its April 2023 meeting to identify justification for its use versus the generic version.

For CPT codes 64590 and 64595, the specialties submitted a revised PE spreadsheet and a letter recommending removal of the supply input SG007 *adhesive, skin (Dermabond)* and addition of one unit of SH076 *adhesive, cyanoacrylate (2ml uou)* in the non-facility setting. The specialties agreed that the use of the specific skin adhesive (Dermabond) is not critical to the procedure and the generic version (cyanoacrylate) is an appropriate substitute. Similarly, for code G0168 *Wound closure utilizing tissue adhesive(s) only*, the specialty submitted a revised PE spreadsheet and a letter

recommending removal of the supply input SG007 *adhesive, skin (Dermabond)* and addition of one unit of SH076 *adhesive, cyanoacrylate (2ml uou)* in the non-facility setting. The specialty supported revising the supply input from the brand name Dermabond to instead using the generic adhesive cyanoacrylate from the CMS direct supply listing. Therefore, for CPT codes 64590 and 64595 and code G0168, the RUC recommends that CMS remove the supply input SG007 *adhesive, skin (Dermabond)* and add one unit of SH076 *adhesive, cyanoacrylate (2ml uou).* **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

There was no specialty society interest for the three HCPCS codes: G0516 *Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)*, G0517 *Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)*, and G0518 *Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants).* The PE Subcommittee noted the extremely low utilization and determined that a similar action should be taken for the three codes in support of the generic alternative. **For codes G0516, G0517 and G0518, the RUC recommends that CMS remove the supply input SG007 *adhesive, skin (Dermabond)* and add one unit of SH076 *adhesive, cyanoacrylate (2ml uou).***

The RUC emphasized the need to obtain invoices for the generic alternatives; also noting that CMS should review the pricing of Dermabond, to ensure it reflects accurate current pricing. **The RUC reiterated its request for CMS to create and price new medical supply item codes for generic adhesive alternatives including the formulations of cyanoacrylate listed below:**

Type	Trade name examples	Characteristic
2-Octyl-cyanoacrylate	Dermabond SurgiSeal Liquiband Exceed	Weaker, less brittle, less dehiscence, more flexible Takes longer to dry Octyl esters provide weaker bond but are more flexible.
n-Butyl-2-cyanoacrylate	Histoacryl Indermil PeriAcryl LiquiBand Swiftset	Stronger, brittle, more dehiscence Butyl esters provide stronger bond but are rigid.
n-Butyl and 2-Octyl-cyanoacrylate COMBINED TOGETHER	GluStitch / GluSeal	Available in high & low viscosity formulations
Ethyl-2-cyanoacrylate	Epiglu SuperGlue	

Laser Treatment - Skin (Tab 8)
Alina Bridges, MD (AADA), Alexandra Flamm, MD (AADA), Alice Gottlieb, MD (AADA), Lawrence Green, MD (AADA), Brent Moody, MD (AADA), Howard Rogers, 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 which was published in September 2016. This was the third article created for this code set, with articles also published in June 2012 and May 2013.

In January 2022, the Relativity Assessment Workgroup reviewed these services again noting that their utilization continues to steadily increase, specifically CPT code 96920. Use of 96920 peaked at 117,256 in 2016, dropped to 79,671 in 2020, and increased to 88,673 in 2021. 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 editorial review at the September 2022 CPT meeting. Since the CPT descriptor was established in 2002, psoriasis is the only approved indication and use for this treatment modality. Although, the specialty societies have noted that the indications have expanded beyond what is currently noted in the code descriptors to include laser treatment for other inflammatory skin disorders such as vitiligo, atopic dermatitis, alopecia areata, etc. This issue was deferred to the February 2023 CPT meeting to complete the full CCA and submit literature supporting excimer laser treatment for other inflammatory skin disorders as the changes were deemed more than editorial given that expanded indications would change the physician work. This issue was subsequently withdrawn from the February 2023 CPT Editorial Panel meeting agenda as it was determined that existing literature was insufficient and did not support expanded indications at this time. Thus, this issue was surveyed for the April 2023 RUC meeting, without any revisions to code descriptors, since the available 2021 Medicare data indicates that the typical patient is being treated for psoriasis (96920, psoriasis = 79.3%).

The RUC expressed concern with the survey that the times have decreased and there was not a proportionate decrease in work. However, there have been multiple reviews of this code set, and the valuation of the codes is currently based on the original valuation over two decades ago in 2002, where the time was *lower* than what is in the database now. Subsequent review in 2012 adopted new survey times while maintaining the work value from 2002 for CPT codes 96920 and 96922. For both the parent code 96920 and the code 96922 with the largest treatment area, the total times have not changed since first implemented more than 20 years ago *Thus, the current value is based on a lower time than the time in the database currently* (please see the table below).

	2002 Intra Time	2002 Total Time	2002 RUC Rec.	2002 CMS RVU	2012 Intra Time	2012 Total Time	2012 RUC Rec.	2012 CMS RVU	Current Intra Time	Current Total Time	Current CMS RVU
96920	17	27	1.15	1.15	23	37	1.15	1.15	23	35	1.15
96921	20	30	1.17	1.17	30	42	1.30	1.30	30	42	1.30
96922	30	40	2.10	2.10	45	57	2.10	2.10	45	57	2.10

96920 ***Excimer laser treatment for psoriasis; total area less than 250 sq cm***
The RUC reviewed the survey results from 41 dermatologists with the proper equipment (excimer laser) to perform the procedure and concurred that the survey respondents overvalued the service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to CPT code 20606 *Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.00, 10 minutes intra-service time, and 27 minutes total time) which falls below the survey 25th percentile and has identical intra-service time that appropriately accounts for the physician work involved in this service. The RUC noted that code 20606, when compared to fifteen recently RUC-reviewed 000-day global codes

with the same intra-service time and similar total time, the crosswalk value of 1.00 falls in the middle of the range in terms of work RVUs. The RUC recommends 10 minutes of pre-service time, 10 minutes of intra-service time, 3 minutes of post-service time, and 23 minutes total time as supported by the survey.

To justify the crosswalk value, the RUC compared the surveyed code to MPC codes 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07, 12 minutes intra-service time, and 24 minutes total time) and 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method* (work RVU = 1.10, 10 minutes intra-service time, and 24 minutes total time) and noted that both comparator codes involve similar intra-service time and slightly more physician work.

For additional support, the RUC compared the surveyed code to MPC codes 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84, 10 minutes intra-service time, and 22 minutes total time) and 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 10 minutes intra-service time, and 27 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the recommendation. The RUC concluded that CPT code 96920 should be valued based on a direct work RVU crosswalk to CPT code 20606 which falls below the 25th percentile as supported by the survey. **The RUC recommends a work RVU of 1.00 for CPT code 96920.**

96921 ***Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm***
The RUC reviewed the survey results from 41 dermatologists with the proper equipment (excimer laser) to perform the procedure and concurred that the survey respondents overvalued the service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to CPT code 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07, 12 minutes intra-service time and 24 minutes total time) which falls below the survey 25th percentile and has identical intra-service time that appropriately accounts for the physician work involved in this service. The RUC noted that, crosswalk code 12011, when compared to four recently RUC-reviewed 000-day global codes with the same intra-service time and similar total time, the crosswalk value of 1.07 falls in the middle of the range in terms of work RVUs. The recommendation also provides for a stepwise progression of the procedure based on the size of the wound or lesion. The RUC recommends 10 minutes of pre-service time, 12 minutes of intra-service time, 3 minutes of post-service time, and a total time of 25 minutes as supported by the survey.

To justify the crosswalk value, the RUC compared the surveyed code to MPC codes 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* (work RVU = 1.10, 12 minutes intra-service time and 27 minutes total time) and 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method* (work RVU = 1.10, 10 minutes intra-service time and 24 minutes total time) and noted that both MPC codes involve similar intra-service time and slightly more physician work.

For additional support, the RUC compared the surveyed code to MPC codes 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.00, 7 minutes intra-service time and 17 minutes total time) and 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14, 15 minutes intra-service time and 27 minutes total time) and noted that the multi-specialty points of comparison values

appropriately bracket the recommendation. The RUC concluded that CPT code 96921 should be valued based on a direct work RVU crosswalk to CPT code 12011 which falls below the 25th percentile as supported by the survey. **The RUC recommends a work RVU of 1.07 for CPT code 96921.**

96922 ***Excimer laser treatment for psoriasis; over 500 sq cm***
The RUC reviewed the survey results from 41 dermatologists with the proper equipment (excimer laser) to perform the procedure and determined that the survey 25th percentile work RVU of 1.32 appropriately accounts for the physician work involved in this service. The RUC agreed that the current value would be inappropriate given the decrease in survey time. However, the work associated with this service has not changed since it was last surveyed. The RUC recommends 10 minutes of pre-service time, 18 minutes of intra-service time, 3 minutes of post-service time, and 31 minutes total time as supported by the survey. It was noted that much of the resetting and re-prepping is intra-service time as indicated in the description of the work. Typically, seven sites are treated, requiring repeated prep, and draping after the procedure is underway.

To justify a work RVU of 1.32, the RUC compared CPT code 96922 to the to the top key reference service code 12007 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm* (work RVU = 2.90, 35 minutes intra-service time and 54 minutes total time) and noted that the intra-service time is nearly twice that of the surveyed code and intensity is more justifying a higher value. The RUC also compared CPT code 96922 to MPC code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44, 17 minutes intra-service time and 29 minutes total time) and noted that the surveyed code involves similar intra-service time and slightly less physician work.

For additional support, the RUC compared CPT code 96922 to MPC code 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, 15 minutes intra-service time and 27 minutes total time) and noted that the surveyed code has more intra-service and total time and is therefore valued higher than the comparator code. The RUC concluded that CPT code 96922 should be valued at the 25th percentile work RVU as supported by the survey. This recommendation also provides a stepwise progression of the procedure based on the size of the wound or lesion. **The RUC recommends a work RVU of 1.32 for CPT code 96922.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed the compelling evidence argument that there has been a notable change in the dominant practice model (eg, pay-per-use subscription-based model) since the code set was last surveyed in 2012 and, in addition, that the patient population has changed. The Subcommittee accepted compelling evidence based on "Evidence that there has been a change in equipment or practice expense cost."

Based on acceptance of compelling evidence, the PE Subcommittee carefully considered the direct practice expense inputs including three new supply inputs for *laser, excimer*, *pay per use* based on size of treatment area. This piece of equipment is typically used via a subscription or a rental model. The dermatologist does not own the laser, rather the laser is placed in the dermatologist's office, and the practice buys a series of treatments. These treatments are purchased in packs of 10 and are based upon the size of the area being treated which corresponds to the three supply codes. A fourth new supply input was included for *Mupirocin 2% Topical Ointment 22 grams*. Following the laser treatment, the physician applies mupirocin to areas of blistering, erosion, and/or impending skin breakdown. The Subcommittee modified this item to reflect a per gram basis.

The PE Subcommittee made several modifications to the spreadsheet including revisions to the clinical staff minutes for CA011 *Provide education/obtain consent*, CA014 *Confirm order, protocol exam* and CA035 *Review home care instructions, coordinate visits/prescriptions*. Also, an additional pair of SB023 *gloves, non-sterile, nitrile* was added to CPT code 96922 which is typical for the larger area. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

RUC Database Flag
The RUC recommends a flag for CPT codes 96920, 96921 and 96922 as "Do Not Use to Validate for Physician Work" since the times are not representative.

CPT Referral
At the April 2023 meeting, the RUC voted to recommend an editorial change to CPT to add "(ie, excimer)" after "Laser treatment" for clarity in code 96920. The CPT Executive Committee voted to further editorially revise code 96920 to align with the intended use of these services exclusively for psoriasis. These editorial revisions are for the CPT 2024 code set. The changes are editorial and do not involve a change in work.

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

Acupuncture – Electroacupuncture (Tab 9)
Kris Anderson, DC (ACA), Leo Bronston, DC (ACA), Gary Estadt, DC (ACA), Brad Fox, MD (AAFP), Carlo Milani, MD (AAPMR), David Reece, DO (AAPMR)

In September 2022, the Relativity Assessment Workgroup identified the acupuncture codes with 2020 Medicare utilization over 10,000 where the service was surveyed by one specialty but is now performed by a different specialty. CPT codes 97810, 97811, 97813, and 97814 were surveyed by the American Chiropractic Association in April 2004. It is important to note that since January 1, 2020, CMS has paid for acupuncture selectively for patients with lower back pain. Therefore, the RUC database reflects two years of claims data which reflects physical medicine and rehabilitation, family medicine, and internal medicine as the top performing specialties. However, Medicare does not cover these services when reported by chiropractors and therefore, the Medicare utilization data does not include these services when provided by chiropractors. The Workgroup confirmed that chiropractors are involved and should be part of the level of interest and survey process. CPT codes 97810-97814 were surveyed for April 2023 RUC meeting.

During the RUC presentation, it was clarified that because the work RVU recommendations are, in some instances, below the current value and the utilization is expected to be the same, this family of codes is budget neutral as it does not exceed current spending. Therefore, compelling evidence for this tab is not required based on RUC standards. The increases from the current work RVU for base codes 97810 and 97813 are supported by a strong survey that includes a representative sample of survey respondents from the top performing specialties. Moreover, the median number of needles placed during the service has increased from the original recommendation. The physician or other qualified healthcare professional work throughout these four services has been refined since the last RUC HCPAC valuation. The changes involve the patient preparation based on current guidelines related to the Clean Needle Technique (CNT) and the guidance on how to approach treatment has changed slightly based on the patient's condition. This is due to the intersection of eastern and

western medicine, as conditions being treated by acupuncture are better understood, the approach to treatment has modernized and informs the practitioners medical decision making.

97810 ***Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient***
The RUC reviewed the survey results from 36 physicians and chiropractors and recommends a work RVU of 0.61 based on the survey 25th percentile, which maintains relativity within the family. The RUC recommends 5 minutes of pre-service time, 13 minutes intra-service time, 5 minutes immediate post-service time, and 23 minutes total time.

For this service, the practitioner inserts sterile, single use, solid filament needles and manually stimulates the needles. The median number of needles used for the initial portion of a typical patient encounter for acupuncture without electric stimulation, as described by one unit of this base code, is 13 needles. The patient rests with the needles for 15 minutes and the practitioner monitors and re-stimulates the needles as needed until the desired effect is achieved. The needles are then removed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes* (work RVU = 0.43, 15 minutes intra-service, and 19 minutes total time) and 98940 *Chiropractic manipulative treatment (CMT); spinal, 1-2 regions* (work RVU = 0.46, 7 minutes intra-service, and 15 minutes total time). The surveyed code is valued appropriately higher when compared to the key reference codes given the typical number of needles and total time to perform the service. For example, the number of typical needles to reach the desired effect is higher than that of the number of regions treated in the key reference services, which supports a higher work RVU for the surveyed code. For additional support, the RUC referenced HCPAC MPC code 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.53, 15 minutes intra-service, and 17 minutes total time). The surveyed code is valued appropriately higher when compared to the MPC code given the work to manually manipulate the needles and overall higher total time. **The RUC recommends a work RVU of 0.61 for CPT code 97810.**

97811 ***Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 physicians and chiropractors and recommends a work RVU of 0.46 based on the survey 25th percentile, which maintains relativity within the family for this add-on code. The RUC recommends 0 minutes of pre-service time, 11 minutes intra-service time, 0 minutes immediate post-service time, and 11 minutes total time.

Following the initial service, the practitioner selects and prepares new treatment points. The practitioner inserts sterile, single use, solid filament needles and manually stimulates the needles. The median number of needles used for the portion of the typical patient encounter for acupuncture without electric stimulation, as described by one unit of this add-on code, is 10 needles. The patient rests with the needles for 15 minutes and the practitioner monitors and re-stimulates the needles as needed until the desired effect is achieved. The needles are then removed. The median number of times this add-on code will be reported with the primary service is 1, based on the 2021 Medicare claims data.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 95886 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more*

muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure) (work RVU = 0.86, 30 minutes intra-service and total time) and MPC code 95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service and total time). The surveyed code work RVU is appropriately bracketed by the key reference services given that the work RVU falls at the midpoint of the reference codes with approximately 10 needles placed during the add-on service. However, the key reference code's time to perform the add-on services is higher given that the physician or qualified health care professional reviews at least 20 voluntary motor units. For additional support, the RUC referenced HCPAC MPC code 11045 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.50, 15 minutes intra-service and total time) which is valued appropriately higher than the surveyed code, given the higher intra-service and total time. **The RUC recommends a work RVU of 0.46 for CPT code 97811.**

97813 ***Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient***
The RUC reviewed the survey results from 33 physicians and chiropractors and recommends a work RVU of 0.74 based on the survey 25th percentile, which maintains relativity within the family. The RUC recommends 5 minutes of pre-service time, 15 minutes intra-service time, 5 minutes immediate post-service time, and 25 minutes total time.

For this service, the practitioner inserts sterile, single use, solid filament needles. The median number of needles used for the initial portion of the typical patient encounter for acupuncture with electric stimulation, as described by one unit of this base code, is 14 needles. The practitioner attaches electrodes to the needles and the appropriate frequency and waveform is selected and manipulated based on patient tolerance. The patient rests with the needles for 15 minutes and the practitioner monitors and re-adjusts the electrical stimulation as needed until the desired effect is achieved. The needles are then removed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 98941 *Chiropractic manipulative treatment (CMT); spinal, 3-4 regions* (work RVU = 0.71, 10 minutes intra-service, and 20 minutes total time) and 20560 *Needle insertion(s) without injection(s); 1 or 2 muscle(s)* (work RVU = 0.32, 10 minutes intra-service, and 16 minutes total time). The surveyed code is valued appropriately higher when compared to the key reference services given that the intra-service and total times are higher. Further, this code is valued appropriately within the family given that it requires the most time, highest median number of needles, and electrical stimulation. For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 15 minutes intra-service, 20 minutes total time), which appropriately supports the surveyed code work RVU as the intra-service time is identical and the total time of the surveyed code is appropriately higher. **The RUC recommends a work RVU of 0.74 for CPT code 97813.**

97814 ***Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 29 physicians and chiropractors and recommends a work RVU of 0.47 based on the survey 25th percentile, which maintains relativity within the family for this

add-on code. The RUC recommends 0 minutes of pre-service time, 15 minutes intra-service time, 0 minutes immediate post-service time, and 15 minutes total time.

Following the initial service, the practitioner selects and prepares new treatment points. The practitioner then inserts sterile, single use, solid filament needles. The median number of needles used for the portion of the typical patient encounter for acupuncture with electric stimulation, as described by one unit of this add-on code, is 10 needles. The practitioner attaches electrodes to the needles and the appropriate frequency and waveform is selected and manipulated based on patient tolerance. The patient rests with the needles for 15 minutes and the practitioner monitors and re-adjusts the electrical stimulation as needed until the desired effect is achieved. The needles are then removed. The median number of times this add-on code will be reported with the primary service is 1, based on the 2021 Medicare claims data.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference MPC code 95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service and total time), noting the identical intra-service times, and the second highest key reference code 95886 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)* (work RVU = 0.86, 30 minutes intra-service and total time). The surveyed code work RVU is appropriately bracketed by the key reference services given that physician or other qualified healthcare provider work falls in the middle of the reference codes with approximately 10 needles carefully placed with electrical stimulation during the intra-service time. For additional support, the RUC referenced HCPAC MPC code 96168 *Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.55, 15 minutes intra-service and total time), which requires similar work and has identical intra-service and total time. **The RUC recommends a work RVU of 0.47 for CPT code 97814.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed and accepted compelling evidenced based on "Evidence that previous practice expense inputs were based on one specialty, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." According to the RUC database, the acupuncture codes were originally presented only by the American Chiropractic Association. Medicare claims data for 2021 show the service is now done primarily by physicians in physical medicine and rehabilitation and family medicine.

The Subcommittee reviewed the direct practice expense inputs and made several modifications as detailed in the PE SOR. The specialty societies and the RUC agreed with the median number of needles used per service (97810 = 13, 97811 = 10, 97813 = 14, 97814 = 10) and discussed that almost all MDs, DOs, DCs, and PTs use Seirin needles. **The RUC noted that CMS should review the pricing of SC075 *needle, acupuncture* to ensure it reflects accurate current pricing for the typical Seirin needles.**

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

RAW Flag
The RUC recommends flagging CPT codes 97810, 97811, 97813, and 97814 since the survey responses for code 97814 fell just below the threshold of 30 responses based on the most recent year of Medicare utilization. These services will be reviewed by the Relativity Assessment Workgroup in three years. At that time, the specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for appropriate action.

Annual Alcohol Screening (Tab 10)
Brad Fox, MD (AAFP), Jeannine Engel, MD (ACP), Charles Hamori, MD (ACP), Korinne Van Keuren, DNP (ANA)

In April 2022, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020, including codes G0442 and G0443. In September 2022, the RUC recommended that these services be surveyed for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.

CMS covers the annual alcohol screening service once per year (G0442). For patients that screen positive, CMS covers up to four brief face-to-face behavioral counseling interventions (G0443) for Medicare beneficiaries. Both services are typically performed during an annual wellness visit and/or an office visit service (codes G0438 or G0439). For G0442, clinical staff will typically assist the patient in completing the screening tool. Medicare does not define what screening instrument should be used, and there are several that are commonly used. The typical work of the physician for G0442 is to review the collected responses, make sure it is appropriate in the electronic medical record, probe for any follow up questions that need to be probed for and make an assessment based on the information collected.

The specialty societies surveyed alcohol screening and counseling codes G0442 and G0443 for the April 2023 RUC meeting but did not obtain the required number of survey responses. The survey was sent to a random sample of members from the three societies but only achieved 17 responses for G0442 and 15 responses for G0443. The RUC recommended the specialty societies work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify physicians and other qualified healthcare professionals who predominantly perform G0442 and/or G0443 and match them with societies to survey those individuals. The specialty societies were also encouraged to expand their survey sample to other sections of their membership that are more likely to perform these services.

The RUC recommends maintaining the current work RVUs as interim for these services. The RUC recommends an interim work RVU of 0.18 for HCPCS code G0442 and an interim work RVU of 0.45 for HCPCS code G0443. The specialty societies will continue collecting survey responses for the September 2023 RUC meeting and work with the RUC's Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample.

Practice Expense
The PE Subcommittee reviewed the proposed direct practice expense inputs and made several modifications. For the clinical labor in G0442, the PE Subcommittee reduced CA021 *Perform procedure/service---NOT directly related to physician work time* to five minutes as the typical time for the clinical staff to administer the screening tool. For G0443, all clinical staff time was removed for this counseling service since the counseling is performed by the physician or other qualified healthcare professional. The materials distributed to the patient were changed to the typical number of 10 pages to be printed out, SK057 *paper, laser printing (each sheet)* for G0442 and to a full SK062 *patient education booklet* for G0443. The equipment minutes were also modified to equal the sum of

clinical staff time plus the physician/QHP time as reflected by the survey median. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee. The RUC noted that the continued survey of physician work for September 2023 would not impact these practice expense recommendations.**

Annual Depression Screening (Tab 11)
Brad Fox, MD (AAFP), Jeannine Engel, MD (ACP), Charles Hamori, MD (ACP), Korinne Van Keuren, DNP (ANA)

Effective October 14, 2011, a new HCPCS code, G0444 *Annual depression screening, 5 to 15 minutes* was added to the Medicare Physician Payment Schedule (MFS) to report annual depression screening for adults in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, treatment and follow up. This service is typically reported with an Evaluation and Management (E/M) service and an Annual Wellness Visit (codes G0438 or G0439). The current work RVU of 0.18 was assigned by CMS in the 2013 Final Rule via the direct crosswalk to CPT 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* given the similarities in work related to screening. In April 2022, the Relativity Assessment Workgroup identified this service with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020. The services were surveyed for April 2023 RUC meeting after CMS published revised code descriptors in the Final Rule for 2023.

HCPCS code G0444 was surveyed for the April 2023 RUC meeting with the Annual Alcohol Screening codes G0442 and G0443. The specialties were unable to meet the required survey threshold of 75 responses for the 2021 utilization of 2,142,759. The survey instrument was sent to a random sample size of 8,500 individuals from three specialty societies collecting a total of 22 responses over a two-and-a-half-week period. While reviewing the survey data, the specialty societies noted that all six surveyed HCPCS codes (G0442-G0447) did not meet the minimum survey threshold for the 2021 utilization. The RUC noted that the HCPCS codes would benefit from a targeted survey using available Medicare databases to identify physicians and other qualified health care professionals who perform these screening services. The specialty societies were also encouraged to expand their survey sample to other sections of their membership that are more likely to perform these services.

The RUC recommends maintaining the current work RVU of 0.18 as interim for HCPCS code G0444. The specialty societies will continue to collect survey responses for the September 2023 RUC meeting and work with the Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample.

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made several modifications. The clinical staff time was reduced for CA021 *Perform procedure/service---NOT directly related to physician work* to five minutes as the typical time for the clinical staff to administer the screening tool. Additionally, supply item SK062 *patient education booklet* was eliminated in favor of SK057 *paper, laser printing (each sheet)* in the amount of 10 sheets. Lastly, the equipment time for EF023 *table, exam* was reduced from 15 minutes to 13 minutes which is equal to 5 minutes of clinical staff time plus 8 minutes of physician/QHP time and reflects the median from survey. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee. The RUC noted that the continued survey of physician work for September 2023 would not impact these practice expense recommendations.**

Behavioral Counseling & Therapy (Tab 12)
Brad Fox, MD (AAFP), Jeannine Engel, MD (ACP), Charles Hamori, MD (ACP)

In April 2022, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020, including codes G0445- G0447. In September 2022, the RUC recommended that these services be surveyed for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.

For G0445, CMS covers up to two individual face-to-face counseling sessions annually for Medicare beneficiaries for high intensity behavioral counseling to prevent sexually transmitted infections (STIs), for all sexually active adolescents, and for adults at increased risk for STIs if provided by a Medicare eligible primary care provider in a primary care setting. For G0446, CMS covers one face-to-face cardiovascular disease risk reduction visit per year for Medicare beneficiaries whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. For G0447 and Medicare beneficiaries with obesity, CMS covers one face-to-face visit every week for the first month, one face-to-face visit every other week for months 2-6 and one face-to-face visit every month for months 7-12 (if the beneficiary meets a 3kg weight loss requirement during the first six months). The G0447 visits would also only be covered when furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting.

The specialty societies surveyed alcohol screening and counseling codes G0445-G0447 for the April 2023 RUC meeting but did not obtain the required number of survey responses. The survey was sent to a random sample of members from the three societies, but only achieved 6 responses for G0445, 7 responses for G0446 and 8 responses for G0447. The RUC recommended for the specialty societies to work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify physicians and other qualified healthcare professionals who predominantly perform G0445-G0447 and match them with societies to survey those individuals. The specialty societies were also encouraged to expand their survey sample to other sections of their membership that are more likely to perform these services.

The RUC recommends maintaining the current work RVUs for these services as interim. The RUC recommends an interim work RVU of 0.45 for HCPCS code G0445, an interim work RVU of 0.45 for HCPCS code G0446 and an interim work RVU of 0.45 for HCPCS code G0447. The specialty societies will continue collecting survey responses for the September 2023 RUC meeting and work with the RUC's Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample.

Practice Expense
The PE Subcommittee reviewed the proposed direct practice expense inputs and made a couple modifications: SK062 *patient education booklet* was eliminated in favor of SK057 *paper, laser printing (each sheet)* in the amount of 10 sheets, and the equipment minutes were modified to equal the sum of clinical staff time plus the physician/QHP time as reflected by the survey median.

The PE Subcommittee agreed with the specialties' modification of the clinical staff time to move two minutes from CA021 *Perform procedure/service---NOT directly related to physician work time* to CA035 *Review home care instructions, coordinate visits/prescriptions.* This more accurately reflects the clinical work involved in arranging follow-up and/or referrals with clinical and community resources and providing educational materials. Also, EP086 *whip mixer* and EP016 *biohazard hood* are currently included among the equipment assigned to code G0445. The specialties believe, and the PE Subcommittee concurred, that this is an error and that those two inputs should be removed. **The RUC**

recommends the direct practice expense inputs as modified by the PE Subcommittee. The RUC noted that the continued survey of physician work for September 2023 would not impact these practice expense recommendations.

XI. Research Subcommittee (Tab 13)

Doctor Margie Andreae, Chair, provided the report of the Research Subcommittee.

- **Review of Research Guidelines/Requirements Document**
  Doctor Andreae welcomed all returning and new Research Subcommittee members for the 2023-2025 Research Subcommittee term. Each Subcommittee member briefly introduced themselves. The Chair briefly gave an overview of the Subcommittee for new members, noting that it is primarily charged with development and refinement of RUC methodology. The Subcommittee briefly discussed the Guidelines and Requirements document and decided that no changes were warranted at this time.

- **Minutes, February 20 Research Subcommittee Specialty Requests Meeting Report Review**
  The Research Subcommittee report from the February 20th conference call included in Tab 13 of the April 2023 agenda materials was approved without modification.

- **Site-of-Service RUC Survey Question**
  During the January 2023 RUC New Business discussion, a RUC member inquired about adding an additional question to the RUC survey to expand beyond the typical site-of-service. The expanded question would inquire if the respondent performs the service in each of the settings. Additionally, it was discussed that site-of-service questions should also be incorporated in the 000-day global survey to reflect the typical site of service. The RUC referred this topic to the Research Subcommittee.

  The Chair summarized the Subcommittee's April 2023 discussion, noting that Subcommittee members expressed broad support for retaining the question in general, and that it might be beneficial to have the survey respondent estimate percentages for hospital, ASC and office. The Chair noted that she will work with AMA Staff to draft potential language for the Subcommittee's consideration at its next in-person meeting. She also noted that if any Subcommittee members have suggested language, please share with AMA Staff.

  Next, the Subcommittee discussed the typical discharge question: "If you *typically* perform this procedure in a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or admitted to the hospital?" The Chair noted that she will work with AMA Staff on potential changes to this question for the Subcommittee to consider at its next in-person meeting.

  Finally, the Subcommittee discussed whether the standard 000-day global survey template should also include site-of-service questions. There was broad support for this change in general; the Chair noted that she would also work with AMA Staff on this topic in general to prepare draft language for the Subcommittee's consideration at its next in-person meeting.

- **RUC Crosswalk Codes General Guidelines**
  During the January 2023 RUC New Business discussion, a RUC member requested general guidelines/guidance for the use of crosswalk codes to support valuation recommendations. This item was referred to the Research Subcommittee for consideration.

During the April 2023 Research Subcommittee meeting, the Chair noted that this item was last considered by the Subcommittee at its January 2018 meeting. At that time, the RUC requested AMA staff to perform an analysis of previous RUC recommendations based on crosswalks. In January 2018, the Subcommittee concluded that the RUC has an excellent track record over the prior two years of selecting appropriate crosswalks and no defined guidelines were necessary.

For the April 2023 RUC meeting, AMA Staff shared this same summary data with the Subcommittee. The Subcommittee discussed whether it would be appropriate to create guidance language with absolute criteria for the RUC panel itself. The Subcommittee agreed that that would not be warranted at this time as the current process is currently working as intended.

Separately, in lieu of guidelines for the RUC itself, AMA RUC staff had drafted text for inclusion in the "Instructions for Developing Work Value Recommendations" document for the Subcommittee's consideration. This document, which is a reference for specialty society advisors and staff, already has a section on alternate ways to develop work RVU recommendations, though does not specifically cover crosswalk codes. The Subcommittee agreed that inclusion of language, in general, in this document would be warranted, though suggested for the text to undergo some wordsmithing between this meeting and the next in-person Subcommittee meeting.

- **Review of American College of Cardiology (ACC) and Society for Cardiovascular Angiography & Interventions (SCAI) Request to Approve National Cardiovascular Data Registry as Extant Datasource**
  The presenter representing American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) provided background for the Research Subcommittee regarding their request to approve the ACC's CathPCI Registry® for use as a RUC-approved extant datasource. The Percutaneous Coronary Intervention (PCI) family of codes was brought up for re-survey at the January 2023 RUC meeting after approval of an independent application for a new CPT code for intravascular lithotripsy (IVL). At the January 2023 meeting, advisors from the ACC and SCAI requested that the new IVL code be valued but that the rest of the code family valuations be delayed so that the societies could make other revisions and updates to several of the codes at CPT. The RUC agreed with this approach. The presenter noted that the data from the CathPCI Registry is part of the ACC's National Cardiovascular Data Registries (NCDR). ACC and SCAI requested for the CathPCI Registry to be approved for possible extant data use at the RUC.

  The Subcommittee reviewed the responses to these requirements in detail. As detailed in the letter submitted as part of this request, the specialties noted and the Subcommittee agreed that the ACC's CathPCI Registry® meets all the RUC's extant database requirements. The presenters noted that the database includes approximately 90% of eligible cases in the United States for patients that undergo these services regardless of payer.

  The Research Subcommittee recommended the RUC approve the ACC's CathPCI Registry® as a database that meets the RUC's extant database criteria.

- **Review of American Burn Association (ABA) Request for Review of Educational Presentation Materials**
  The American Burn Association, which is anticipating conducting its first RUC survey in many years over the summer, requested Research Subcommittee review and approval of the ABA's use of standard RUC presentation, "Understanding the RUC Survey Instrument Surgical Services", with modifications at the ABA's Leadership Bootcamp session on May 16th. The Chair noted

concerns with the modified slide deck even though it is very similar to the standard slides on the RUC collaboration website. A member recommended the ABA use the standard slide deck without modifications. The ABA accepted that recommendation and withdrew their request for use of a modified version of the standard presentation.

The Research Subcommittee accepted the ABA decision to move forward with use of the standard RUC presentation, "Understanding the RUC Survey Instrument Surgical Services".

The RUC approved the Research Subcommittee Report.

XII. Practice Expense Subcommittee (Tab 14)

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

At the January 2023 RUC meeting, the PE Subcommittee requested that AMA staff deconstruct the supply packs in order to review pricing after noting a discrepancy with the SA051 *pack, pelvic exam* while reviewing Tab 13 Pelvic Exam (PE Only). The PE Subcommittee's subsequent review of the 23 deconstructed packs uncovered numerous discrepancies between the aggregated cost of a pack and the individual item components. The purpose of the packs is to simplify the process of identifying and recommending PE supply direct inputs, and one would expect the pack price to be identical to the total cost of its contents. **The RUC agreed to share the deconstructed packs document and volume analysis with CMS with recommended corrections in CY2024 rulemaking.** The PE Subcommittee also formed a workgroup to review the content of the packs to assess if they are still typical and revise as necessary.

Also, the PE Subcommittee will continue its discussion of post-operative patient communications at the September meeting, specifically as it relates to phone calls outside of the 090-day global standard:

- All phone calls, standardized to 3 minutes. No phone calls are allowed in the post-operative period for 010 and 90 day global codes.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 15)

Gregory DeMeo, MD, Vice Chair of the Relativity Assessment Workgroup (RAW), provided the RUC with a summary of the Workgroup's report.

Review Action Plans

Work Neutrality CPT 2018
Psychiatric Collaborative Care Management Services (99484, 99492-99494)
In October 2019, the RUC identified codes 99484 and 99492-99493 as having more than 10% increase in work RVUs for 2018 than what was projected. However, the specialty societies noted, and the Workgroup agreed that the initial work neutrality calculation was conducted using the estimated low utilization of G codes G0502, G0503, G0504 and G0507, instead of the estimate provided by the specialty societies on the original SOR submitted to the RUC. The estimated utilization was very close to the actual 2018 Medicare claims data. **If the correct estimates were used in the calculation,**

this code family was work neutral. The Workgroup recommends removing 99484 and 99492-99494 from further review regarding work neutrality.

CPT Code		G code Source Utilization (2017)	SOR Estimated Util	Actual Medicare Utilization (2018)
99492	G0502	845	10,000	10,031
99493	G0503	813	36,000	5,927
99494	G0504	596	14,000	16,421
99484	G0507	8,093	21,049	23,002

Lastly, these services were identified on the new technology/new services list. **The specialty societies indicated, and the Workgroup agrees that the utilization for 99484 and 99492-99494 is appropriate and that these services should be removed from list as there is no demonstrated technology diffusion that impacts work or practice expense.**

New Technology/New Services

The Relativity Assessment Workgroup continued review of CPT 2019 codes that were flagged at the April 2017, October 2017 and January 2018 RUC meetings, with three years of available Medicare claims data (2019, 2020 and 2021). **The Workgroup reviewed the action plans and recommended the following:**

CPT Code	Issue	Workgroup Recommendation
10011 10012 77021	Fine Needle Aspiration	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33274 33275	Leadless Pacemaker Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33285 33286	Cardiac Event Recorder Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33289 93264	Pulmonary Wireless Pressure Sensor Services	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33340	Closure Left Atrial Appendage with Endocardial Implant	**Survey in 1 year, April 2024, to allow for the technology to stabilize a bit more prior to survey.**
33412 33413 33440	Aortoventriculoplasty with Pulmonary Autograft	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33477	Transcatheter Pulmonary Valve Implantation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
53854	Transurethral Destruction of Prostate Tissue	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
76391	Magnetic Resonance Elastography	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
76978 76979	Contrast-Enhanced Ultrasound	**Refer to CPT Assistant** to educate members about the removal of the bubble contrast agent (SD332) from direct practice expense, effective January 1, 2023. The supply item should be reported separately as a HCPCS Level II supply code such as Q9950.

CPT Code	Issue	Workgroup Recommendation
		Remove from new technology/new services list, no demonstrated technology diffusion that impacts work or practice expense.
76981 76982 76983	Ultrasound Elastography	**Survey for September 2023 meeting.**
77046 77047 77048 77049	Breast MRI with Computer-Aided Detection	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
95836	Electrocorticography	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99451 99452	Interprofessional Internet Consultation	**Review in 2 years (April 2025).**

Reiteration of Screens
Site of Service Anomalies

Outpatient Setting but Includes Hospital Visits
The Workgroup identified one code with Medicare data from 2019-2021 indicating it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period and 2021 Medicare utilization over 10,000. Typically, codes identified via the site of service screen are placed directly on the level of interest (LOI) for survey and the Workgroup initially indicated as such for CPT code 38571 *Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy.* However, later in the agenda CPT code 38571 was identified with code 55866 as being reported together 75% or more and an action plan will be reviewed on this issue at the September 2023 meeting. **Therefore, to avoid surveying code 38571 just prior to any changes at CPT, the Workgroup agreed to postpone surveying 38571 until the possible code bundling solution is addressed. The Workgroup requests an action plan for 38571 for review at the September 2023 meeting.**

Inpatient Hospital Setting but includes half discharge day management (99238)
The Workgroup identified two codes, 36558 and 33274, with Medicare data from 2019-2021 and utilization over 10,000 in which the service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. **The Workgroup had questions regarding the possible bundling of 36558 with fluoroscopic guidance (CPT code 77001) and requests an action plan for September 2023.** The Workgroup noted that 33274 was on this meetings' new technology/new services list for review and was reviewed for that screen. The Workgroup questioned the site of service for code 33274. The Workgroup noted that the RUC valued this service as typically involving an overnight stay that is less than 24 hours in length. **The Workgroup recommends that CPT code 33274 and relevant codes in the family be surveyed for September 2023.**

High Volume Growth (92523 and 90901)
The workgroup identified two codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2016 through 2021. **The Workgroup requests that the specialty societies submit an action plan for codes 90901 and 92523, for September 2023.**

Surveyed by one specialty and now performed by a different specialty
The Workgroup identified four codes with 2021 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 38222 and 64590 for September 2023 and to remove codes 93050 and 95937 from the screen.**

Category III High Volume
The Workgroup identified five Category III codes with 2021 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the high volume Category III codes. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. **The Workgroup requests action plans for codes 0101T, 0330T, 0358T, 0421T and 0598T for September 2023.**

CPT Assistant Analysis (95921, 95922, 95923, 95924)
The Workgroup identified one issue, which the RUC referred to CPT Assistant and an article was published in 2020. In January 2020, the RUC recommended referring codes 95921-95924 to CPT Assistant in 2020 to clarify correct coding on how to report these services and the Workgroup review the specialty mix again in 3 years of those reporting the services (Sept 2023). **The Workgroup requests an action plan for Autonomic Function Testing (95921, 95922, 95923, 95924) for the September 2023.**

Work Neutrality CPT 2021
The Workgroup identified two issues for codes that were reviewed for CPT 2021 (April 2019, October 2018 and January 2020) that have more than 10% increase in work RVUs from what was projected. **The Workgroup requests action plans for Remote Retinal Imaging (92227 & 92228) and External Extended ECG Monitoring (93224-93227 and 93241-93248) for September 2023.**

Services Performed Together 75% or More
The Workgroup identified four 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 2021 Medicare claims data and/or contained at least one ZZZ global service were removed. The Workgroup noted that a code bundling solution for 25310/25447 is already scheduled to be addressed for the May 2023 CPT Editorial Panel meeting. **The Workgroup requests action plans for September 2023 to determine if specific code bundling solutions should occur for codes 38571/55866, 65820/66984 and 91120/91122.**

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.

New Business
Category III High Volume
When discussing the Category III High Volume threshold of 1,000 in Medicare utilization to be identified on the screen, a Workgroup member questioned if the threshold should be raised. AMA staff noted that the threshold is NOT to gauge if a valid survey can be conducted, but whether a Category I code should be created. The Medicare utilization of Category III codes does not represent the total utilization of those services. The Workgroup agreed to maintain the utilization threshold of 1,000 to identify high volume Category III codes.

Practice Expense Screens
A Workgroup member questioned what practice expense screens may be developed to identify high practice expense and/or anomalies. AMA staff indicated that they have conducted a PE High-Cost screen as well as a PE Units screen. AMA staff indicated they will summarize what previous screens have been completed to facilitate a discussion on what additional PE screens may be developed.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Administrative Subcommittee (Tab 16)

James Waldorf, MD, Chair of the Administrative Subcommittee provided a summary of the Subcommittee report to the RUC.

Rotating Seat Policies and Election Rules
The Administrative Subcommittee reviewed the Society of Hospital Medicine (SHM) request to add Hospital Medicine to the Internal Medicine Subspecialties and thus be eligible to run for the Internal Medicine rotating seats. The vast majority of SHM's members who self-report a specialty in the SHM membership database were trained in Internal Medicine (70-80%). Their expertise is in caring for patients throughout their hospitalization, coordinating care across specialties and service lines, and improving systems and processes to advance care quality and efficiency. Most hospitalists train in Internal Medicine residency programs and enter the field directly after completing their residency training.

The Administrative Subcommittee reviewed SHM's request and determined that Hospital Medicine is an Internal Medicine Subspecialty. The Administrative Subcommittee amended the RUC Rotating Seat Policies and Election Rules document to add Hospital Medicine as an Internal Medicine Subspecialty.

Rotating Seat Policies and Election Rules Excerpt to be revised:

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, Internal Medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Hematology, **Hospital Medicine**, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.
- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.
- The "other rotating seat" on the RUC shall not be open to Internal Medicine subspecialties.

The RUC approved the Administrative Subcommittee Report.

XV. New Business (Tab 17)

- A RUC member requested guidelines for RUC database searches and parameters for crosswalks. Other RUC members present supported this request. **The request for database search guidelines and crosswalk guidelines were referred to the Research Subcommittee for discussion.**

- A RUC member raised a question regarding the evaluation process employed by the Relativity Assessment Workgroup (RAW) for issues on the new technology/new services list. The member sought clarification on how both the RUC and the Workgroup determine whether an issue is not solely related to utilization or technology diffusion but has been flagged for an alternative reason.

  When evaluating items on the new technology/new services list, the RAW takes a comprehensive approach. Rather than focusing on individual items or one specific data point (such as utilization), the Workgroup considers the entirety of the services and relies on an explanation provided by societies. The action plans presented to the Workgroup encompass various aspects, including the screen in which it was identified, volume, and other relevant parameters.

  Furthermore, if the RUC identifies a distinct rationale to re-evaluate a service, independent of it being a new technology or service, there is a separate dedicated flag in the RUC rationale. This flag indicates why the service(s) should be re-examined at a time certain. The RAW will then thoroughly analyze the relevant data for these services and provide the RUC with a recommendation on the most effective approach to address the identified concerns.

- A RUC member inquired about the value of intensity and how that impacts the adjudication of services. With continuing advancements in technology, the inquiring member, and other RUC members, were aligned that the use of evolving technology, which may lead to a decrease in time, does not equate to less intensity and/or complexity of a procedure. As a result of the discussion, another RUC member requested that the Research Subcommittee review the intensity and complexity questions on the RUC survey to better reflect how intense/complex a given procedure is relative to other procedures in the MFS. **The request was referred to the Research Subcommittee for discussion.**

The RUC adjourned at 11:08 AM PT on Friday, April 28, 2023.

Members: Margie Andreae, MD (Chair), Jeffrey Paul Edelstein, MD (Vice Chair), Anita Arnold, DO, Michael Doll, PA-C, Leisha Eiten, AuD, CCC-A, John Heiner, MD, Omar Hussain, DO, Kristopher Kimmell, MD, M. Douglas Leahy, MD, Swati Mehrotra, MD, Anne Miller, MD, Marc Raphaelson, MD, Sanjay A. Samy, MD, Kurt Schoppe, MD, James Shoemaker, MD, Matthew Sideman, MD, Mark Villa, MD, David Yankura, MD, Robert Zipper, MD, Robert Zwolak, MD

I. Introductions and Review of Research Guidelines/Requirements Document

Doctor Andreae welcomed all returning and new Research Subcommittee members for the 2023-2025 Research Subcommittee term. Each Subcommittee member briefly introduced themselves. The Chair briefly gave an overview of the Subcommittee for new members, noting that it is primarily charged with development and refinement of RUC methodology. The Subcommittee meets 3 times per year virtually to review specialty society requests pertaining to the RUC survey process for CPT codes under review. The Subcommittee also typically has 2-3 in-person meetings per year to consider potential general refinement of RUC methodology. The Subcommittee briefly discussed the Guidelines and Requirements document and decided that no changes were warranted at this time.

II. Minutes, February 20 Research Subcommittee Specialty Requests Meeting Report Review

The Research Subcommittee report from the February 20th conference call included in Tab 13 of the April 2023 agenda materials was approved without modification.

III. Site-of-Service RUC Survey Question *(referred from January 2023 RUC New Business)*

During the January 2023 RUC New Business discussion, a RUC member inquired about adding an additional question to the RUC survey to expand beyond the typical site-of-service. The expanded question would inquire if the respondent performs the service in each of the settings. Another member further clarified that the Summary of Recommendation (SOR) document should be updated to include the word "typical" to match question 2C on the 010-day and 090-day surveys *(this editorial change has already been made by AMA RUC staff).* Additionally, it was discussed that site-of-service questions should also be incorporated in the 000-day global survey to reflect the typical site of service. The RUC referred this topic to the Research Subcommittee.

The Research Subcommittee first discussed whether the standard 010-day and 090-day RUC survey templates should be revised to capture additional site-of-service information. Several respondents supported an idea to change the question to ask the survey respondent what % of the time they perform the survey code in the hospital, ASC and office settings. An additional idea to volume-weight these responses using each survey's annual performance rate response was also offered. A Subcommittee member noted their preference for a more simplified change, that would largely retain the current format, but then also ask yes/no whether the respondent ever performs the service in the office setting (which would be germane to whether the service should be valued in the non-facility setting for practice expense).

The Chair summarized the discussion, noting that Subcommittee members expressed broad support for retaining the question in general, and that it might be beneficial to have the survey respondent estimate percentages for hospital, ASC and office. The Chair noted that she will work with AMA Staff to draft potential language for the Subcommittee's consideration at its next in-person meeting in the fall. She also noted that if any Subcommittee members have suggested language, please share with AMA Staff. A Subcommittee also asked whether it would be possible to pilot test the weighting of the site of service

survey data. The Chair noted that she would explore that possibility with AMA Staff and consider some sort of analysis, if possible.

Next, the Subcommittee discussed the typical discharge question: "If you *typically* perform this procedure in a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or admitted to the hospital?" Subcommittee members expressed concern with how changes to the first question would impact this subsequent question and whether the question should only be asked of survey respondents that typically perform the survey code in the hospital setting, or any respondents that perform the service in the hospital setting (including a minority of the time). The Chair noted that she will work with AMA Staff on potential changes to this question for the Subcommittee to consider at its next in-person meeting.

Finally, the Subcommittee discussed whether the standard 000-day global survey template should also include site-of-service questions. There was broad support for this change in general; the Chair noted that she would also work with AMA Staff on this topic in general to prepare draft language for the Subcommittee's consideration at its next in-person meeting.

IV. RUC Crosswalk Codes General Guidelines *(referred from January 2023 RUC New Business)*
During the January 2023 RUC New Business discussion, a RUC member requested general guidelines/guidance for the use of crosswalk codes to support valuation recommendations. This item was referred to the Research Subcommittee for consideration.

At the Research Subcommittee meeting, the Chair noted that this item was last considered by the Subcommittee at its January 2018 meeting. At that time, the RUC requested for AMA staff to perform an analysis of previous RUC recommendations based on crosswalks. In January 2018, the Subcommittee concluded at the time that the RUC has an excellent track record over the prior two years of selecting appropriate crosswalks and no defined guidelines were indicated. For that meeting, AMA staff analyzed 468 codes from the past 6 RUC/HCPAC meetings. 104 (22%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 95% of the time. For a significant number of codes, the RUC recommended time was within 10% of the time for the crosswalk code (79% intra-time and 60% total-time). Nearly every crosswalk code selected had been reviewed by the RUC (98%). Since that time, when the RUC has used crosswalk code recommendations, it has followed the same pattern, the same work RVU, same global and similar times.

For the April 2023 RUC meeting, AMA Staff shared this same summary data with the Subcommittee. The Subcommittee discussed whether it would be appropriate to create guidance language with absolute criteria for the RUC panel itself. The Subcommittee agreed that that would not be warranted at this time as the current process is currently working as intended.

Separately, in lieu of guidelines for the RUC itself, AMA RUC staff had drafted the below text for inclusion in the "Instructions for Developing Work Value Recommendations" document for the Subcommittee's consideration. This document, which is a reference for specialty society advisors and staff, already has a section on alternate ways to develop work RVU recommendations, though does not specifically cover crosswalk codes.

> *Typically, the expert panel methodology uses a comparison or "crosswalk" code to determine an appropriate work value recommendation. To identify an appropriate crosswalk code, first identify a RUC-reviewed reference code with the same amount of physician work as the survey code. When the RUC relies on the crosswalk methodology for RUC recommendations, the RUC recommends a work RVU that is identical to the crosswalk code. In addition, the survey code and the crosswalk code should have the same global period. Whenever possible, the crosswalk code should have been*

reviewed by the RUC recently, have a similar amount of intra-service and, total time, and have clinical similarities to the survey code.

The Subcommittee agreed that inclusion of language like this, in general, in this document would be warranted, though suggested for the text to undergo some wordsmithing between this meeting and the next in-person Subcommittee meeting. The Chair noted that she would welcome member suggested changes in writing and then she will work with AMA staff on refining this language for the Subcommittee's consideration at the next in-person meeting and would work in the language regarding suggested ranges.

V. Review of American College of Cardiology (ACC) and Society for Cardiovascular Angiography & Interventions (SCAI) Request to Approve National Cardiovascular Data Registry as Extant Datasource

The presenter representing American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) provided background for the Research Subcommittee regarding their request to approve the ACC's CathPCI Registry® for use as a RUC-approved extant datasource. The Percutaneous Coronary Intervention (PCI) family of codes was brought up for re-survey at the January 2023 RUC meeting after approval of an independent application for a new CPT code for intravascular lithotripsy (IVL). At the January 2023 meeting, advisors from the ACC and SCAI requested that the new IVL code be valued but that the rest of the code family valuations be delayed so that the societies could make other revisions and updates to several of the codes at CPT. The RUC agreed with this approach. The presenter noted that the data from the CathPCI Registry which is part of the ACC's National Cardiovascular Data Registries (NCDR). ACC and SCAI requested for the CathPCI Registry to be approved for possible extant data use at the RUC.

The societies provided the following review of how the CathPCI Registry meets the RUC's criteria for extant database approval in a letter prior to the Subcommittee meeting:

Existing RUC Extant Database Requirements:

- *Databases must have data integrity/reliability:*
  - *Must collect data prospectively,*
    CathPCI Registry®: The database collects the data prospectively, however, some data must be collected retrospectively, e.g. post discharge outcome data. Most data that will be used by the RUC, such as intra-service time, is captured at the time of the procedure.

  - *Should have the ability to identify and assess outliers – multiple procedures resulting in greater LOS; diseases with high mortality rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)*
    CathPCI Registry®: Yes, the database captures very specific procedures, allowing data to be isolated to a single procedure performed that can be mapped directly to the individual PCI CPT code. Since the data capture is specific to a field, it is possible to identify and assess outliers within the dataset.

  - *Should have the ability to have transparency of data to compare to other databases including the RUC database*
    CathPCI Registry®: The specialties have included the CathPCI Registry® data collection form that shows what data is collected. The data is entered into the database by an employed Data Administrator at the participating facility, who is specifically trained to enter the collected data into the database for analysis. The Registry has policies and procedures, clearly outlined, regarding data collection and entry. Access to data is governed by ACC policies and procedures, the underlying NCDR participant agreement with hospitals and HIPAA requirements.

    The underlying participant agreement including the Business Associate Agreement/ Data

Use Agreement grants the American College of Cardiology Foundation ("ACCF") the following specific permissible uses of data captured in the registries:
1. provide data aggregation services relating to the health care operations of Covered Entities (Registry Participants) for which ACCF contracts.
2. the right de-identify PHI it receives from Covered Entities, pursuant to 45 CFR §164.514, which de-identified data, and any derivative works from such data, shall be owned by ACCF, in all forms and media worldwide, and may be used by ACCF for any lawful purpose; and
3. the right to create and disclose a Limited Data Set provided that the applicable provisions of the Data Use Agreement entered into with Covered Entities are satisfied and such use of Limited Data Sets is limited to health care operations of Covered Entities, Public Health and Research as such terms are defined by the Health Insurance Portability and Accountability Act ("HIPAA").

- *Should have the ability to audit the database*
  CathPCI Registry®: Yes, the CathPCI Registry® is externally audited to ensure quality and accuracy of the data.

- *Should have the ability to track the data/changes over time*
  CathPCI Registry®: Yes, the CathPCI Registry® can track the data/changes over time. It is unclear exactly what this criterion represents. For the CathPCI Registry® to have the ability to track the data/changes over time will depend on what is being measured. While outcomes data can be tracked over time, it may not be possible (or proper) to track individual data field changes over time.

- *Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, should have sampling criteria that are statistically valid to eliminate sampling bias*
  CathPCI Registry®: The CathPCI Registry® captures all relevant PCI procedures performed across the county for all patients that meet the inclusion criteria and whose facilities participate in the CathPCI Registry.

- *Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes*
  CathPCI Registry®: The current version of the CathPCIRegistry® has data going back to the beginning of 2018. Prior versions go back farther in time.

- *Databases should collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)*
  CathPCI Registry®: The CathPCI Registry® collects the procedure start and stop time and LOS. The Registry does not collect information on phone calls or ventilator hours.

- *Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting.*
  CathPCI Registry®: The CathPCI Registry® data collection includes equipment that can be used to correlate mapping to a CPT code. Data is also collected on certain lesion characteristics (chronic total occlusion, AMI, graft) that map to other CPT codes in the PCI family.

- *Databases must list their limitations – include what is provided and not provided with respect to the RUC database.*
  CathPCI Registry®: The societies have included the data collection form, which provides the complete set of data collected by the CathPCI Registry®. The main components that are captured in the CathPCI Registry® that are also found in the RUC database include the intra-

service time data, co-morbidities and risk factor data (to determine vignettes and possibly critical care) and LOS.

- *Databases must be representative:*
  - *The data should be geographically representative e.g., regionally and nationally for the specialty,*
    CathPCI Registry®: The CathPCI Registry® is a national database that collects data for all patients that meet the inclusion criteria.

  - *The data should have various levels of patient severity.*
    CathPCI Registry®: There are inclusion criteria for patients undergoing PCI, so the data captured is as diverse as is allowed for the procedures based on FDA and regulatory criteria. The registry captures patient severity from elective to salvage.

  - *The data should have adequate practice site representation and sample size – practice sites and rural and urban representation.*
    CathPCI Registry®: The significant majority of sites performing PCI's report to the database, which ensures that the diversity of sites is captured. Currently 1750 sites report to the registry.

  - *The data should be from various practice types – representative of the academic, non-academic and other types of practices for the specialty*
    CathPCI Registry®: With the vast majority of sites performing PCIs reporting to the database, the diversity of sites is captured.

  - *The data should be collected from the majority specialties (including subspecialties) that perform the procedure or encounter*
    CathPCI Registry®: With the vast majority of sites reporting, data is collected from the vast majority of interventional cardiology operators.

  - *The data should be collected from either hospital/institution or individual physician.*
    CathPCI Registry®: The CathPCI Registry® data is collected at the facility level. The registry also captures some operator information such as the NPI.

The Subcommittee reviewed the responses to these requirements in detail. The Chair requested for the presenter to expand upon how time will be identified for individual procedures and whether both the start time and the stop time for the skin-to-skin time for each procedure would be captured in this database. The presenter noted that both start and stop time for the intra-service period are captured which represents the total skin-to-skin time for the procedure. The Chair also inquired if the dataset could isolate patients that underwent a single procedure and the presenter noted that yes this is possible. A Subcommittee member inquired how accurate the intra-service times are in the registry and the presenter noted that the times are very accurate and they are captured to the minute in real-time. A Subcommittee member inquired whether it would be possible to isolate the registry times and other data to individual CPT codes. The presenter noted that it would be possible in some cases. They also noted that the registry would fit nicely with current structure of PCI with respect to matching the data with individual CPT codes.

As detailed in the letter submitted as part of this request, the specialties noted and the Subcommittee agreed that the ACC's CathPCI Registry® meets all of the RUC's extant database requirements. The presenters noted that the database includes approximately 90% of eligible cases in the United States for patients that undergo these services regardless of payer.

The Research Subcommittee recommended for the RUC to approve the ACC's CathPCI Registry® as a database that meets the RUC's extant database criteria.

VI. Review of American Burn Association (ABA) Request for Review of Educational Presentation Materials

The American Burn Association, which is anticipating to conduct its first RUC survey in many years over the summer, requested Research Subcommittee review and approval of the ABA's use of standard RUC presentation, "Understanding the RUC Survey Instrument Surgical Services", with modifications at the ABA's Leadership Bootcamp session on May 16th. The ABA plans to have Doctor Bill Hickerson (RUC Advisor, ABA Coding Committee Chair) and Doctor Jeffrey Carter (potential CPT Advisor/RUC Alternate and ABA Coding Committee Member) give this presentation to members of the ABA at this session.

The Chair noted concerns with the modified slide deck even though it is very similar to the standard slides on the RUC collaboration website. A member recommended the ABA use the standard slide deck without modifications. The ABA accepted that recommendation and withdrew their request for use of a modified version of the standard presentation.

The Research Subcommittee accepted the ABA decision to move forward with use of the standard RUC presentation, "Understanding the RUC Survey Instrument Surgical Services".

A Subcommittee member requested for the Subcommittee to periodically review the slide deck. The Chair noted that this would be warranted for the Subcommittee to review the standardized educational materials, time uncertain.

AMA/Specialty Society RVS Update Committee **Tab 14**
Practice Expense Subcommittee
April 26, 2023

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, John Blebea, MD, Michael Booker, MD, Neal Cohen, MD, William Gee, MD, David Han, MD, Katie Jordan, OTD, OTR/L, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, MBA, Donald Selzer, MD, Edward Vates, MD, Elisabeth Volpert, DNP, APRN, Thomas J. Weida, MD, Adam Weinstein, MD, and Tim Swan, MD (CPT Resource)

I. Post-Operative Patient Communications

The Practice Expense (PE) Subcommittee agreed to discuss the issue of post-operative patient communications at its April meeting to determine if the PE benchmark regarding phone calls needed to be modified in light of action taken at the January 2023 PE meeting on Tab 07 Posterior Nasal Nerve Ablation, CPT codes 30117 *Excision or destruction (eg, laser), intranasal lesion; internal approach* and 30118 *Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)*.

In January, the PE Subcommittee approved an additional 3 minutes for CA037 *Conduct patient communications* in CPT codes 30117 and 30118. The specialty society indicated that this call to a patient is typical 1-2 days post-op, and the PE members agreed that this type of communication immediately following a surgery is evolving and reflects best practice that may be applied to other 090-day global codes. However, the Subcommittee recognized that a phone call is outside of the 090-day global standard:

- All phone calls, standardized to 3 minutes. No phone calls are allowed in the post-operative period for 010 and 90 day global codes.

The PE Subcommittee discussed the existing benchmarks including the standard for Discharge Day Management:

- Discharge day management
  If the claims data indicate site-of-service is:
  less than 50% inpatient – 6 minutes (.5 99238)
  greater than 50% inpatient – 12 minutes (99238); 15 minutes (99239)
  more than 50% non-facility (e.g., office) – 0 minutes

The PE Subcommittee agreed that the existing benchmark for Discharge Day Management should clarify that it encompasses phone calls. There are two 3-minute phone calls provided for in the ½ day discharge and four 3-minute phone calls in a full day discharge code 99238.

The PE Subcommittee will continue its discussion of post-operative patient communications at the September meeting after CMS has released the Proposed Rule. It was explained that the new Evaluation and Management (E/M) services account for the work and practice expense three-days prior to the visit and seven-days following the visit. A phone call performed outside this period (ie, in the immediate days following the surgery) would not be incorporated into the bundled E/M visits in the global period. The Subcommittee will evaluate the outcome of CPT codes 30117 and 30118 in the Proposed Rule and better determine if the PE benchmark regarding phone calls needs to be modified in light of the E/M code revisions and typical communications to the patient.

II. Pricing of Packs

At the January 2023 RUC meeting, the PE Subcommittee requested that AMA staff deconstruct the packs in order to review pricing after noting a discrepancy with the SA051 *pack, pelvic exam* while reviewing Tab 13 Pelvic Exam (PE Only), CPT code 9X036 *Pelvic exam (List separately in addition to code for primary procedure)*. The SA051 pack is priced at $20.16 while the four individual items therein total $2.81 according to the 2023 CMS Direct PE Inputs Medical Supplies Listing.

One would expect the pack price to be identical to the total cost of its contents. The purpose of the packs is to simplify the process of identifying and recommending PE supply direct inputs. By using the packs, the RUC does not need to repeat all the individual supplies each time they are used in a code and it simplifies review of line items. The packs are for simplicity-sake only, so the pricing should be exactly the same as the total cost of the individual supplies.

AMA Staff prepared a document with the 23 deconstructed packs for consideration by the PE Subcommittee. Review of the pack pricing uncovered numerous discrepancies between the aggregated cost of a pack and the individual item components. Prior to the meeting, staff reached out to inquire about this issue to the Centers for Medicare & Medicaid Services (CMS) and received the following response:

"We agree that this is an issue that should be fixed, as the price of the individual components should be consistent across the supply packs and match the standalone prices of supplies (like gloves and sterile gauze and such). However, it needs to be tackled in comprehensive fashion to ensure consistency across the dozens of supply packs which will be a sizable undertaking. Resolving these pricing discrepancies in the supply packs is something that we will consider addressing in future rulemaking."

Accordingly, the RUC will share the deconstructed packs document and volume analysis with CMS with recommended corrections in CY2024 rulemaking. The PE Subcommittee also formed a workgroup to review the content of the packs to assess if they are still typical and revise as necessary.

III. Practice Expense Recommendations for CPT 2025:

Tab	Title	PE Input Changes	Consent Calendar
4	Iris Procedures	No Changes	
5	Optical Coherence Tomography (OCT)	Modifications	
6	Telemedicine Evaluation and Management Services	No Changes	
7	Skin Adhesives (PE Only)	No Changes	
8	Laser Treatment – Skin	Modifications	

Tab	Title	PE Input Changes	Consent Calendar
9	Acupuncture/ Electroacupuncture	Modifications	
10	Annual Alcohol Screening	Modifications	
11	Annual Depression Screening	Modifications	
12	Behavioral Counseling/Therapy	Modifications	

AMA/Specialty Society RVS Update Committee **Tab 15**
Relativity Assessment Workgroup
April 27, 2023

Members: Doctors Matthew Grierson (Chair), Gregory DeMeo (Vice Chair), Jennifer Aloff, Amr Abouleish, Dale Blasier, Audrey Chun, Martha Gray, Gregory Harris, Karen Smith, RD, Michael Sutherland, John Thompson, Korinne Van Keuren, DNP, and David Wilkinson.

I. Review Action Plans

Work Neutrality CPT 2018
Psychiatric Collaborative Care Management Services (99484, 99492-99494)
In October 2019, the RUC identified codes 99484 and 99492-99493 as having more than 10% increase in work RVUs for 2018 than what was projected. However, based on the utilization data for these services, it appeared that one independent clinic was performing most of these services in the pediatric population. The Workgroup recommended that CMS investigate the reporting of services by this specific independent clinic. The specialty society discussed that perhaps a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. However, due to the incorrect reporting of these services by one specific provider, the referral for a CPT Assistant article was removed.

AMA staff researched the Medicare Physician & Other Practitioners - by Provider and Service database and noted that the 2020 data indicates that codes 99492 and 99494 are no longer being reported by the one pediatric clinic in Houston, TX (codes 99484 and 99493 were not dominated by this provider). In 2019, the pediatric clinic in question provided 72% of 99492 and 85% of 99494. This clinic no longer provided any of these services in 2020.

Additionally, the specialty societies noted and the Workgroup agreed that the initial work neutrality calculation was conducted using the estimated low utilization of G codes G0502, G0503, G0504 and G0507, instead of the estimate provided by the specialty societies on the original SOR submitted to the RUC. The estimated utilization was very close to the actual 2018 Medicare claims data. **If the correct estimates were used in the calculation, this code family was work neutral. The Workgroup recommends removing 99484 and 99492-99494 from further review regarding work neutrality.**

CPT Code		G code Source Utilization (2017)	SOR Estimated Util	Actual Medicare Utilization (2018)
99492	G0502	845	10,000	10,031
99493	G0503	813	36,000	5,927
99494	G0504	596	14,000	16,421
99484	G0507	8,093	21,049	23,002

Lastly, these services were identified on the new technology/new services list. **The specialty societies indicated and the Workgroup agrees that the utilization for 99484 and 99492-99494 is appropriate and that these services should be removed from list as there is no demonstrated technology diffusion that impacts work or practice expense.**

New Technology/New Services

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 continued review of CPT 2019 codes that were flagged at the April 2017, October 2017 and January 2018 RUC meetings, with three years of available Medicare claims data (2019, 2020 and 2021). **The Workgroup reviewed the action plans and recommends the following:**

CPT Code	Issue	Workgroup Recommendation
10011 10012 77021	Fine Needle Aspiration	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33274 33275	Leadless Pacemaker Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33285 33286	Cardiac Event Recorder Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33289 93264	Pulmonary Wireless Pressure Sensor Services	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33340	Closure Left Atrial Appendage with Endocardial Implant	**Survey in 1 year, April 2024, to allow for the technology to stabilize a bit more prior to survey.**
33412 33413 33440	Aortoventriculoplasty with Pulmonary Autograft	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33477	Transcatheter Pulmonary Valve Implantation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
53854	Transurethral Destruction of Prostate Tissue	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
76391	Magnetic Resonance Elastography	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
76978 76979	Contrast-Enhanced Ultrasound	**Refer to CPT Assistant** to educate members about the removal of the bubble contrast agent (SD332) from direct practice expense, effective January 1, 2023. The supply item should be reported separately as a HCPCS Level II supply code such as Q9950. Remove from new technology/new services list, no demonstrated technology diffusion that impacts work or practice expense.
76981 76982 76983	Ultrasound Elastography	**Survey for September 2023 meeting.**
77046 77047 77048 77049	Breast MRI with Computer-Aided Detection	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
95836	Electrocorticography	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99451 99452	Interprofessional Internet Consultation	**Review in 2 years (April 2025).**

II. Reiteration of Screens

Site of Service Anomalies

Outpatient Setting but Includes Hospital Visits

The Workgroup identified one code with Medicare data from 2019-2021 indicating it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period and 2021 Medicare utilization over 10,000. Typically, codes identified via the site of service screen are placed directly on the level of interest (LOI) for survey and the Workgroup initially indicated as such for CPT code 38571 *Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy*. However, later in the agenda CPT code 38571 was identified with code 55866 as being reported together 75% or more and an action plan will be reviewed on this issue at the September 2023 meeting. **Therefore, to avoid surveying code 38571 just prior to any changes at CPT, the Workgroup agreed to postpone surveying 38571 until the possible code bundling solution is addressed. The Workgroup requests an action plan for 38571 for review at the September 2023 meeting.**

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

The Workgroup identified two codes, 36558 and 33274, with Medicare data from 2019-2021 and utilization over 10,000 in which the service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. **The Workgroup had questions regarding the possible bundling of 36558 with fluoroscopic guidance (CPT code 77001) and requests an action plan for September 2023.** The Workgroup noted that 33274 was on this meetings' new technology/new services list for review and was reviewed for that screen. The Workgroup questioned the site of service for code 33274. The Workgroup noted that the RUC valued this service as typically involving an overnight stay that is less than 24 hours in length. **The Workgroup recommends that CPT code 33274 and relevant codes in the family be surveyed for September 2023.**

High Volume Growth (92523 and 90901)

The workgroup identified two codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2016 through 2021. **The Workgroup requests that the specialty societies submit an action plan for codes 90901 and 92523, for September 2023.**

Surveyed by one specialty and now performed by a different specialty

The Workgroup identified four codes with 2021 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 38222 and 64590 for September 2023 and to remove codes 93050 and 95937 from the screen.**

Category III High Volume

The Workgroup identified five Category III codes with 2021 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the high volume Category III codes. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. **The Workgroup requests action plans for codes 0101T, 0330T, 0358T, 0421T and 0598T for September 2023.**

CPT Assistant Analysis (95921, 95922, 95923, 95924)

The Workgroup identified one issue, which the RUC referred to CPT Assistant and an article was published in 2020. In January 2020, the RUC recommended referring codes 95921-95924 to CPT Assistant in 2020 to clarify correct coding on how to report these services and the Workgroup review the specialty mix again in 3 years of those reporting the services (Sept 2023). **The Workgroup requests an action plan for Autonomic Function Testing (95921, 95922, 95923, 95924) for the September 2023.**

Work Neutrality CPT 2021

The Workgroup identified two issues for codes that were reviewed for CPT 2021 (April 2019, October 2018 and January 2020) that have more than 10% increase in work RVUs from what was projected. **The Workgroup requests action plans for Remote Retinal Imaging (92227 & 92228) and External Extended ECG Monitoring (93224-93227 and 93241-93248) for September 2023.**

Services Performed Together 75% or More

The Workgroup identified four 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 2021 Medicare claims data and/or contained at least one ZZZ global service were removed. The Workgroup noted that a code bundling solution for 25310/25447 is already scheduled to be addressed for the May 2023 CPT Editorial Panel meeting. **The Workgroup requests action plans for September 2023 to determine if specific code bundling solutions should occur for codes 38571/55866, 65820/66984 and 91120/91122.**

III. 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.

IV. New Business

Category III High Volume

When discussing the Category III High Volume threshold of 1,000 in Medicare utilization to be identified on the screen, a Workgroup member questioned if the threshold should be raised. AMA staff noted that the threshold is NOT to gauge if a valid survey can be conducted, but whether a Category I code should be created. The Medicare utilization of Category III codes does not represent the total utilization of those services. The Workgroup agreed to maintain the utilization threshold of 1,000 to identify high volume Category III codes.

Practice Expense Screens

A Workgroup member questioned what practice expense screens may be developed to identify high practice expense and/or anomalies. AMA staff indicated that we have conducted a PE High Cost screen as well as a PE Units screen. AMA staff indicated they will summarize what previous screens have been completed to facilitate a discussion on what additional PE screens may be developed.

AMA/Specialty Society RVS Update Committee **Tab 16**
Administrative Subcommittee
April 27, 2023

Members: Doctors James Waldorf (Chair), Donna Sweet (Vice Chair), Kris Anderson, DC, James Blankenship, Shannon Butkus, PhD, Nelda Spyres, LCSW, Scott Collins, Peter Hollmann, Gwenn Jackson, Lance Manning, John McAllister, Carlo Milani, Christopher Senkowski, Clarice Sinn and Afnan Tariq.

I. Welcome and Introduction to the Administrative Subcommittee

Doctor Waldorf welcomed all the Administrative Subcommittee members and Susan Clark, AMA Staff, provided an overview of all the materials that the Administrative Subcommittee members should become familiar with, including the Structure and Functions, Rules and Procedures, Rotating Seat Policies and Election Rules, and Annotated List of RUC Actions.

II. **Rotating Seat Policies and Election Rules**

The Administrative Subcommittee reviewed the Society of Hospital Medicine (SHM) request to add Hospital Medicine to the Internal Medicine Subspecialties and thus be eligible to run for the Internal Medicine rotating seats. The vast majority of SHM's members who self-report a specialty in the SHM membership database are trained in Internal Medicine (70-80%). Their expertise is in caring for patients throughout their hospitalization, coordinating care across specialties and service lines, and improving systems and processes to advance care quality and efficiency. Most hospitalists train in Internal Medicine residency programs and enter the field directly after completing their residency training.

The Administrative Subcommittee reviewed SHM's request and determined that Hospital Medicine is an Internal Medicine Subspecialty. The Administrative Subcommittee amended the RUC Rotating Seat Policies and Election Rules document to add Hospital Medicine as an Internal Medicine Subspecialty.

Rotating Seat Policies and Election Rules Excerpt to be revised:

Internal Medicine Subspecialty

- For purposes of electing an internal medicine subspecialty rotating seat on the RUC, Internal Medicine includes the following: Allergy/Immunology, Endocrinology, Gastroenterology, Hematology, **Hospital Medicine**, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine and Rheumatology.

- Internal Medicine subspecialties not included on the RUC approved list of Internal Medicine specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.

- The "other rotating seat" on the RUC shall not be open to Internal Medicine subspecialties.

AMA/Specialty Society RVS Update Committee **Tab 06**
Telemedicine E/M Services
Facilitation Committee #1

Members: Bradley Marple, MD (Chair), Amy Aronsky, DO, Scott Collins, MD, William Donovan, MD, Jeffrey Edelstein, MD, Peter Hollmann, MD, Richard Rausch, DPT, James Shoemaker, MD, and James Waldorf, MD

Audiovisual – Established Patient

Code	Descriptor	Pre	Intra	Post	Total Time	Work RVU	Xwalk	Pre	Intra	Post	Total Time	Work RVU
9X079	AV Est Stfd	4	10	3	17	**0.70 (passed at 25th Percentile)**	N/A					
9X080	AV Est Low	5	15	5	25	**1.22**	72126 72129 73702	5 5 5	15 15 16	5 5 5	25 25 26	1.22 1.22 1.22
9X081	AV Est Mod	6	21	5	32	**1.74**	74176	5	22	5	32	1.74
9X082	AV Est High	10	30	10	50	**2.40**	75574	10	30	10	50	2.40

9X079 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.***

The RUC reviewed the survey results from 151 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 4 minutes pre-service time, 10 minutes intra-service time and 3 minutes post-service time. **The RUC recommends a work RVU of 0.70 for CPT code 9X079. (PASSED)**

9X080 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.***

The Facilitation Committee reviewed the survey results from 189 physicians and qualified health care professionals and determined that a work RVU of 1.22 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 5 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time. The Committee recommends a direct crosswalk to CPT codes 72126 *Computed tomography, cervical spine; with contrast material* (work RVU = 1.22 and 25 minutes total time), 72129 *Computed tomography, thoracic spine; with contrast material* (work RVU = 1.22 and 25 minutes total time) and 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU 1.22 and 26 minutes total time).

For additional support, the RUC referenced MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and 70491 *Computed tomography, soft tissue neck; with contrast material(s)* (work RVU = 1.38, 17 minutes intra-service time and 27 minutes total time). **The Committee recommends a work RVU of 1.22 for CPT code 9X080.**

9X081 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.***

The Facilitation Committee reviewed the survey results from 207 physicians and qualified health care professionals and determined that a work RVU of 1.74 appropriately accounts for the work required to perform this service. The Committee recommends 6 minutes pre-service time, 21 minutes intra-service time and 5 minutes post-service time. The Committee recommends a direct crosswalk MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time).

For additional support, the Committee referenced MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time). **The RUC recommends a work RVU of 1.74 for CPT code 9X081.**

9X082 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.***

The Facilitation Committee reviewed the survey results from 171 physicians and qualified health care professionals and determined that a work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 30 minutes intra-service time and 10 minutes post-service time. The Committee recommends a direct crosswalk to code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (*work RVU = 2.40, 30 minutes intra-service time and 50 minutes total time). **The RUC recommends a work RVU of 2.40 for CPT code 9X082.**