AMA/Specialty Society RVS Update Committee
The Westin Chicago River North, Chicago, IL
April 24-27, 2024

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in April 2024. Doctor Ezequiel Silva, III, called the meeting to order on Friday, April 26, 2024, at 9:03 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva, III, MD
Amr Abouleish, MD, MBA
Jennifer Aloff, MD
Margie C. Andreae, MD
Amy Aronsky, DO
Gregory L. Barkley, MD
James Blankenship, MD, MHCM
Robert Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Scott Collins, MD
Gregory DeMeo, DO
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
Swati Mehrotra, MD
Gregory Nicola, MD
John Proctor, MD, MBA
Richard Rausch, DPT, MBA
Kyle Richards, MD
Christopher Senkowski, MD, FACS
G. Edward Vates, MD
Thomas J. Weida, MD
Robert Zipper, MD, MMM

RUC Alternates:
Megan Adamson, MD
Anita Arnold, DO
Eileen Brewer, MD
Neal Cohen, MD
Neeraj Desai, MD
Daniel Duzan, MD
Leisha Eiten, AuD
William Gee, MD
Patrick Godbey, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kevin Kerber, MD
Thomas Kintanar, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Lauren Nicola, MD
Michael Perskin, MD
Sanjay Samy, MD
James L. Shoemaker, MD
Matthew Sideman, MD
Clarice Sinn, DO
Michael Sutherland, MD
Timothy Swan, 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 attendees shall respect our confidentiality provisions indicated in the agreement to which you attested via the registration process.
  - Confidentiality requirements extend to both materials and discussions at this 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 welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
  - Tamika Brock – Health Insurance Specialist
  - Arkaprava Deb, MD – Medical Officer
  - Edith Hambrick, MD – Medical Officer
  - Michael Soracoe, PhD – Medical Officer
  - Gift Tee – Deputy Director, Hospital and Ambulatory Policy Group (HAPG)
    - Doctor Silva congratulated Mr. Tee on his promotion to Deputy Director!

- Doctor Silva welcomed the following Contractor Medical Directors:
  - Janet Lawrence, MD
  - Barry Whites, MD

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

- Doctor Silva recognized the new RUC members:
  - Jennifer Aloff, MD – Primary Care Rotating Seat
  - Gregory Nicola, MD (ACR)
  - Robert Zipper, MD (SHM)

- Doctor Silva recognized the new RUC alternate members:
  - Megan Adamson, MD – Primary Care Rotating Seat
  - Martha Gray, MD (ACP)
  - Thomas Kintanar, MD (AAFP)
  - Lauren Nicola, MD (ACR)
  - Daniel Duzan, MD (SHM)

- Doctor Silva recognized dedicated departing RUC participants for 30+ years of service:
  - William Gee, MD – AUA RUC Member, Alternate Advisor, PE Member
  - David McKenzie – ACEP Staff

- 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.

- 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.

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:
  - The PPI Survey will be fielded by Mathematica through June 2024.
  - More than 11,000 practices, representing nearly 300,000 physicians were invited to participate in the survey.
  - Financial experts from the 11,000 practices were contacted via email and USPS mail and invited to participate in the effort.
  - Mathematica recently emailed physicians from these practices to collect patient care hours and to inform those physicians that their practice was invited to participate in the PPI Survey effort.
  - The AMA and Medscape are also directly contacting physicians to collect patient care hours and encourage physician engagement to ensure practice surveys are completed.
  - Mathematica also launched surveys for non-MD/DO health care professionals, clinical laboratories, and independent diagnostic testing facilities (IDTFs).
  - 2,150 of the 11,000+ practices have engaged with the survey. Challenges: contact information, cybersecurity concerns. Mathematica will again contact larger practices via USPS mail. Weekly email reminders.
  - More than 200 practices have completed the survey. Several large health systems note to be in progress of completing (75 have engaged with the survey and several have contacted Mathematica with technical questions).
  - 50+ completed surveys for primary care practices (general practice, family medicine, internal medicine, geriatric medicine and pediatric medicine).

- 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 the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches 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 2022 Medicare claims data and updated 2024 Conversion Factor (CF).

- 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 by clicking "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 2026 and 2027 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Aug 27, 2024	Sept 25-28, 2024	Washington, DC	CPT 2026
Dec 10, 2024	Jan 15-18, 2025	Anaheim, CA	CPT 2026
Apr 1, 2025	Apr 23-26, 2025	Chicago, IL	CPT 2027

- Ms. Smith addressed questions from attendees:
    - A RUC member encouraged RUC participants to get their physician members and their practices to complete the PPI Survey. The member further stated that this survey effort will inform indirect practice expense which is a large portion of the total practice expense RVU.
    - Ms. Smith followed this comment by stating that a number of specialties have been very active in communicating to their members about the survey and its importance. Further, AMA staff have been circulating current communications by the AMA and specialty societies that can be used as examples to follow up with physician members and encourage participation in the survey effort.
    - A RUC Member inquired about incentivizing academic medical centers to participate in the survey process and specialty society efforts to educate their financial leaders about the importance of the survey process. The member inquired about AMA efforts with the American Hospital Association (AHA). Ms. Smith responded that the AMA would follow up with AHA on this topic. Further, the AMA has worked with the Medical Group Management Association (MGMA) and American Medical Group Association (AMGA) on the survey initiative and both organizations participated in the initial sign on letter.
    - A RUC member asked if state medical societies have participated in the survey process. Ms. Smith confirmed that the state medical societies were part of the initial sign on letter and have been encouraged to send communications to their physician members.

IV. Approval of Minutes from the January 2024 RUC Meeting

The RUC approved the January 2024 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, CPT Ad Hoc Workgroups, and upcoming CPT meeting:

- May 2024 CPT Editorial Panel Meeting

- 60 items of business
  - Notable agenda items:
    - 6 Digital medicine related Coding Change Applications (CCAs)
    - 20 Category III code applications
    - 5 RUC referrals to CPT
  - The Panel has several notable items on the agenda:
    - Prior Authorization Services
    - Cat III 0421T to Cat I-Transurethral Robotic-assisted Resection of Prostate
    - Limb Lengthening – Femur
    - Limb Lengthening – Tibia
    - Laparoscopic Prostatectomy
    - Prostate Biopsy Services
    - Cat III 0042T to Cat I-CT Angiography-Head & Neck and Cerebral Perfusion
    - Colon Motility Services
    - Code Set Maintenance
    - Modifier 95 Reporting Instructions

- CPT Ad Hoc Workgroups
  - Tumor Genomics Neoplastic Targeted Genomic Sequencing Procedures (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 two subgroups of the GSP Workgroup, Subgroup A and Subgroup B, submitted CCAs for the May Panel meeting. Subgroup A's CCA is Tab 30-GSP-Carrier Genetic Testing, which proposes revisions to codes 81412 and 81443 for carrier genetic testing procedures (WITHDRAWN). Subgroup B's CCA is Tab 31-GSP-Hereditary Cancer Disorders, which proposes changes to reporting of testing for hereditary breast and colon cancer-related and neuroendocrine tumor-related disorders, and for hereditary cancer predisposition.

  - Maternity Care Services Workgroup
    - Co-Chairs: Padma Gulur, MD and Timothy L. Swan, MD
    - Workgroup Charge: The Workgroup will assess the current practice of Maternity Care including antepartum care, labor management, delivery, and postpartum services to bring forth a Code Change Application with suggested changes to existing codes as well as proposed new codes which reflect the current practice of medicine while aligning to the rules, guidelines, and conventions of the current CPT code set, while meeting the needs of all stakeholders.
    - The workgroup shall conduct its first virtual meeting on April 29th and an in-person meeting is planned during the Panel meeting on May 8th in Loews Hotel Chicago.

- Digital Medicine Coding Committee (DMCC)
  - Co-Chairs: Richard Frank, MD, PhD and Mark Synovec, MD
  - Workgroup Charge: The charge of the DMCC is to respond to requests from the Panel and to support the Panel on coding issues that involve or may include a digital medicine and/or an artificial intelligence component by providing or obtaining expertise or advice on a specific subject matter. At all times, the Panel shall have the sole authority to create, revise and update codes, descriptions, and applicable guidelines for appropriate CPT coding.
  - The workgroup conducted its first virtual meeting on April 11th with an in-person meeting planned during the Panel meeting on May 8th at Loews Hotel Chicago.

- Upcoming CPT Editorial Panel Meetings
  - The next Panel meeting is May 9-11, 2024 (Thursday-Saturday) – Chicago
  - The next application submission deadline is June 12, 2024, for the September 2024 CPT Editorial Panel meeting.

VI. Centers for Medicare & Medicaid Services Update

Gift Tee, HAPG Deputy Director, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the CY 2024 Medicare Physician Payment Schedule (MFS) Final Rule.

- CMS 2024 Final Rule
  - On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes policy changes for Medicare payments under the Physician Payment Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2024.
  - Some of the topics covered in the final rule include:
    - CY 2024 PFS Ratesetting and Conversion Factor
    - Evaluation and Management Services
    - Behavioral Health Services
    - Dental and Oral Health Services
    - Telehealth Services
    - Caregiver Training Services
    - Social Determinations of Health (SDOH) Risk Assessment
    - Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

- Consolidated Appropriations Act (CAA), 2024
  - On March 9, 2024, President Biden signed the Consolidated Appropriations Act, 2024, which included a 2.93 percent update to the CY 2024 Conversion Factor (CF) for dates of service March 9 through December 31, 2024. This replaces the 1.25 percent update provided by the Consolidated Appropriations Act, 2023, therefore the CY 2024 CF for dates of service January 1 through March 8, 2024, is $32.74.
  - CMS has implemented the new legislation by adjusting the CY 2023 CF of $33.07 by 2.93 percent and the budget neutrality adjustment for a CY 2024 CF of $33.29 for dates of service March 9 through December 31. CMS has released updated payment files, including the MPFS and associated abstract files, the Ambulatory Surgical Center (ASC) FS, and Anesthesia file.

  - The increases in payment schedules are exempt from budget neutrality requirements and would not factor into any determinations of payment schedule amounts in future years.

- CY 2025 Physician Payment Schedule (PFS) Rulemaking Updates/Other Updates
  - CMS is actively working on CY 2025 PFS rulemaking.
  - CMS is developing sub-regulatory guidance, including Medicare Learning Network (MLN) and Frequently Asked Questions (FAQs) Material for certain policies finalized for CY 2024.

- Mr. Tee addressed questions from attendees:
  - Mr. Tee emphasized Ms. Smith's comments related to the AMA effort on the PPI Survey and that CMS will review the data when received and other data as it considers how to update inputs to the PFS rates calculation process. He encouraged participation in the survey to inform the data collection effort. Mr. Tee also thanked AMA staff for their contributions on the survey effort and all collaborative efforts with CMS.

VII. Contractor Medical Director Update

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

- New Coverage – 2024 Physician Final Rule
  - Change Request (CR) 13452
    - Caregiver Training
    - Community Health Integration (CHI) services
    - Marriage and Family Therapist (MFT) and Mental Health Counselor (MHC) enrollment
    - Principal Illness Navigation (PIN) services
    - Psychotherapy for Crisis
    - Social Determinants of Health (SDOH)

- Caregiver Training
  - Physician, nonphysician practitioner, or therapist (physical, occupational or speech language pathologist)
  - Patient presence not required
  - CPT 96202 (group; 60 mins.); add on +96203 (plus 30 mins.)
  - 97550, 97551, 97552 (include activities of daily living)
    - Billed by outpatient therapists requires modifier KX
    - Plan of Care (POC) modifiers – GP, GN, or GO
    - Not allowed via telehealth

- Community Health Integration (CHI) Services
  - Community health workers involved in patient treatment
    - May be interdisciplinary team
  - CHI initiating visit – could be from annual wellness visit (AWV) or other Evaluation and Management (E/M)
    - Capture patient's health-related social needs impacting care
    - Consent from patient required and provide continuing patient care
    - Emergency room visits typically will not qualify

  - HCPCS G0019 – CHI services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month
  - +G0022 – each additional 30 minutes per calendar month

- Marriage/Family Therapists (MFT) and Mental Health Counselors (MHC) Enrollment and Billing
  - Expanding behavioral and mental health - January 1, 2024
    - MFT and MHC
      - Includes alcohol and drug addiction counselors if meets state laws
      - Performed at least two years or 3,000 hours of post master's degree clinical supervised experience; state licensed or certified as MHC or MFT
    - Reimbursed at 75 percent of payment schedule
      - Equivalent to Licensed Clinical Social Worker (LCSW)
  - Upcoming MFT and MHC enrollment webinar – February 7
  - CMS FAQ

- Principal Illness Navigation (PIN) Services
  - CR 13452 Medicare Physician Payment Schedule Final Rule
  - Person-centered planning, promote patient self-advocacy, and facilitating access to community- based resources
    - Cancer treatment and other high-risk, serious illness navigation
    - Expected three-month duration
      - Includes severe mental illness and substance use disorder
  - No telehealth coding
  - Billing provider initiates during E/M visit, AWV, psychiatric diagnostic evaluation, or Health Behavior Assessment and Intervention (HBAI) services
    - Develops treatment plan
  - Auxiliary staff (patient navigators or peer support specialists) involved
    - Under general supervision for this care management
    - Read more: SAMHSA January 2024 - Consumer Guide: How Can a Peer Specialist Support My Recovery From Problematic Substance Use? For People Seeking Recovery
  - G0023 – Principal illness navigation services by certified or trained auxiliary personnel under direction of physician or other practitioner, including patient navigator; 60 minutes per calendar month
    - +G0024 – each additional 30 minutes per calendar month
  - G0140 – Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month
  - +G0146 – each additional 30 minutes per calendar month

- Psychotherapy for Crisis
  - Psychotherapy for crisis services for patients in high distress with life-threatening, complex problems requiring immediate attention
  - Psychotherapy for crisis includes:
    - Providing urgent assessment and history of crisis state
    - Performing mental status exam and psychotherapy
    - Mobilizing resources to defuse crisis and restore safety
    - Using interventions to minimize potential for psychological trauma

  - Letters sent to all providers October 2023
  - CMS Psychotherapy for Crisis
  - G0017 – Psychotherapy for crisis furnished in applicable site of service (any place of service with non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes
  - +G0018 – each additional 30 minutes (add-on code)
  - Applicable non-facility settings
    - Fee amount based on 150 percent of CPT codes 90839 and 90840
    - Non-facility settings outside of the office setting, including home or mobile unit

- Social Determinants of Health (SDOH) Risk Assessment
  - New code G0136
    - Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes
  - May provide with evaluation and management, behavioral health, or annual wellness visits
    - Allowed every six months, when need identified
    - Patient cost share – co-pay and unmet deductible
  - Have reason to believe patient has unmet SDOH
    - Discuss assessment findings with patient

- Telehealth Place of Service (POS) – Started January 2024
  - POS 02 – Telehealth to indicate you provided the billed service as a professional telehealth service, when the originating beneficiary site is other than the patient's home – no modifier
  - POS 10 – Telehealth for services when patient is in their home – no modifier
  - Exceptions:
    - For outpatient therapy telehealth services, by a PT, OT, or SLP, continue to bill with their actual POS (e.g., office 11), as if patient was seen at their site and append the modifier '95', rather than telehealth POS code
    - For outpatient hospital clinicians, POS on-campus (22) and off-campus (19) for services when patient is in their home – append modifier '95'
  - MLN901705 – Telehealth Services

- Telehealth Platform – HIPAA Compliant
  - Must be HIPAA approved video and/or audio technology
    - Non-public facing remote communication
      - Examples: Zoom or Facetime (not live) set up with secured "one-time use" password
    - Non-acceptable public-facing platforms
      - Check with internal compliance or website below
    - Office for Civil Rights (OCR) monitors HIPAA regulations
      - Notification of Enforcement Discretion for Telehealth Remote Communications

- Local Coverage Determinations (LCD) Updates
  - Updated LCDs
    - Trigger Point Injections (TPI) – April 1, 2024
  - Draft LCD – Minimally Invasive Arthrodesis of Sacroiliac Joint
    - Comment period: March 28 – May 11, 2024

  - LCD comment period closed March 2, 2024
    - Cervical Fusion
    - Facet Joint Interventions for Pain
  - Noridian Proposed LCDs Report on CMS Website

- Billing and Coding Articles Recently Updated
  - Minimal Residual Disease Testing for Hematologic Cancers
  - Trigger Point Injections

- Pending New LCD Requests
  - Kidney Neoplasm
  - Tumor Immune Microenvironment
  - Renasight Kidney Gene
  - Plasma mcfDNA sequencing
  - AVISE Lupus
  - BluePrint® Assay
  - The NIS4 Test
  - The OGM-DxTM HemeOne (Z03MR)
  - Multi-gene molecular profiling using HDPCR (High-Definition PCR)

- Molecular Diagnostic Services Program (MOLDX)
  - New LCD requests in progress
  - Prelude Dx
  - Hereditary transthyretin amyloidosis (hATTR)
  - Heritable thoracic aortic disease (HTAD)

- Dental
  - No new information
  - Still evaluating claims data
  - All Medicare Administrative Contractors (MACs) report a large number of beneficiary claims

- Artificial Intelligence
  - Nothing new to report
  - A number of procedures and evaluations use this technology
  - Evaluating the data regarding how it is being billed

- Behavioral Health Links
  - Behavioral Health Integration (BHI) Services
    - Incorporates primary care with behavioral health
    - Psychiatric Collaborative Care Model (CoCM)
    - General BHI
  - CMS Psychotherapy for Crisis
  - CMS Opioid Use Disorder Screening & Treatment

- Social Determination of Health (SDOH) Resources
  - CMS Framework for Health Equity 2022-2032
  - CMS Office of Minority Health
  - CMS Improving Collection of SDOH Data Infographic
  - CMS Z-Codes Infographic

- CDC Social Determinants of Health (SDOH) Maps- Socioenvironmental: Poverty

- Doctor Lawrence addressed questions from attendees:
  - A RUC member inquired about the implementation of HCPCS code G2211 and the current utilization data given the impact on the conversion factor. Mr. Tee responded to this question and offered that CMS will share information as soon as they are able. Doctor Lawrence noted that CMDs are seeing some utilization but possibly not what was initially expected, and this is likely due to confusion of appropriate reporting. The RUC member asked a follow up question regarding if the utilization is in fact not as expected, does CMS plan to update the conversation factor. Mr. Tee acknowledged the importance of the question, and that CMS will follow what they have traditionally done via rulemaking.
  - Another RUC member followed up with a question related to local MACs denying claims for G2211. The member noted that MACs understand verbal instructions from CMS that it is in fact appropriate to use, however, they have not received official written instructions and cannot proceed until that information is received. Mr. Tee responded that getting appropriate coding guidance published for G2211 is a priority and CMS hopes to do so sooner rather than later.
  - A RUC member encouraged CMS to continue tracking SDOH data so that information can be acted upon. Doctor Lawrence responded that this data is being tracked and further education is provided based on the data.

VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy on Medicare Physician Payment Reform, the Change Healthcare Cyberattack, and Telehealth.

- **2024 Medicare Physician Payment**

- Medicare Conversion Factor (CF)
  - On March 9, 2024, President Biden signed the Consolidated Appropriations Act, 2024, which included a 2.93 percent update to the CY 2024 Physician Payment Schedule Conversion Factor for dates of service March 9 through Dec. 31, 2024. This replaces the 1.25 percent update provided by the Consolidated Appropriations Act, 2023.

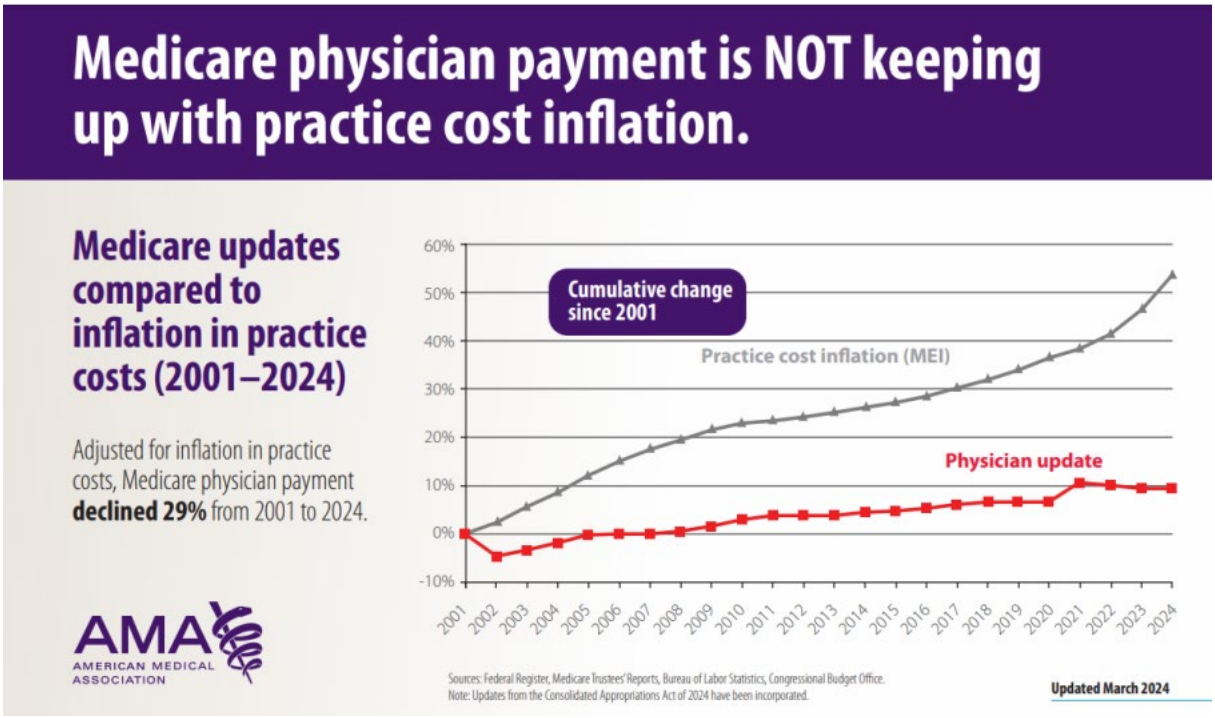
Year	Conversion Factor	Percentage Change
2023	$33.8872	-2.0%
Jan. 1-Mar. 8, 2024	$32.7442	-3.37%
Mar. 9-Dec. 31, 2024	$33.2875	1.66%

- AMA: Patients, physicians continue to endure Medicare cuts
  - "While we appreciate the challenges Congress confronted when drafting the current 2024 appropriations package, we are extremely disappointed that about half of the 2024 Medicare physician payment cuts will be allowed to continue. There were many opportunities and widespread support to block the 3.37 percent Medicare cuts for physician services that took place Jan. 1, but in the end Congress opted to reverse only 1.68 of the 3.37 percentage payment reduction required by the Medicare Schedule Schedule. The need to stop the annual cycle of pay cuts and patches and enact permanent

Medicare payment reforms could not be more clear." - Jesse M. Ehrenfeld, MD, MPH, President, American Medical Association

- **Medicare Physician Payment Reform**

- Organized Medicine's Long-Term Solutions
  - Annual, Automatic Inflation-Based Payment Updates
  - Limit Frequent, Unpredictable Redistributions Caused by Budget Neutrality
  - Prevent Unsustainable Merit-based Incentive Payment System (MIPS) Penalties, Reduce Burden, and Increase Relevance
  - Expand Alternate Payment Model (APM) Development and Physician Participation
  - Characteristics of a Rational Medicare Payment System Principles



- HR 2474, the Strengthening Medicare for Patients and Providers Act
  - Bipartisan legislation to replace current law updates (e.g., -2.93% in 2025) with updates based on the increase in the Medicare Economic Index (MEI)
  - We have been working very hard to increase the number of cosponsors from both parties. As of this month, there are 130 cosponsors.
  - There is growing recognition in Congress of the need for physician payment rates to reflect inflation in their costs, but it's critically important for physicians to keep pressing their Members of Congress on this issue.
  - Let them know the financial pressures you face and how important this is, and how the lack of an update affects your patients' care.

- MedPAC Report to Congress: Tie Physician Payment to MEI
  - For the second year, MedPAC recognized that physician pay has not kept up with the cost of practicing medicine and recommended a permanent update

  - AMA statement: "The AMA has long championed this move and appreciates MedPAC's acknowledgement that the current Medicare physician payment system is inadequate—a critical first step toward the larger, necessary work of reforming Medicare to make it more rational and serve patients better."

- HR 6371, Provider Reimbursement Stability Act of 2023
  - Updating the Budget Neutrality Threshold
    - Amends the Social Security Act to adjust the budget neutrality threshold for Medicare physician payments.
    - The threshold, initially set at $20,000,000 until 2024, will be raised to $53,000,000 in 2025 and will adjust annually thereafter based on the MEI.
  - Corrections for Overestimates and Underestimates in Utilization
    - Adds provisions to correct payments retrospectively if the estimated service utilization differs significantly from the actual service utilization.
    - The Secretary of the Department of Health and Human Services (HHS) is required to make these corrections by September 1 of the year following the adjustment application year. The correction period for adjustments is specified as the second year following the adjustment application year.
  - Timely Updates to Direct Costs Used to Calculate Practice Expense RVUs
    - Mandates regular updates (at least every five years) to the direct cost inputs used to calculate practice expense RVUs, such as clinical staff wages, medical supplies, and equipment prices.
    - The Secretary must consult with relevant stakeholders, including physician specialty societies, during these updates.
  - Limitation on Year-to-Year Conversion Factor Variance
    - Introduces a cap on the annual variation in Medicare conversion factors (the base amount used to determine physician payments) to a maximum of 2.5% from one year to the next, whether increasing or decreasing.
    - Also provides specific rules for transition years when new conversion factors are introduced under the Medicare program.

- S 3503/ HR 5013, the Value in Health Care (VALUE) Act
  - Value-based APMs have a successful track record of improving health outcomes and reducing costs.
  - The VALUE Act would extend the 5 percent APM bonus and maintain the 50 percent revenue threshold for two years.
  - This bipartisan legislation would help ensure that physicians in communities across the country have meaningful incentives to participate in APMs that will deliver high quality, coordinated health care for patients.

- Senate Finance Committee Hearing "Bolstering Chronic Care Through Medicare Physician Payment"
  - AMA Statement for the Record: Preserve patient access to care through physician financial stability through annual inflation-based updates, reforms to budget neutrality redistributions, reductions in unfair MIPS penalty and undue burden, and expanded APM opportunities
  - Sign-on letter in support of H.R. 2829, the Chronic Care Management Improvement Act of 2023, which would eliminate patient cost-sharing for Chronic Care Management (CCM) services, a significant barrier that has hindered the widespread adoption of these essential services

- Agreement that current system is not keeping pace with inflation and driving significant administrative burden. Focus on budget neutrality reforms, APMs as solution. Criticisms of Fee-for-Service (FFS) Medicare.

- Your Voice Matters
  - Share your story about how Medicare payment cuts have affected you and your patients at https://fixmedicarenow.org/share-yourstory
  - Use this patient reception area flyer to get patients involved

  - If you don't already, subscribe to the bi-weekly AMA Advocacy Update at https://www.ama-assn.org/health-care-advocacy/advocacy-update

- **Change Health Care Cyberattack**

- Practices Continue to Face Dire Consequences
  - 80% have lost revenue from unpaid claims
  - 85% have had to commit additional staff time/resources to complete revenue cycle tasks
  - 55% of respondents had to use personal funds to cover practice expenses
  - "I am now going to get acquired by a hospital system because I just can't bear the financial responsibility."
  - "SOOOO much overtime dealing with this. Cost me additional $50,000 in payroll."
  - "…patients are suffering from delays in medical care and increased medical bills because alternative options could not be given with an appropriate estimate because of this attack."
  - Based on an informal survey from 3/26 and 4/3 with 1,400 respondents

- AMA Advocacy
  - AMA Statement for the Record: Committee on Energy and Commerce Subcommittee on Health "Examining Health Sector Cybersecurity in the Wake of the Change Healthcare Attack"
  - The AMA is continuing to call for:
    - Suspension of all prior authorization, quality reporting and similar administrative requirements
    - A broader focus on restoring function for independent physician practices
    - A prohibition on retroactive denials based on eligibility or lack of utilization management approval

        - Waivers for timely filing deadlines for claims and appeals
    - Latest information: https://www.ama-assn.org/practicemanagement/sustainability/change-healthcare-cyber-outage

- **Telehealth**

- Ways & Means Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities
    - A hearing held on March 12, 2024 focused attention on the benefits of the technological advances that have contributed to enhanced care and access for patients in rural and underserved communities, while recognizing that the Medicare telehealth and Hospital at Home flexibilities are both set to expire.
    - Overarching topics included expanding care delivery at home, remote patient monitoring to treat chronic disease, and the overall extension of COVID-19 Medicare telehealth policies and the need to need to permanently extend Medicare telehealth coverage by passing legislation such as CONNECT for Health Act and the Telehealth Modernization Act of 2024.
    - Concerns raised by some Members about telehealth fraud, overutilization, and need for "guardrails" in legislation extending telehealth.

- Ways & Means Hearing: Acute Care at Home
    - AMA joined many Hospital-at-Home (HaH) participants in sign-on letters to Congressional Leadership calling for at least a 5-year extension of current HaH waiver that began during COVID Public Health Emergency (PHE)
        - >300 hospitals across 129 health systems in 37 states participating
        - HaH research has found patients and families prefer HaH, which delivers excellent clinical outcomes, reduces adverse events, lowers caregiver stress
        - Extension will allow continued work on logistics, supply chain, workforce
        - Treating patients at home who can be and want to frees up hospital capacity for patients who need to be in the hospital inpatient unit

- Ways & Means Hearing: AMA Statement for the Record (SFR)
    - AMA Statement for the Record reinforces HaH extension recommendation
    - AMA SFR supports CONNECT, opposes in-person requirement, shares AMA reports on the state of health at home models, future of health case study with Atrium Health, payment and delivery in rural hospitals.
    - AMA SFR also shares reports from government agencies such as Office of Inspector General, U.S. Department of Health and Human Services (HHS OIG), Assistant Secretary for Planning and Evaluation (ASPE) and the Agency for Healthcare Research and Quality (AHRQ) highlighting that telehealth does not lead to increased fraud, drive overutilization, or increase Medicare spending.

- Ms. Hananoki addressed questions from attendees:
    - A RUC member inquired about the positive outcomes related to the conversion factor (CF) that were discussed throughout the Washington Report. Ms. Hananoki responded that the update to the CF from Congress was 2.93%. However, this number is counterbalanced by the budget neutrality estimate and replaces the 1.25 percent update provided by the Consolidated Appropriations Act, 2023 which was in place until March 9th, 2024. Please refer to slide 3 in Ms. Hananoki's presentation on the RUC collaboration site to see that the cut ends up being just less than 2%. The member asked a follow up

question regarding if these changes will be retroactive to January 1. Ms. Hananoki responded that this change is not retroactive, however, Congress offered a slightly higher update at 2.93% to account for the lost time during the first part of the calendar year.

- A RUC member stated that on January 2, 1992, at the implementation of the RBRVS, the CF was $31, however, adjusted for inflation that is $71 dollars today. Further adding that there is a noticeable difference of 57% between the two and that should be considered moving forward.
- Another RUC member highlighted several items for consideration regarding increasing inflation and that labor costs are unequivocally going up and that is ultimately impacting the health care industry as consolidation occurs and physicians are working for large health systems and corporations. The member emphasized that change is needed to keep up with inflation. Ms. Hananoki agreed and encouraged RUC members to relay this information to their representatives in Congress.
- A RUC member inquired about whether the AMA has looked at what percentage of the positive updates to Merit-based Incentive Payment System (MIPS) are going to private equity backed groups. Ms. Hananoki responded that the delay in MIPS data is problematic and the most recent year of accessible data is from 2021. The AMA is awaiting 2022 data, however, it is in flux because of COVID and the flexibilities that remained in place throughout the 2022 calendar year. Ms. Hananoki continued that there have been studies, specifically from the Government Accountability Office (GAO), that do demonstrate that incentive payments in MIPS are going to integrated healthcare systems and that they are not making their way to small independent practices and rural practices which is going to continue to be a problem. Further, another study identified that it is $12,800 per physician, per year to participate in MIPS based on 2019 data and as most physicians know, the MIPS requirements have become more onerous since then. Ms. Hananoki offered reassurance that the AMA is in talks with the entire house of medicine in addition to discussions with CMS on what the AMA would like to see in the CY 2025 Proposed Rule and statutory changes to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)that would be required as well to see significant positive change.
- A RUC advisor inquired about the AMA strategy related to the recent Federal Trade Commission (FTC) actions on eliminating most noncompete agreements. Ms. Hananoki said that the AMA has been watching this closely and that they will continue to confer over the best coordinated strategy moving forward.

IX. Relative Value Recommendations for CPT 2026

<u>Endovascular Therapy with Imaging (Tab 4)</u>
Curtis Anderson, MD (OEIS), Robert Kennedy, MD (SIR), Minhajuddin S. Khaja, MD (SIR), Andrew Moriarity, MD (ACR), Jacob Ormsby, MD (ASNR), Clemens Schirmer, MD (CNS), Henry Woo, MD (AANS)

In April 2022, the Relativity Assessment Workgroup (RAW) identified services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in 2020 Medicare claims data and/or contained at least one ZZZ global service were removed. The RAW requested action plans to determine if specific code bundling solutions should occur for 61624/75894 and 61624/75898. In September 2022, the RUC referred this issue to CPT for a code bundling solution. CPT code 61626 was added to the proposal for bundling. In February 2024, the CPT Editorial Panel revised codes 61624 and 61626 to include all associated radiological supervision and interpretation (RS&I), intra-procedural guidance and road-mapping, and

imaging necessary to document completion of the procedure, in addition to instructional parentheticals regarding diagnostic radiology vascular procedures. The code family was surveyed for the April 2024 RUC meeting.

Compelling Evidence
The RUC reviewed and concurred that there is compelling evidence to support a change in physician work for CPT codes 61624 and 61626 based on evidence that (1) incorrect assumptions were made in the previous valuation of the service and (2) physician work has increased due to changes in technique, knowledge/technology, and patient population. CPT codes 61624 and 61626 were created for CPT 1992 and the original physician work value was established by the Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA), and may have been a gap fill for a code for which Harvard did not provide a value, thus flawed methodology was used in the previous valuation.

The RUC discussed compelling evidence about changes in technology and patient population for codes 61624 and 61626. Changes to the devices used for these procedures removes the lower intensity time components of the procedure by providing near-instantaneous deployment of individual coils. This is in contrast to first-generation detachable coils used 20+ years ago that required waiting for the successful detachment, typically several minutes per coil, and increasing time as the case progressed due to the increased dispersion of the electric current in the increasingly dense coil mass. Current technology has resulted in a more intense procedure due to eliminating low intensity time intervals, resulting in less time, but time that is all intense. New technology allows for increasingly complex procedures that would have required an open procedure or no procedure for patients unable to undergo an open procedure and has allowed a higher level of acuity since the codes were established in 1992 for patients undergoing endovascular aneurysm treatment.

The RUC also discussed changes to patients undergoing intracranial aneurysms who are treated in one of two ways: surgical treatments such as microsurgical clipping with or without bypass techniques, and endovascular methods such as coiling, balloon- or stent-assisted coiling, or intravascular flow diversion and intravascular flow disruption. In 1997, about 20% of intracranial aneurysms underwent endovascular embolization and the remainder of aneurysms underwent open surgical clipping due to the challenges involved in performing the service using the endovascular approach. Over the last decade, this proportion has been distinctly reversed with over 75% of intracranial aneurysms undergoing endovascular embolization with many more complex pathologies within reach of this treatment modality (i.e., more complex and intense procedure). Treatment techniques and management guidelines for intracranial aneurysms have been continually developing, and this rapid development has altered treatment decision-making for physicians. The physician must consider several crucial factors including age, past medical history, and comorbidities to determine the patient's ability to tolerate a specific treatment. For example, a young patient with a ruptured intracranial aneurysm may be a good candidate for open surgery with better prospects of a long-term durable result and with lower rates of rebleeding. In contrast, an elderly patient with comorbidities, a ruptured intracranial aneurysm and a diffusely swollen and friable brain, endovascular coil embolization may be favored over open surgery. As surgical indications, techniques, and technology have advanced, more intense and complex endovascular treatments are being performed to save and extend the lives of patients not previously considered candidates for treatment.

In addition, the RUC reviewed and concurred that there is compelling evidence to support a change in physician work for CPT codes 75894 and 75898 based on evidence that (1) incorrect assumptions were made in the previous valuation of the service and (2) physician work has increased due to changes in patient population and dominant specialty. The RUC noted that CPT code 75894 has never been RUC surveyed, thus the current times are CMS/Other and not valid for comparison. Previously,

there was no vignette developed for this service, thus it could be contended that the current values do not appropriately reflect the use of this code. CPT code 75898 was included when CPT codes 37211-37214 were reviewed at the April 2012 RUC meeting, however, code 75898 was not surveyed at that time and the RUC recommended contractor pricing for this service (and 75896). *The CMS/Other time source makes it impossible to compare the current numbers to the times and values derived from the survey results.*

Medicare claims data from 2022 indicates that CPT code 75894 was reported 87.7% of the time with CPT code 61624 and 75898 was reported 82.5% with 61624. At the February 2024 CPT meeting, code changes made to codes 61624 and 61626 resulted in the RS&I services (75894 and 75898) now being bundled with codes 61624 and 61626. This bundling will result in a different patient population, one expected to be predominantly serviced by interventional radiology, not neurosurgery.

The RUC concurred that there is compelling evidence that the physician work for these services has changed due to flawed methodology in the initial valuation and due to changes in technique, knowledge/technology, and patient population.

61624 ***Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; central nervous system (intracranial, spinal cord)***
The RUC reviewed the survey results from 93 physicians and determined that the survey 25th percentile work RVU of 20.00 appropriately accounts for the physician work involved in this service and falls below the current total value for 61624 and bundled codes 75894 and 75898. The RUC recommends the following physician time components: 40 minutes pre-service evaluation, 8 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, 33 minutes immediate post-service time, and 246 minutes total time.

The RUC agreed with the selection of pre-service time package 4-FAC *Difficult Patient/Difficult Procedure.* The RUC determined that 40 minutes (standard package 4 time) correctly accounted for pre-service evaluation and that 8 minutes (5 minutes more than package 4 time) accounted for the additional supervision of positioning of the patient, imaging equipment, and anesthesia lines to allow physician access to the operative area. The RUC reduced the survey immediate post-service time to match the standard package 9B time of 33 minutes. The RUC clarified that the typical patient is typically treated within 12-72 hours of presenting to the emergency department.

To justify a work RVU of 20.00, the RUC compared the surveyed code to the top key reference service code 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 25.00, 180 minutes intra-service time and 276 minutes total time) and noted that the surveyed code has less intra-service and total time and is therefore appropriately valued lower than the reference service. The RUC also compared CPT code 61624 to the second key reference service code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) and noted that the surveyed code has more intra-service and total time and is therefore appropriately valued higher than the reference service. The RUC further noted that the reference codes have different patient acuity than the surveyed code.

The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period that include a similar amount of physician work, so the pool of

potential reference codes was severely limited. For additional support, the RUC compared CPT code 61624 to MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes intra-service time and 166 minutes total time). The RUC noted that although the MPC code requires significantly less intra-service and total time, the intensity (IWPUT) was similar for both codes that represent embolization procedures. The RUC concluded that CPT code 61624 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 20.00 for CPT code 61624.**

61626 ***Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)***

The RUC reviewed the survey results from 122 physicians and determined that the survey 25th percentile work RVU of 15.31 appropriately accounts for the physician work involved in this service and falls below the current value of the code. The RUC recommends the following physician time components: 40 minutes pre-service evaluation, 8 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, and 30 minutes immediate post-service time, 213 minutes total time.

The RUC noted that pre-time package 4-FAC *Difficult Patient/Difficult Procedure* was selected with the following modifications:

- Evaluation time: Standard package time of 40 minutes.
- Positioning time: Standard package time of 3 minutes for supine positioning plus an additional 5 minutes (total = 8 minutes) to account for positioning the patient, imaging equipment, and anesthesia lines to allow physician access to the operative area.
- Scrub, dress, wait time: Reduced by 5 minutes (total time = 15 minutes) to be consistent with the survey median.

Also, immediate post-service time package 9B was reduced by 3 minutes (total time = 30 minutes) to be consistent with the survey median.

To justify a work RVU of 15.31, the RUC compared the surveyed code to the top key reference service MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes intra-service time and 166 minutes total time) and noted that the surveyed code has more intra-service and total time and is therefore appropriately valued higher than the reference service. The RUC also compared CPT code 61626 to the second key reference service code 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 25.00, 180 minutes intra-service time and 276 minutes total time) and noted that the surveyed code has less intra-service and total time and is therefore appropriately valued lower than the reference service.

For additional support, the RUC compared CPT code 61626 to MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes intra-

service time and 166 minutes total time) and noted again that the comparator code requires significantly less intra-service and total time and is appropriately valued lower than the surveyed code. The RUC reiterated that many other MPC codes have a 000-day global assignment, but none that are clinically similar to the physician work required of 61626.

Finally, the RUC noted that the surveyed code is appropriately bracketed by comparator codes 33901 *Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral* (work RVU = 14.50, 120 minutes intra-service time and 236 minutes total time) and 33903 *Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral* (work RVU = 16.50, 120 minutes intra-service time and 241 minutes total time). The RUC concluded that CPT code 61626 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 15.31 for CPT code 61626.**

75894 ***Transcatheter therapy, embolization, any method, radiological supervision and interpretation***

The RUC reviewed the survey results from 37 radiologists and determined that the survey 25th percentile work RVU of 2.25 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components as supported by the survey: 20 minutes pre-service evaluation time, 60 minutes intra-service time, and 20 minutes immediate post-service time, 100 minutes total time. The RUC acknowledged the anticipated low utilization of the surveyed code and recognized the atypical workflow where the surgeon is performing the procedure and the radiologist is performing the RS&I concurrently, but separately, outside of the procedure room.

To justify a work RVU of 2.25, the RUC compared the surveyed code to the top key reference service code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 25 minutes intra-service time and 35 minutes total time) and noted that the surveyed code requires significantly more intra-service and total time and is therefore appropriately valued higher than the reference service. The surveyed code was selected as more intense/complex overall than the key reference service code 74175 by 95% of survey respondents. The RUC also compared the surveyed code to the second key reference service code 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.81, 25 minutes intra-service time and 35 minutes total time) and noted again that the surveyed code has significantly more intra-service and total time and is therefore appropriately valued higher than the key reference service.

For additional support, the RUC noted that the surveyed code is appropriately bracketed by MPC codes 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour* (work RVU = 1.86, 60 minutes intra-service time and 70 minutes total time) and 36455 *Exchange transfusion, blood; other than newborn* (work RVU = 2.43, 60 minutes intra-service time and 120 minutes total time). The RUC concluded that CPT code 75894 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.25 for CPT code 75894.**

75898 ***Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis***
The RUC reviewed the survey results from 37 radiologists and determined that the survey 25th percentile work RVU of 1.85 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components as supported by the survey: 15 minutes pre-service evaluation time, 45 minutes intra-service time, and 17 minutes immediate post-service time, 77 minutes total time. The RUC acknowledged the anticipated low utilization of the surveyed code.

To justify a work RVU of 1.85, the RUC compared the surveyed code to both the key reference service codes 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 25 minutes intra-service time and 35 minutes total time) and 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.81, 25 minutes intra-service time and 35 minutes total time) and noted that the surveyed code requires more intra-service and total time and is therefore appropriately valued slightly higher than the reference services.

For additional support, the RUC noted that the surveyed code is appropriately bracketed by MPC codes 94011 *Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age* (work RVU = 1.75, 30 minutes intra-service and 70 minutes total time) and 99239 *Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter* (work RVU = 2.15, 45 minutes intra-service time and 64 minutes total time). The RUC concluded that CPT code 75898 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.85 for CPT code 75898.**

Practice Expense
The Practice Expense (PE) Subcommittee concurred with the specialty societies that there is compelling evidence to support an increase over the aggregate current cost for clinical activities, supplies and equipment. Specifically, based upon evidence that there has been a change in specialties, with a consequent change in the clinical staff types, and a change in technology which now allows for the service to be performed in a non-facility setting. Also, an error in the previous valuation applies because codes 75894 and 75898 were previously contractor-priced and therefore never had direct PE inputs. CPT codes 75894 and 75898 recommend the use of L041A *Vascular Interventional Technologist* rather than L041B *Radiologic Technologist* as it is expected the utilization will transition to radiology services, specifically interventional radiology, thereby supporting clinical staff support from a vascular interventional technologist, rather than the radiologic technologist as defined within the reference codes.

The PE Subcommittee discussed the request for non-facility inputs for CPT code 61626 and noted that the typical patient for the non-facility setting is described in a separate vignette in the PE SOR. Per 2022 claims data, 61624 and 61626 are performed in the facility setting almost 100% of the time, yet the Subcommittee agreed to allocate direct inputs in the non-facility setting for the minority number of anticipated patients, noting that the typical patient is similar to the facility-setting but with less severity. CPT code 61626 recommends use of L041A *Vascular Interventional Technologist* and L037D *RN/LPN/MTA* blend. The Subcommittee made a single amendment to the inputs for 61626 to remove ED032 *printer, laser, paper*.

The PE Subcommittee questioned the existing high-cost supply input, SF058 *LC Beads (2mL vial)*, as recommended with a quantity of two. It was noted that the number of beads is based on stasis of blood flow and even though the patient is not as urgent as in the facility, the tissue level embolization

is essentially the same procedure and is a particle embolization which uses beads, not coils. **The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes.**

For CPT codes 61624 and 61626, the PE Subcommittee accepted the 3 minutes for CA001 *Complete pre-service diagnostic and referral forms* but removed the 3 minutes for CA003 *Schedule space and equipment in facility light, exam*, noting that one 3-minute phone call would be accounted for in the pre-service period. It was acknowledged that this standard 3-minute phone call in the pre-service period would occur as part of the post-service work required for an emergency procedure in the facility setting where work that would typically occur in the pre-service period gets shunted to the post-service period because of the emergent nature of the procedure. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Do Not Use to Validate for Physician Work
The RUC recommends that CPT codes 75894 and 75898 should be flagged as **Do Not Use to Validate for Physician Work** due to the uncertainty regarding the vignette and who would perform the service and in what circumstances. The survey vignette was not found to be typical for 75898 (46%) and the percentage of survey respondents who found the vignette to be typical for 75894 was also low (54%).

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

<u>Dark Adaptation Diagnostic Screening and Services (Tab 5)</u>
Charles Fitzpatrick, OD (AOA), Ravi Parikh, MD (AAO), John Thompson, MD (ASRS)

In October 2020, CPT code 99284 was identified via the Harvard valued screen and surveyed and reviewed by the RUC in April 2021. At that time, the RUC recommended that this service be referred to CPT to editorially revise and include the word "diagnostic" in the code descriptor, which occurred at the May 2021 CPT meeting. The RUC placed 92284 on the New Technology list for follow-up review in two years due to the RUC's recognition that the proposed direct expense practice expense recommendation was recently replaced by emerging technology for administering the test. Following the RUC's review, CMS rejected the RUC-recommended work value of 0.14 RVU for 99284 and assigned a work value of 0.00 in 2023, indicating that the test was primarily performed for screening for macular degeneration despite the revised code descriptor. In September 2023, the specialty societies indicated, and the Relativity Assessment Workgroup (RAW) agreed, that this issue be referred to the February 2024 CPT meeting to differentiate between the diagnostic and screening tests before both codes are resurveyed for the RUC.

The specialty societies prepared and submitted a Category I Code Change Application to create CPT code 92288, which describes the screening test for retinal and optic nerve disease. CPT also added a parenthetical to 92284 to describe how the diagnostic dark adaptation test is conducted to identify patients with macular degeneration or inherited retinal diseases when they have symptomatic visual loss without any identifiable cause or clinical examination. An uptick in Medicare claims volume for CPT code 92284 may be attributable to the misreporting of that code when the screening test is performed, and this distinction from CPT will address the increased utilization as well as provide further clarification and coding direction. Further, a CPT Assistant article with coding guidance on correct reporting of these two services was also recommended by the CPT Editorial Panel. It is notable that both the diagnostic and screening test services in this code family describe bilateral

services and would only be reported once per patient. This code family was surveyed for the April 2024 RUC meeting.

Compelling Evidence
The specialty societies presented a rationale for compelling evidence to support a change in physician work for CPT code 92284 based on flawed methodology. First, when 99284 was last surveyed by the RUC in 2021, there was significant confusion from survey respondents and discussion from the RUC regarding whether this service was a diagnostic test for retinal disorders or a screening test for macular degeneration. Second, there was additional concern regarding the median survey intra-service time of 15 minutes for 92284 and whether this was an error in which survey respondents conflated physician time with clinical technician time in their estimates. The RUC recommended a work value of 0.14 with 3 minutes intra-service time and 5 minutes total time on the basis that the survey data was representative of a mix of both diagnostic and screening test experience and overestimated physician time. In 2023, CMS assigned a work value of 0.00 for 92284 under the assumption that the diagnostic test is done for screening purposes and/or might be included as part of an office or eye visit. At the April 2024 meeting, the RUC agreed with the specialty societies that dark adaptation testing is not included in either an evaluation and management office visit or an eye visit and that there is physician work involved in interpreting test results, whether it be a diagnostic test or screening.

92284 ***Diagnostic dark adaptation examination (eg, rod and cone sensitivities, rod-cone breakpoint), with interpretation and report***
The RUC reviewed the survey results from 35 optometrists and ophthalmologists and determined a work RVU of 0.32 appropriately accounted for the physician work involved with this service. The RUC recommends 1-minute pre-service evaluation time, 7 minutes intra-service time and 1-minute post-service time for a total time of 9 minutes. Based on the discussion at pre-facilitation, the RUC agreed with the specialty societies that the survey 25th percentile work RVU of 0.43 was too high of an estimation for the physician work involved with this procedure. Therefore, the specialty societies recommended that CPT code 92284 be valued based on a direct crosswalk to CPT code 92228 *Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral* (work RVU = 0.32 work RVU, 7 minutes intra-service time and 9 minutes total time), as both services require similar physician work to perform.

In reviewing the survey results, the specialty societies recommended decreasing both the survey median pre-service evaluation and immediate post-service times from 5 minutes down to 1 minute each but determined the survey median intra-service time of 7 minutes was appropriate for this service. In 2021, the survey median intra-service time was 15 minutes, which the specialty societies noted is an overestimation attributable to survey respondents' misunderstanding that only physician time should be counted in the time estimates; the RUC recommended 3 minutes of intra-service time. Based on the more recent survey with updated wording and clarification, the specialty societies determined the 4 additional minutes of intra-service time appropriately accounts for the work required to perform this service. After CPT code 92284 was revised for CPT 2026 before being resurveyed, the descriptor specifically describes bilateral diagnostic testing that requires interpretation of test validity and individual, separate rod and cone plots and rod/cone intercepts for each eye resulting in a large amount of data to consider with the dark adaptation results and many diagnostic possibilities for the physician to assess. It is important to note that this testing is conducted using a legacy tabletop instrument which is not automated and is supervised and operated by a clinical technician in attendance with the patient. The specialty societies further clarified that because this procedure is typically performed on the same day as an office or eye visit, a reduction in both pre-service evaluation and immediate post-service times is also appropriate. Including 1 minute of pre-service

evaluation time is necessary for explaining the nature and necessity of the diagnostic test to the patient, as well as determining a testing strategy. Additionally, 1 minute of immediate post-service time is necessary to enter the information into the medical record, sign the report, and add the findings to the referral report. The RUC agreed with all time modifications made by the specialty societies recognizing that an additional 4 minutes of intra-service work is required for this service and that the pre-service and post-service activities listed in the work descriptions are not part of the same-day office or eye visit and should be accounted for.

While survey respondents ranked the surveyed code identical in terms of overall intensity and complexity to the top two selected reference services, CPT codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2*) (work RVU = 0.50, 10 minutes intra-service time and 13 minutes total time) and 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time), the specialty societies determined that neither was an acceptable crosswalk to value the surveyed code. The intra-service time and work RVU of both reference services are significantly greater than CPT code 92284, and the RUC agreed that neither code would make an appropriate relative comparison.

The RUC concluded that CPT code 92284 be valued at a work RVU of 0.32 per a direct crosswalk to CPT code 92228 to more accurately reflect the physician work, time and intensity involved with this procedure in addition to maintaining rank order with the other services in this code family. For additional support, the RUC referenced MPC code 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time), which requires identical physician work and time to perform as the surveyed code, thus supporting the RUC recommended work RVU of 0.32. **The RUC recommends a work RVU of 0.32 for CPT code 92284.**

92288 ***Screening dark adaptation measurement (eg, rod recovery intercept time), with interpretation and report.***

The RUC reviewed the survey results from 30 optometrists and ophthalmologists and determined a work RVU of 0.17 appropriately accounted for the physician work involved with this service. The RUC recommends 1-minute pre-service evaluation time, 3 minutes intra-service time and 1-minute post-service time for a total time of 5 minutes. Based on the discussion at pre-facilitation, the RUC agreed with the specialty societies that the survey 25th percentile work RVU of 0.30 was too high of an estimation for the physician work involved with this procedure. Therefore, the specialty societies recommended that CPT code 92288 be valued based on a direct crosswalk to CPT code 73010 *Radiologic examination; scapula, complete* (work RVU = 0.17, 3 minutes intra-service time and 5 minutes total time), as both services require similar physician work to perform.

In reviewing the survey results, the specialty societies recommended decreasing the survey median pre-service evaluation, intra-service and immediate post-service times to more accurately reflect the physician work and time involved with this service. The specialty societies articulated that the survey median intra-service time of 6 minutes is too long for this service, as the screening test requires less data interpretation compared to the 7 minutes of intra-service time that are necessary for performing the diagnostic test. The specialty societies further clarified that because this procedure is typically performed on the same day as an office or eye visit, a reduction in both pre-service evaluation and immediate post-service times is also appropriate. Including 1 minute of pre-service evaluation time is necessary for explaining the nature of the screening test and the reason for performing it to the patient, as well as determining a testing strategy. Additionally, 1 minute of immediate post-service

time is necessary to enter the information into the medical record, sign the report, and add the findings to the referral report. The RUC agreed with all time modifications made by the specialty societies recognizing that 3 minutes of intra-service work is required for this service and that the pre-service and post-service activities listed in the work descriptions are not part of the same-day office or eye visit and should be accounted for.

While survey respondents ranked the surveyed code identical in terms of overall intensity and complexity to the top two selected reference services, CPT codes 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30, 7 minutes intra-service time and 10 minutes total time) and 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50, 10 minutes intra-service time and 13 minutes total time), the specialty societies determined that neither was an acceptable crosswalk to value the surveyed code. The intra-service time and work RVU of both reference services are significantly greater than CPT code 92288, and the RUC agreed that neither code would make an appropriate relative comparison.

The RUC concluded that CPT code 92288 be valued at a work RVU of 0.17 per a direct crosswalk to CPT code 73010 to accurately reflect the physician work, time and intensity involved with this procedure in addition to maintaining rank order with the other services in this code family. 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 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes intra-service time and 6 minutes total time). Both reference codes require near-identical physician work and similar time to perform, thus supporting the RUC recommended work RVU of 0.17. **The RUC recommends a work RVU of 0.17 for CPT code 92288.**

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the specialty societies that there is compelling evidence to support an increase over the aggregate current cost for clinical activities, supplies and equipment for the code family due to a change in technology and also a change in equipment/new device. The PE Subcommittee reviewed the practice expense inputs for CPT codes 92284 and 92288 and made two modifications to the medical supplies and equipment involved with these services. SK057 *paper, laser printing (each sheet)* was added for CPT code 92284 to account for the printed readout resulting from the dark adaptation examination. The specialty societies clarified that the paper only applies to 92284 and not 92288, as there is no printout for the screening test. The PE Subcommittee discussed and approved a new equipment input, *Dark Adaptometer, Second Generation*, for CPT code 92288, clarifying that the supporting invoice confirms that the monthly payment plan listed is a purchasing agreement and not a lease as it is typical for the device to be purchased not leased. The PE Subcommittee also reviewed for any potential overlap between the physicians and clinical staff and agreed with the specialty societies that there are 7.5 minutes of staff time for each eye tallying 15 minutes for 92284 and 5 minutes of staff time for each eye tallying 10 minutes for 92288. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 99284 and 92288 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

RUC Database Flag
The RUC recommends that CPT code 92288 should be flagged as **Do Not Use to Validate for Physician Work** given the RUC valuation for this code is based on the rationale provided by the specialty societies and not on survey results.

Facilitation Committee #2
Coronary Therapeutic Services and Procedures (Tab 6)
Mark Hoyer, MD (SCAI), Afnan Tariq, MD (SCAI), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)

In October 2010, CPT code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* was identified by the Relativity Assessment Workgroup (RAW) via the MPC List screen. The RAW requested that the specialty societies survey this code for RUC review. Subsequently, the specialty societies referred the code to the CPT Editorial Panel to revise the family of procedures to more accurately describe the current physician work involved in percutaneous coronary intervention (PCI). At the October 2011 CPT meeting, the Panel approved 13 new codes to describe PCI services. The societies surveyed the family and the RUC submitted recommendations to the Centers for Medicare & Medicaid Services (CMS) in January 2012. Instead of accepting the RUC recommendations, CMS opted to assign bundled status to all the add-on codes for the additional branches off the major coronary arteries (codes 92921, 92929, 92934, 92938, 92944). In addition, CMS increased values and intra-times of all the base codes using a mathematical formula to include a fraction of the time and value of the add-on codes, based on the billed together data available at the time. For example, using 2011 Medicare claims data, CMS anticipated that the service described by add-on code 92921 would be performed with the procedure described by base code 92920 27.4% of the time. To bundle the work value of the add-on code into base code 92920, CMS multiplied the RUC recommendation for the add-on code of 4.00 by 27.4% (or 1.10) and added that fractional value to the RUC recommendation for the base code (9.00+1.10=10.10). The value of moderate sedation, which was bundled into the base codes, was systematically removed when separate moderate sedation CPT codes were created for CPT 2017.

In September 2022, the CPT Editorial Panel created one new Category I CPT code for percutaneous coronary lithotripsy. Sixteen other PCI codes were considered part of the code family. For the January 2023 RUC meeting, the specialty societies opted to survey nine of the sixteen codes. The specialty societies opted to not survey the add-on codes in the family that describe the intervention in additional branches off major coronary arteries. As described above, CMS and payers have never recognized these add-on codes as separately payable services, therefore they have no Medicare utilization. After reviewing the survey results in preparation for the January 2023 RUC meeting, the surveying specialty societies requested, and the RUC agreed, to submit a recommendation only for the new add-on code 92972 for CPT 2024 and referred the entire PCI code family to the CPT Editorial Panel for restructuring for the CPT 2025 cycle. The code family was revised at the February 2024 CPT Editorial Panel meeting for the CPT 2026 cycle and the family was surveyed for the April 2024 RUC meeting.

The new/revised PCI code family is built on progressive hierarchies with more intensive services being inclusive of lesser intensive services. The base PCI codes include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy when performed through

the access sheath, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. These codes include angioplasty (eg, conventional balloons, cutting balloons, wired balloons, cryoplasty balloons), atherectomy (eg, directional atherectomy, rotational atherectomy, orbital atherectomy, laser atherectomy), and stenting (eg, balloon expandable stents, self-expanding stents, bare metal stents, drug-eluting stents, covered stents). Each base code in this family also includes balloon angioplasty, when performed.

Compelling Evidence
The RUC reviewed compelling evidence based on a change in technique. At the time of the 2012 survey, PCI was typically performed via the femoral artery, whereas fewer than 5 percent of PCI were performed via the radial artery at the time. Due to improvements in technique and catheter technology, PCI is now typically performed through the radial artery (more than 60 percent of the time nationally). This approach requires different skills and techniques that are more difficult to perform than access through the femoral artery. Research has shown the radial approach to be safer for patients and involves a significant reduction in the risk of patient bleeding. The specialties noted that the average radial artery is about 2 mm compared to femoral arteries which average about 9 mm. While safer for the patient, the service is technically more challenging for the operator. Unlike the femoral artery, not only does the operator give local anesthesia, but they also must administer additional medications intra-arterially because of the tendency for the radial and brachial arteries to go into spasms. Procedures that involve the radial artery involve injections by the physician into the artery once the artery has been canulated. **The RUC accepted compelling evidence based on a change in technique.**

Pre-service and Post-service Time
The RUC agreed to make the times consistent with the survey pre-service time for each 000-day global code to reflect the time typically required to perform the pre-service evaluation and other work to prepare for the procedure, as well as additional post-service time for several of the codes. The pre-service evaluation was adjusted to 35 minutes for every 000-day code, except for emergent code 92941, which was instead adjusted to 22 minutes. Also, pre-service scrub, dress, wait time was adjusted to 10 minutes for every 000-day procedure code. Similarly, the post-service time for each 000-day service was adjusted to 30 minutes or the surveyed post-service time (if surveyed time was less than 30).

These changes were in part based on the additional time needed to evaluate and prepare access site(s) (one or both radial arteries and/or one or both femoral arteries). The myriad of techniques that are now available for percutaneous coronary intervention has expanded and that requires a full discussion with the patient because each one carries separate risks. Left and right radial pulses are also evaluated using an Allen test to determine which are available for access and which of the two offers preferable access. It is typical for the physician to prepare at least two access sites. Many operators give an anti-vasospastic cocktail routinely which also takes additional time to prepare for during the pre-service period. As part of the evaluation, the operator discusses the results of Heart Team consultations (if performed) and describes various PCI techniques, and the possibility of conversion to emergency surgery, among other typical tasks. The Heart Team for coronary revascularizations is a multidisciplinary team convened to evaluate complex patients and helps make patient-centered, evidence-based clinical decisions for patients considered for coronary revascularization.

92920 ***Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)***
The RUC reviewed the survey results from 140 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU = 8.35, 45 minutes intra-service time and

155 minutes total time) appropriately accounts for the work required to perform this service. Both services typically involve a similar amount of intra-service time and the same overall amount of physician work. The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved similar times, so the pool of potential reference codes was limited for most survey codes in this code family. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 48 minutes intra-service time, and 27 minutes immediate post-service time.

The specialties noted that operators now see patients undergoing PCI who have more comorbidities than when the PCI code family was last reviewed in 2012. Attention to stricter adherence to statins and other medicines in revascularization and chest pain guidelines has excluded many patients who otherwise may have been treated with lower acuity PCI. The remaining patients are more complex than they were a dozen years ago. This is true for the patient population for each of the new/revised codes in this code family. The specialty also noted that typically, to close the radial artery access site (which is now typical), the operator uses a radial artery occluder band and this work takes much less time relative to what femoral closure used to involve when this service was last valued in 2012. The femoral artery closure work was a low-intensity portion of the intra-service work back in 2012, though took up a fair amount of time. With the replacement of this work with the usage of occluder bands, the typical intra-service work has a higher average intensity as a lower proportion of the time is dedicated to the closure.

For additional support, The RUC also referenced CPT code 31601 *Tracheostomy, planned (separate procedure); younger than 2 years* (work RVU = 8.00, 45 minutes intra-service time and 135 minutes total time) and CPT code 33952 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)* (work RVU = 8.15, 60 minutes intra-service time and 158 minutes total time). **The RUC recommends a work RVU of 8.35 for CPT code 92920.**

92924 *Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)*
The RUC reviewed the survey results from 137 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)* (work RVU= 10.13, 70 minutes intra-service time and 112 minutes total time) appropriately accounts for the work required to perform this service. The RUC acknowledged that this direct crosswalk has a different global period, though also noted the relative dearth of available reference codes that are 000-day global major surgical procedures that have similar times and involve a similar amount of physician work in general. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, and 30 minutes immediate post-service time. This service includes the entire physician work of CPT code 92920 when performed, plus the additional work of performing percutaneous transluminal coronary atherectomy. This places the recommendation for 92924 with appropriate relativity to the recommendation for 92920.

For additional support, the RUC referenced CPT code 33986 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older* (work RVU = 10.00, 60 minutes intra-service time and 205 minutes total time.) and CPT code 33964 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula by*

sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed) (work RVU = 9.50, 60 minutes intra-service time and 195 minutes total time).**The RUC recommends a work RVU of 10.13 for CPT code 92924.**

92928 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); one lesion involving one or more coronary segments***
The RUC reviewed the survey results from 140 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 33986 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older* (work RVU= 10.00, 60 minutes intra-service time and 205 minutes total time) appropriately accounts for the work required to perform this service. The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved a similar amount of physician work and similar times, so the pool of potential reference codes was limited. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, and 28 minutes immediate post-service time. This service includes the entire physician work of CPT code 92920 when performed, plus the additional placement of intracoronary stent(s). The RUC noted that the recommendation for this service is slightly lower than that of 92924, as this service involves two minutes less total time.

The specialties noted that the former intra-service time for CPT 92928 was based on the survey 75th percentile intra-service time from the prior survey conducted for the January 2012 meeting, whereas their recommendation based on the 2024 survey for this revised service is based on the survey median intra-service time.

For additional support, the RUC referenced CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)* (work RVU= 10.13, 70 minutes intra-service time and 112 minutes total time). **The RUC recommends a work RVU of 10.00 for CPT code 92928.**

92930 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); two or more distinct coronary lesions with two or more coronary stents deployed in two or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch***
The RUC reviewed the survey results from 138 interventional cardiologists and determined that the survey 25th percentile work RVU of 12.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, and 29 minutes immediate post-service time. The specialties noted that CPT code 92930 was created to allow coding for the work involved in placement of intracoronary stent(s) (previously coded as 92928) that exceeds the typical stenting case.

The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved a similar amount of physician work, so the pool of potential reference codes was severely limited. The RUC compared the surveyed code to key reference codes 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing*

and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry (work RVU = 15.00, 120 minutes intra-service time and 199 minutes total time) and 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 11.75, 118 minutes intra-service time and 186 minutes total time) and determined that although the surveyed code involves less intra-service time and total time, it is a much more intense service to perform than both of these reference codes. The RUC concurred that the total amount of physician work for the surveyed code is slightly more than the 2nd key reference code, CPT code 37225. The RUC concluded that CPT code 92930 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 12.00 for CPT code 92930.**

92933 ***Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)***
The RUC reviewed the survey results from 140 interventional cardiologists and determined that the survey 25th percentile work RVU of 11.94 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, and 30 minutes immediate post-service time. The RUC noted that this service typically involves the same intra-service time as 92930 and a very similar total time, and should be valued similarly,.

The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved a similar amount of physician work, so the pool of potential reference codes was severely limited. The RUC compared the surveyed code to key reference codes 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 11.75, 118 minutes intra-service time and 186 minutes total time) and 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* (work RVU = 13.75, 90 minutes intra-service time and 178 minutes total time) and determined that the surveyed code involves much more intensity than both reference codes. 86 percent of the survey respondents who selected top key reference code 37225 had rated the surveyed code as more intense/complex to perform. 60 percent of the survey respondents that selected second key reference code 93583 had indicated the surveyed code is more intense/complex to perform. The RUC concluded that CPT code 92933 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 11.94 for CPT code 92933.**

92937 ***Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single vessel major coronary artery and/its branches***
The RUC reviewed the survey results from 141 interventional cardiologists and determined that the survey 25th percentile work RVU of 11.30 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time. The RUC noted that, relative to the currently assigned CMS from 2012, this recommendation involves 2 minutes less of intra-service time though 17 more minutes of total time. Also, as described in the introductory section, these services are more intense relative to when this service was previously reviewed.

The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved a similar amount of physician work, so the pool of potential reference codes was severely limited. The RUC compared the surveyed code to key reference codes 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 11.75, 118 minutes intra-service time and 186 minutes total time) and 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* (work RVU = 13.75, 90 minutes intra-service time and 178 minutes total time) and determined that the surveyed code involves much more intensity than both reference codes. 84 percent of the survey respondents who selected top key reference code 37225 had rated the surveyed code as more intense/complex to perform. 68 percent of the survey respondents who selected second key reference code 93583 had indicated the surveyed code is more intense/complex to perform. The RUC concluded that CPT code 92937 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 11.30 for CPT code 92937.**

92941 ***Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single major coronary artery and/or its branches or single bypass graft and/or its subtended branches***

The RUC reviewed the survey results from 139 interventional cardiologists and determined that the survey 25th percentile work RVU of 12.72 appropriately accounts for the work required to perform this service. The RUC recommends 22 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time. The specialties noted and the RUC concurred that this service is the most intense service to perform in the code family as it is emergent and involves a patient undergoing acute myocardial infarction. Since it is emergent, the pre-service evaluation time is typically shorter than all the planned 000-day global procedures in the code family. Also, this service is the most intense procedure to perform in the code family.

The RUC acknowledged the dearth of potential reference codes that are major surgical procedures with the 000-day global period and involved a similar amount of physician work, so the pool of potential reference codes was severely limited. The RUC compared the surveyed code to key reference codes 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* (work RVU = 13.75, 90 minutes intra-service time and 178 minutes total time) and 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 11.75, 118 minutes intra-service time and 186 minutes total time) and determined that the surveyed code involves much more intensity than both reference codes. 83 percent of the survey respondents who selected top key reference code 93583 had rated the surveyed code as more intense/complex to perform. 91 percent of the survey respondents that selected second key reference code 37225 had indicated the surveyed code is more intense/complex to perform. The RUC concluded that CPT code 92941 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 12.72 for CPT code 92941.**

92943 ***Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach***

The RUC reviewed the survey results from 132 interventional cardiologists and determined that the survey 25th percentile work RVU of 13.69 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, and 30 minutes immediate post-service time. The specialty noted that this is one of the longest services to perform in the code family, as it involves multiple catheter changes and multiple techniques being attempted.

The RUC compared the surveyed code to key reference codes 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 15.00, 120 minutes intra-service time and 199 minutes total time) and 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time and 208 minutes total time) and determined that the surveyed code typically involves an identical amount of intra-service time as these two reference codes, though somewhat less total time. The RUC concurred that the recommended times and values fit appropriately with both reference services, as the surveyed code involves less total work. The RUC concluded that CPT code 92943 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 13.69 for CPT code 92943.**

92945 ***Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches***

The RUC reviewed the survey results from 118 interventional cardiologists and determined that the survey 25th percentile work RVU of 15.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 130 minutes intra-service time, and 30 minutes immediate post-service time. The specialties noted that CPT code 92945 was created to allow coding for revascularization of a chronic total occlusion when both antegrade and retrograde approaches are employed. The specialty noted that this is one of the longest services to perform in the code family, as it involves multiple catheter changes and multiple techniques being attempted.

The RUC compared the surveyed code to key reference codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time and 208 minutes total time) and 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 15.00, 120 minutes intra-service time and 199 minutes total time). The RUC noted that the surveyed code

involves 10 minutes more of total time and either identical or similar total time to both reference codes. The RUC concluded that CPT code 92945 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 15.00 for CPT code 92945.**

92972 ***Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)***
The RUC concurred with the societies that this add-on service should be affirmed, as it was most recently surveyed in January 2023 and the current time and value remain appropriate. The RUC affirms 30 minutes of intra-service and total time. **The RUC recommends affirming a work RVU of 2.97 for CPT code 92972.**

92973 ***Percutaneous transluminal coronary thrombectomy aspiration mechanical (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 140 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75 and 20 minutes of intra-service time) appropriately accounts for the work required to perform this service. The RUC noted that both add-on services typically involve the same amount of time to perform and the same average physician work intensity. The RUC recommends 20 minutes of intra-service time and total time.

The RUC compared the surveyed code to key reference codes 37186 *Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)* (work RVU = 4.92, 60 minutes intra-service time and total time) and 92974 *Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)* (work RVU = 3.00, 42.5 minutes intra-service time and total time) and noted that both key reference codes involve more than twice as much time to perform as this add-on survey code, though the surveyed code typically involves more work intensity. **The RUC recommends a work RVU of 1.75 for CPT code 92973.**

93571 ***Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; initial vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 138 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 37252 *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.80, 20 minutes intra-service time and 22 minutes total time) appropriately accounts for the work required to perform this service. The RUC noted that both services typically involve an identical intra-service time, similar total time, and the same amount of physician work. The RUC recommends 20 minutes of intra-service time and total time.

The RUC compared the surveyed code to key reference code 92974 *Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)* (work RVU = 3.00, 42.5 minutes intra-service and total time) and noted that although the surveyed code involves roughly half as much time, the surveyed code is

more intense to perform. The RUC concurred that this justifies a work value that is 60 percent of the value of the reference code. **The RUC recommends a work RVU of 1.80 for CPT code 93571.**

93572 ***Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 138 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU= 1.44, 20 minutes intra-service time and 21 minutes total time) appropriately accounts for the work required to perform this service. Although the reference code involves more time, the surveyed code is a more intense service to perform. The RUC concurred that both services are comparable in terms of the total amount of physician work typically required ot perform each service. The RUC recommends 16 minutes of intra-service time and total time. The RUC noted that this is an increase of 5 minutes relative to the currently assigned CMS Time, a 45 percent increase.

To support the recommended work RVU, the RUC compared the surveyed code to key reference code 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80, 20 minutes intra-service and 22 minutes total time) and determined that it is appropriate to assign the surveyed code a lower work value than this key reference code. **The RUC recommends a work RVU of 1.44 for CPT code 93572.**

Practice Expense
The RUC recommends no direct practice expense inputs for the PCI code family as they are facility-only services.

RUC Flag
The RUC recommends that CPT code 92924 should be flagged as **Do Not Use to Validate for Physician Work**. The direct work RVU crosswalk for this survey code was a different global period, ZZZ.

New Technology/New Services List
CPT code 92972 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

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

<u>Respiratory Syncytial Virus (RSV) Monoclonal Antibody Administration (Tab 7)</u>
Suzanne Berman, MD (AAP), Steve Krug, MD (AAP), Korinne Van Keuren, DNP, (ANA)

In September 2023, the CPT Editorial Panel created two codes to report administration of respiratory syncytial virus (RSV), monoclonal antibody and seasonal dose, with and without counseling. These two administration codes were created following FDA approval of Nirsevimab to protect against severe disease caused by RSV, which is common throughout the fall and winter seasons and highly contagious, sometimes deadly, for infants. CPT codes 96380 and 96381 were effective October 6,

2023, for immediate use. CPT codes 96380 and 96381 were reviewed and valued with interim recommendations to CMS the following week at the September 28-30, 2023, RUC meeting. Following that expedited review, CPT codes 96380 and 96381 were surveyed for the April 2024 RUC meeting after more widespread use occurred. These codes are not subject to compelling evidence since the September RUC recommendations were interim.

96380 ***Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional***
The RUC reviewed the survey results from 112 pediatricians and nurse practitioners and determined the survey median work RVU of 0.28 appropriately accounts for the work required to perform this service. The RUC recommends 8 minutes intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an Evaluation and Management (E/M) office visit.

The RUC compared code 96380 to the top key reference service CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.24- and 7-minutes intra-service and total time). The RUC agreed that the surveyed code requires slightly more physician work and time than CPT code 90460. The counseling associated with administering the RSV monoclonal antibodies is distinct in that, beyond discussing whether the infant/child should receive the product, counseling also needs to address how this product differs from traditional pediatric vaccines and optimal product administration timing. Therefore, an additional minute of intra-service time for that additional discussion beyond that of what is included in CPT code 90460 is justified. However, infants born to mothers who are administered RSV monoclonal antibodies at least two weeks before delivery will have protection and, in most cases, should not also need RSV monoclonal antibodies directly.

The RUC noted that although the vignette described a 6-month-old, the specialty societies and the RUC believe that the typical patient receiving the RSV monoclonal antibody will be much younger than a 6-month-old. Additionally, the specialty societies indicated that currently, this monoclonal antibody is not typical for patients over 8 months old unless they are in a specific high-risk category, which is less than 2% of infants nationally. Further, it is typical that patients will only receive this antibody once in their lifetime.

For additional support, the RUC referenced MPC code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVW = 0.28, 7 minutes intra-service time and 13 minutes total time), CPT code 77073 *Bone length studies (orthoroentgenogram, scanogram)* (work RVU = 0.26, 5 minutes intra-service time and 7 minutes total time), CPT code 71110 *Radiologic examination, ribs, bilateral; 3 views* (work RVU = 0.29, 6 minutes intra-service and 8 minutes total time), and MPC code 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVW = 0.32, 7 minutes intra-service time and 9 minutes total time). The RUC determined that the median work value of 0.28 appropriately places CPT code 96380 relative to other services in the MFS based on time, work, intensity and complexity. **The RUC recommends a work RVU of 0.28 for CPT code 96380.**

96381 ***Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection***
The RUC reviewed the survey results from 97 pediatricians and nurse practitioners and determined that the survey 25th percentile work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes intra-service and total time. There is no pre-

service or post-service time as this service is typically reported with an Evaluation and Management (E/M) office visit.

The RUC compared the surveyed code to the top key reference service CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17, 7 minutes intra-service and total time) and determined that the physician work required to perform these services are the same. The RUC noted when 90471 was last surveyed, the specialties survey time data was disparate, based on the specialty completing the survey. After much discussion, the RUC agreed that the time and work for 90471 and 96381 are comparable.

For additional support, the RUC referenced CPT code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (*work RVW = 0.17, 3 minutes intra-service time and 7 minutes total time). CPT code 96372 was recently valued by the RUC in 2017 and is the code that would have been used to report this service before the creation of this new code. The RUC also referenced CPT code 73080 (work RVU = 0.17, 3 minutes intra-service time and 5 minutes total time), MPC code 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* (work RVW = 0.18, 5 minutes intra-service time and 7 minutes total time), and CPT code 90970 *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older* (work RVU = 0.18, 3.2 minutes intra-service and total time). The RUC determined that the survey 25th percentile work RVU of 0.17 appropriately places CPT code 96381 relative to other services in the MFS based on time, work, intensity and complexity. **The RUC recommends a work RVU of 0.17 for CPT code 96381.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct inputs for CPT codes 96380 and 96381 and made one modification. Clinical staff activity CA005 *Complete pre-procedure phone calls and prescription* was removed as this time is already captured in the typically associated E/M service. The Subcommittee accepted 5 minutes for CA007 *Review patient clinical extant information and questionnaire*. Four additional minutes of clinical staff time were recommended by the surveying societies to complete the monoclonal antibody pre-check eligibility process (see attachment Nirsevimab Visual Guide). The PE Subcommittee agreed that the time required to check the mother's RSV immunization status and timing of dose in the typical patient is a minimum of 5 minutes. Clinical staff have the expertise and access to non-patient (i.e., the mother) information. This activity requires looking up the mother's records at the birthing hospital or physician office as it is not typical for this information to be sent to the state immunization registry. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Services List
CPT codes 96380 and 96381 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions. The RUC noted that the Relativity Assessment Workgroup may want to examine the typical patient since the specialty societies and RUC agreed that the typical patient receiving the RSV monoclonal antibody to be much younger than 6 months old.

X. CMS Request/Relativity Assessment Identified Codes

Closure Left Atrial Appendage with Endocardial Implant (Tab 8)
Mark Hoyer, MD (SCAI), David Slotwiner, MD (HRS), Afnan Tariq, MD (SCAI), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)

CPT code 33340 was created for CPT 2017 and was reviewed by the Relativity Assessment Workgroup (RAW) in 2023 as part of the new technology/new services screen. At that time, the specialty societies noted that a new FDA indication was recently released, suggesting this service was still changing. The RAW recommended and the RUC agreed that the specialty societies should conduct a survey for the April 2024 RUC meeting. The delay would allow for the technology and indications to stabilize prior to survey.

33340 ***Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation***
The RUC recommends a work RVU of 10.25 based on a direct crosswalk to CPT code 49614 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated* (work RVU = 10.25, 75 minutes intra-service and 165 minutes total time), which maintains relativity within the Medicare Physician Payment Schedule (MFS). The RUC recommends 47 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 70 minutes intra-service time and 30 minutes immediate post-service time.

This service is typically performed on a patient under general anesthesia. The specialty societies added 7 minutes of pre-service evaluation time to the package as reflected by the survey, to include additional time for the operator to review cardiac CT images to fine-tune pre-procedure planning for placement of the occlusion device. This service is the transcatheter closure of the left atrial appendage, performed via a catheter. This is distinct from the surgical closure, which can be performed by surgeons using thoracoscopy. This service is exclusively performed in a hospital and the patient is typically discharged 1-2 days later.

The RUC noted that the survey 25th percentile work RVU of 16.00 is higher than the current value of 14.00 for CPT code 33340. However, the survey respondents indicated that the intra-service time has decreased by 20 minutes, from 90 to 70 minutes, with total time decreasing by 18 minutes since it was initially surveyed in 2016. Moreover, electrophysiologists, the physicians who typically report this service, indicated that the intra-service time typically requires 75 minutes to complete. The RUC noted that there are a limited number of 000-day surgical procedures with similar intra-service time.

For additional support, the RUC compared code 33340 to MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75 and 90 minutes intra-service time and 166 minutes total time), which requires more time, thus valued higher; and MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90

minutes intra-service time and 141 minutes total time), which also requires more time to performed than 33340, however is appropriately has a lower intensity because it is a less intense/complex procedure that does not involve working inside the heart across the septum.

The RUC determined that a crosswalk work value of 10.25 appropriately places CPT code 33340 relative to other services in the MFS based on time, work, intensity, and complexity. **Therefore, the RUC recommends a work RVU of 10.25 for CPT code 33340.**

Practice Expense
The Practice Expense Subcommittee noted that the specialties recommended the current existing facility only direct practice expense inputs for CPT code 33340 and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

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

Biofeedback Training (Tab 9)
Jon Hathaway, MD (ACOG), Angela Pennisi, DPT (APTA), Jonathan Kiechle, MD (AUA), Thomas Turk, MD (AUA)

In April 2023, the Relativity Assessment Workgroup (RAW) identified CPT code 90901 via the high-volume growth screen for codes with 2021 Medicare utilization of 10,000 or more that increased by at least 100% from 2016 through 2021. In September 2023, the Workgroup reviewed the action plan for CPT code 90901 and agreed with the specialty societies that 90901, along with the other services in this code family (90912 and 90913) should be surveyed for the April 2024 RUC meeting.

However, when the specialty societies were preparing to survey the services, they determined they could not proceed and instead requested to revise the code family through the CPT process before surveying. The specialty societies noted that the current code descriptor for CPT code 90901 is not well understood based on their review of past RUC rationales for valuation, claims data, and the vignettes used for review in 1995 and 1996 by the RUC and RUC HCPAC Review Board. In the 1995 RUC rationale, the vignette described 45–60-minute sessions (and brief 30-minute sessions) and included information about psychiatrists and psychologists, though it is unclear who was surveyed. However, the 1996 RUC rationale of the HCPAC review was based on a different vignette and surveyed by physical therapists, which led to a reduction of the work RVU from 0.89 to 0.41 based on a comparison to a time-based therapy code, CPT code 97110. The specialty societies note that although 90901 is not time-based, the comparison for the current value was to a 15-minute time-based code despite the current intra-service time being 45 minutes. In their letter to request a referral to CPT for this code family, the specialty societies proposed revising the code descriptor for CPT code 90901 to be consistent with other physical therapy time-based and modality codes, as well as similar to other biofeedback training codes. Additionally, code descriptor clarification may resolve the continued confusion about the intent and correct coding for 90901. **The RUC recommends that CPT codes 90901, 90912 and 90913 be referred to the September 2024 CPT Editorial Panel meeting for revision. The specialties anticipate a requested global period change for CPT codes 90901 and 90912 from a 010 to a 000-day global at the time of revision due to a change in patient population and specialties that perform the services.**

XI. Research Subcommittee (Tab 10)

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

- **Minutes, February 20 Research Subcommittee Specialty Requests Meeting Report Review**
  The Research Subcommittee report from the October 10th conference call included in Tab 10 of the April 2024 agenda materials was approved without modification.

- **Discussion – Physician Work Intensity Survey Questions**
  During the RUC's *New Business* discussion at the April 2023 RUC meeting, a RUC member inquired about physician work intensity and the survey intensity/complexity questions. The RUC referred the survey intensity and complexity questions topic to the Research Subcommittee for discussion and it was most recently briefly discussed in January 2024.

  At the April 2024 meeting, AMA RUC staff prepared a detailed historical overview as a reference for the Subcommittee which is available in tab 10 of the April 2024 RUC meeting materials. The Chair noted and several members agreed that the intensity elements of work have been considered subjective and therefore challenging to measure from the initial Harvard process and that has not changed.

  The Subcommittee discussed the summary data from January 2022 that detailed the trend of the overall intensity complexity relationship to the KRS over the prior two-year period. The Chair noted that, while the summary data demonstrate a slight right shift in the scale (survey code more intense than KRS), the reasons behind this are not entirely clear. One reason may be that the survey respondents are asked to select the reference code that is most like the survey code and the RSL is ordered from low to high RVW services with the respondent selecting the first code from the top that is similar instead of going further down the list. It is also possible that there could sometime be some survey bias toward higher intensity of the code under survey versus the KRS by the mere fact of the code being under review. The "much less" and "much more" intense choices are also relatively infrequently selected; this is perhaps due to the survey respondents being asked to select a reference service from the RSLs that is most similar to the survey code.

  Some Subcommittee members noted that the current I/C questions are streamlined and strike the right balance between ease of the survey respondent and providing information to the RUC. Subcommittee members concurred that I/C questions are inherently subjective to the individual. They noted that the survey I/C questions are much more streamlined now with only 5 dropdown questions per survey code, whereas before 2015, the standard RUC survey required for the respondent to answer 22 dropdown questions on intensity and complexity per survey code. This change still preserved the original definitions and reduced survey fatigue.

  The Vice Chair provided a summary of their observations of the measure of physician work intensity, the Intra-service Work per Unit of Time (IWPUT). They noted that magnitude estimation is the primary role of magnitude estimation. They noted that IWPUT is most accurate when used *within code families* due to similar underlying work/time assumptions. They observed that IWPUT becomes less reliable when comparing relativity beyond code families. They also noted their concern with the work per unit time (WPUT) metric and its use in valuation discussions is, at best, confirmatory, but more frequently irrelevant.

Other Subcommittee members suggested adding an additional survey question to compare the I/C of the survey code to its past self for codes that are being re-surveyed. Others noted that this could be misleading for existing codes that underwent a coding structure change. AMA RUC staff also noted that a similar question was included in survey instruments for the 2nd Five-Year review in 2000. **The Research Subcommittee agreed that no changes are necessary at this time to either the intensity and complexity measures or to any of the RUC processes instructions documentation with respect to intensity and complexity.**

The RUC approved the Research Subcommittee Report.

XII. Practice Expense Subcommittee (Tab 11)

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

High-Cost Supplies
The PE Subcommittee acknowledged the increased frequency of high-cost supplies in the RUC recommendations and continues to strongly support the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes.

The PE Subcommittee noted that there are 84 services in which the practice expense payment does not even cover the supply expense. For 20 services, the practice expense payment does not cover the cost of a single high cost supply utilized in the provision of the service. CPT code 33285 *Insertion, subcutaneous cardiac rhythm monitor, including programming* was provided as an egregious example where the total Medicare Non Facility Payment equals $4,138.97 while the PE supply cost totals $5,077.38 due to high-cost supply item SA127 subcutaneous cardiac rhythm monitor system priced at $5,032.50. AMA staff will share these analyses at the next RUC meeting.

Radiology-specific Clinical Activities
The PE Subcommittee discussed the use of Clinical Activity (CA) code CA014 *Confirm order, protocol exam.* The guidelines for this clinical activity specify "For use in imaging services only. 1 minute standard." Protocoling exams has a very specific meaning in CT and MRI that describes the work of choosing which imaging sequences or contrast phases to perform. However, it was noted that CA014 has been repeatedly requested for non-imaging procedures despite the instructions which state that the task is only for imaging.

The PE Subcommittee considered a database search that showed over 20 of the 66 codes with CA014 greater than 0 minutes are non-imaging. The Subcommittee determined that the CA014 minutes could be allocated in the non-radiology codes and will develop a few examples ("e.g.") to clarify the instructions. The PE Subcommittee agreed to further discuss examples for CA014 at its September meeting. In addition, they will need to determine whether the other 5 codes that state "for imaging services" should remain radiology specific or whether the statement should be removed such that every procedure could justify the 1 or 2 minutes standard as needed.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 12)

Doctor Matthew Grierson, Chair, provided the report of the Relativity Assessment Workgroup (RAW).

Review of Action Plans
Doctor Grierson indicated that the Workgroup reviewed action plans from 8 screens, comprising 32 families of codes or 123 codes exactly and provided recommendations. Additionally, the Workgroup will review action plans for approximately 30 codes based on 6 different screens that we reiterated based on current 2022 Medicare data.

Low Performance Rate
The Workgroup discussed a possible new screen based on low performance rates for surveys where the survey respondents indicate they typically did not perform the surveyed service. The Workgroup determined that a process is already in place to address these issues on a case-by-case basis and did not recommend a new screen to be developed at this time.

High Cost Disposable Supplies
The Workgroup discussed the high cost disposable supplies issue and whether or not there should be a screen that could be useful to help the RUC collect data that could potentially bolster the RUC's position that the high cost, disposable supplies be paid for separately. The 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting.

The Workgroup indicated that it would be part of existing precedent to identify services for PE review only. The Workgroup indicated it would like to review the codes and data in more detail. **The Workgroup determined to review the list of impacted services at the September 2024 Relativity Assessment Workgroup meeting and determine next steps.**

In addition, it was suggested that at the time a new code is reviewed and a supply item costing more than $500 is included in the direct inputs, the code should be flagged as new technology. The PE Subcommittee should note those codes with high-cost supplies to the RUC at the time of review and the RUC could opt to add the code to new technology.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 13)

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

Review of MPC History Process and Criteria Document
At the January 2024 MPC Workgroup meeting during Other Business, the Workgroup discussed future review and refinement of the Suggested Criteria listed in the MPC Summary of Process document after the specialty societies had been solicited by AMA staff for their feedback regarding the submission form. The Workgroup Chair also recommended an addition to the Suggested Criteria list wherein codes that were surveyed for the RUC within the last 10 years are given preference over those that were surveyed more than 10 years ago. It was discussed that this suggested criterion may prevent less turnover on the MPC list with respect to the 15-year sunset review and prioritize including more recent codes.

In preparation for the April 2024 MPC Workgroup meeting, AMA staff drafted the MPC History, Process and Criteria document, a new and revised version of the former MPC Summary of Process document. This new document more clearly organizes the historical content included in the old document, including reordering criteria and categorizing the history of the process more appropriately for reference. The new document also includes the proposed suggested criteria for codes surveyed within the last 10 years.

The MPC Workgroup reviewed the MPC History, Process and Criteria document and recommends the following two revisions:

- *Modifying existing language to account for the annual 15-year sunset review*: "Review the codes on the current MPC list **that have been valued more than 15 years prior** and identify those to be retained according to the new criteria."
- *Adding a new line to the Suggest Criteria*: **"Codes should have undergone RUC review within the past 10 years."**

The MPC Workgroup approved the revised MPC History, Process and Criteria document with the addition of the proposed suggested criterion.

In preparation for the January 2025 MPC Workgroup meeting, the Workgroup noted that the MPC Submission Form will be distributed to specialty societies for the annual review of the MPC list. The revised form will include an additional comment box to provide specialty societies the opportunity to provide a rationale for whether a code should be included on the MPC list or not if it was not valued by RUC survey (e.g., crosswalk evaluation). The Workgroup recognized that the updates to the submission form will help in the proposal and review of code recommendations to the MPC list.

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

XV. HCPAC Review Board (Tab 14)

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

The RUC HCPAC Review Board voted to approve the addition of American Association of Marriage and Family Therapy (AAMFT) to the HCPAC Structure and Processes, bringing the total amount of participating organizations from twelve to thirteen. Marriage/family therapists are required to use CPT to report the services they provide independently to Medicare patients under the defined Medicare benefit outlined in the CY 2024 CMS Final Rule. AAMFT is eligible to appoint advisors for attendance at future RUC HCPAC Review Board meetings.

The HCPAC Review Board reviewed the following Relative Value Recommendations for CPT 2026:

Hearing Device Services (Tab 14)
Paul Pessis, AuD (AAA), Deborah Carlson, PhD, CCC-A/SLP (ASHA)

At the February 2024 CPT Editorial Panel meeting, 12 new Category I codes were created to report hearing devices services (eg, air-conduction hearing aids) including hearing aid candidacy determination, hearing aid selection, hearing aid fitting, follow-up after fitting, hearing aid verification, and assistive-device services. The current CPT codes, 92590-92595, are recommended for deletion. It is important to note that codes 92590-92595 are considered non-covered services by

CMS. Therefore, the RUC database reflects minimal data related to the delivery and utilization of these services. Given the current status of Medicare coverage, CPT codes 92590-92595 have never been surveyed by the RUC HCPAC Review Board. CPT codes 92628-92642 were reviewed at the April 2024 RUC HCPAC meeting.

The RUC HCPAC Review Board reviewed the recommendation from the specialty societies to contractor price all 12 of the new hearing device services codes. The recommended codes for deletion to report hearing aid services (92590-92595) are currently non-covered by Medicare. The specialty societies noted that since these services, which are predominantly performed by audiologists, are either noncovered services for commercial payers or statutorily excluded services for government health care programs they should be contractor priced. Further, existing payment models for hearing aid services are varied, and may be bundled into payments for hearing aids. The RUC HCPAC Review Board agreed with the recommendation of contractor pricing for all 12 codes.

The RUC HCPAC Review Board recommends contractor pricing for CPT codes 92628, 92629, 92631, 92632, 92634, 92635, 92636, 92637, 92638, 92639, 92641, 92642.

The RUC filed the HCPAC report as presented.

XVI. New/Other Business (Tab 15)

- A RUC member inquired about the number of times a crosswalk code did not have the same global period as the surveyed code. He questioned whether this would have a historical impact on CMS review and acceptance of these RUC recommendations. A RUC member responded that at the September 2024 RUC meeting, and documented in the Structure & Function Annotated List of RUC Actions, the RUC did approve language regarding crosswalks including that they should have the same global period, be recently reviewed, have similar intra-service time and total time, be clinically similar to the surveyed code, and not be flagged as "Do Not Use to Validate Physician Work" in the RUC database. Another member stated that the instructions for developing work RVU recommendations document is for specialty societies developing recommendations and does not necessarily limit the RUC or facilitation committees specifically as they review RVU recommendations for a code or code family. Another member agreed that guidelines would be helpful for RUC members to use when evaluating an appropriate crosswalk. **AMA staff confirmed that the RUC discussed crosswalks at the January 11-14, 2023 RUC meeting and approved new language for the "Instructions for Developing Work RVU Recommendations" document at the September 28-30, 2023 RUC meeting. This document is included in the survey materials for each RUC meeting. The new language is as follows:**

  Alternative Ways to Develop Work Relative Value Recommendations:

  The RUC requires that a survey be conducted for each CPT code presented to the RUC. The survey data is the primary source of information to value physician work for codes presented to the RUC. However, the specialty and/or the RUC may find that the survey results are either flawed or need additional support and may consider alternative ways to develop work relative values. The Specialty RVS committee may wish to consider the following alternative ways of valuing the codes other than use of the survey results, either as a means of strengthening the rationales for its recommendations or as an alternative basis for its recommendations. If either of these alternates is used instead of or in support of the survey results, include a justification on the Summary of Recommendation form.

Expert Panel Methodology: The survey remains the primary source of information to value physician work for codes submitted to the RUC. Expert panel methodology may be submitted if a specialty society determines that the survey may be flawed or needs to be supplemented. A specialty society that chooses to use an expert panel as its primary source of developing a work relative value recommendation must present the survey data and their rationale for using the expert panel.
The expert panel methodology may use comparison codes to determine an appropriate work value recommendation. A "crosswalk" comparison code is a RUC-reviewed code with the same amount of physician work as the survey code, hence the work RVU for the survey code will match that of 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, have clinical similarities to the survey code, and not be flagged in the database as problematic for comparison. In addition, "reference" comparison codes-should be used to support the expert panel's recommendations. A reference code does not need to have the same work RVU as the code under review; however, whenever possible, should share the other attributes of the "crosswalk" codes. A search of the RUC Database will assist specialties and RUC reviewers in finding crosswalk and reference codes that meet these parameters.

The Research Subcommittee will discuss whether further review/action is needed on this topic at their May 2024 meeting.

- A RUC member noted that specialties should have adequate time to present and articulate their recommendations to the RUC. The specialties should understand that the RUC may offer them a break to research a response and then reconvene in the same meeting, if needed. The member stated that the Chair is very effective at this but offered that the specialty societies should be reminded that they have an opportunity to step away from the table if needed. **AMA staff confirmed that this information is included in the introductory presentation from the Chair of the RUC under on the "Procedural Issues" slide stating, "At any time if specialty society presenter requires 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."**

- A RUC member questioned the effectiveness of virtual pre-facilitation committee meetings. **It was noted that the objective of pre-facilitation is stated at the start of each pre-facilitation committee, and includes the following: "To not rehash the RUC reviewer comments that were already submitted to the specialties or for the specialties to provide a full presentation, the pre-facilitation will be conducted as follows:**
    - **The specialty societies will propose any new questions or request help based on the written issues raised by the reviewers;**
    - **The reviewers (first) and then other members (second) will ask the specialty societies any additional questions;**
    - **Last, the specialty societies will bring up any other issues they would like to discuss."**

- A RUC member inquired about the Relativity Assessment Workgroup (RAW) reviewing codes that are flagged in the RUC database as "Do not Use to Validate Physician Work" to see if these codes warrant a screen for re-review. Two RUC members supported re-visiting the codes that are

flagged in the RUC database. **This item has been referred to the Relativity Assessment Workgroup for further discussion.**

- A RUC member inquired about intensity and negative IWPUT and requested that a review is conducted, and guidelines are created on how to treat codes that have negative IWPUT. Further, the intensity of some services seems to outweigh the intensity of others and the member requested that a RUC subcommittee review what criteria could be used to determine circumstances of extraordinarily high intensity. The member also suggested that qualitative and quantitative measures of intensity may differ, and guidelines may also be necessary to appropriately categorize levels of relative intensity. **AMA Staff confirmed that in October 2017, the Relativity Assessment Workgroup identified and examined all 22 services that had a negative IWPUT with Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC noted that going forward the RUC would ensure not to make recommendations that resulted in a negative IWPUT.**

- A RUC member inquired about practice expense inputs related to high-cost disposable supply items, and another member agreed that these items need to be handled separately within the MFS. Both the PE Subcommittee and the RAW considered the issue of high-cost supplies at this meeting. **The RUC strongly supports the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

- A RUC member inquired about the intensity/complexity survey question and the use of the option to have "identical" intensity/complexity or if it should instead state "similar" intensity/complexity compared to the key reference services. Another RUC member stated that because of the definitions, "identical" falls in the middle of the intensity/complexity scale and offered that "similar" does not as there could be an unknown of more or less when it comes to similarity. **AMA staff relayed that this topic was discussed, and the Research Subcommittee report (*see Tab 10*) was approved by the RUC. The Research Subcommittee will discuss on its May 2024 call if there should be further review of these survey questions.**

- A RUC member inquired about how new business referrals are handled. AMA staff responded that if the RUC would like to vote on new business items, then it would be worthwhile to receive them in writing and allow time for AMA staff to research previous RUC actions so that the RUC as a whole can decide on if a referral to a subcommittee/workgroup is appropriate. Another RUC member suggested that the current process should be maintained so that staff can research each item and prioritize issues of importance and further determine appropriate committee/workgroup workload per meeting. **AMA staff request that, when possible, New Business items are received in writing by the RUC recommendation deadline, the Handouts deadline, or by 5pm on Friday of the meeting so that each item can be researched by staff and the appropriate history can be included in the New Business discussion.**

- A RUC participant inquired about gender equity in an RVU system based on the September 2020 article in the New England Journal of Medicine. The participant stated that the findings of the article articulated that female identifying primary care physicians underestimate time spent with their patients when compared to their male counterparts. The participant requested that the appropriate committee should review this potential survey biases. **AMA staff provide the following excerpt from the January 13, 2022 Relativity Assessment Workgroup meeting and approved at the January 12-15, 2022 RUC meeting:**

Gender Equity Payment

The American College of Obstetricians and Gynecologists (ACOG) and the American Urological Association (AUA) convened a joint workgroup to review activities highlighting potential disparities in healthcare reimbursement for female procedure compared to their counter male procedures.

This issue was previously brought to ACOG's attention following the 2017 publication of *Comparison of 2015 Medicare relative value units for gender-specific procedures: Gynecologic and gynecologic-oncologic versus urologic CPT coding. Has time healed gender-worth?* A subsequent evaluation of the code pairs in the article revealed methodologic flaws with their code pairs, including no consideration for the global periods, intra-service work per unit of time (IWPUT), or the methodology of valuation (i.e., Harvard valued or RUC valued). An internal analysis by ACOG's Committee on Health Economics and Coding (CHEC) found there was no marked disparity in the value of services performed on women that have similar services performed on men for code sets that were recently reviewed and had comparable global periods.

The 2017 article resurfaced in an AMA House of Delegates proposed resolution, and again in a 2020 commentary. A subsequent article published in 2021 challenged the physician survey reporting of time when compared to the American College of Surgeon's National Surgical Quality Improvement Program (NSQIP) data, though the comparison did not consider the date of the surveys or the difference in reporting intra-service time on the surveys. Finally, a recently published article, *Reimbursement for Female-Specific Compared With Male-Specific Procedures Over Time,* surmises that female-specific procedures are valued higher than comparable male-specific procedures and that compensation rates are responsible for lower payment. An analysis of the code pairs for the 2021 article revealed the same methodological errors found in the 2017 article.

The ACOG/AUA disparities workgroup reviewed all the services discussed in the articles and identified code pairs for services performed on women that had clinically comparable services performed on men. The workgroup then reviewed CPT in its entirety and identified additional clinically comparable pairs. In total, 19 code pairs were identified for the workgroup analysis looking for potential gender inequity within CPT code values. Of the 19 clinically comparable code pairs, 11 were identified as "Clean" Pairs (i.e., same global periods and comparable time reviewed). The 11 "Clean" pairs revealed higher Medicare physician work RVUs for female procedures in 8 of the clean code pair sets and higher for the male procedures in 3 of the clean pair sets. Of the 19 clinically comparable code pairs, three were identified as "Comparable" Pairs (i.e., varying global periods or different review periods). Of the 19 clinically comparable code pairs, five pairs were identified as "mixed" pairs (i.e. varying global periods, varying dates of review, varying dominant specialties).

Additional Analysis
The ACOG/AUA disparities workgroup analyzed the RUC database comparing gynecology, Urology, and gastrointestinal surgery to gain a broad view of the overall differences in the three specialties. All codes valued by the RUC since 2008 across the 000, 010 and 090-day global periods were compared, including a work RVU per minute of intra-service time. Comparison across the code set revealed no statistical differences between the three specialties.

Conclusions
The workgroup reviewed global periods, intensity of work per unit of time (IWPUT), work per unit of time (WPUT), dominant specialties, utilization data, follow-up care and time-period of last review. The workgroup felt it was not appropriate to compare the five "mixed" code pairs due to their varying global periods, varying dates of review and varying dominant specialties (dermatology/podiatry). It is important to note that many of the services referenced in the publications have 2019 Medicare utilization rates well below 30,000. **Upon conclusion of the analysis, the ACOG/AUA disparities workgroup found that there was no marked disparity in the value of the services performed on women that have similar services performed on men. The societies will continue to work on dissemination of this information through society communication and peer reviewed journal submission.**

In January 2022, the Relativity Assessment Workgroup reviewed the history of this issue, data and articles. A Relativity Assessment Workgroup member summarized this agenda item.

- Issue: Three articles and one commentary in the GYN literature claiming gender-specific procedure RVU value bias and reimbursement discrepancy
- Critique of articles: Significant misunderstanding of how RUC procedures are valued, incorrect assumptions
- Response: ACOG/AUA Workgroup Evaluation of 10 gender paired codes
    - No RVU disparity identified with thorough RUC eval: work RVU, intra-time, total time, IWPUT, WPUT, follow-up care, last review
    - Flawed methods in published studies
    - Upcoming publication of article

Articles Related to Gender Equity Payment
- Benoit (2017):
    - Premise: Gender-specific procedure reimbursement bias based on 1997 study
    - Methods: Aired 50 procedures that were "anatomically similar"
    - Conclusion: Based on work RVU only, authors concluded bias existed in gender related procedures
    - Critique: No other RUC criteria were evaluated: time, global period and post-op, when/how RUC reviewed, CMS accepted/rejected

- Uppal (2021)
    - Premise: Relook at gender-specific procedures
    - Methods:
        - NSQIP median incision to closure time (excluding <5%, >95) vs. RUC typical intra-time: reported difference as "median over-reported time"
        - Calculated work RVU per hour for multiple surgical specialties (gyn in middle range of RVU/hour)
    - Conclusions:
        - "AMA-RUC uses inaccurate self-reported RUC surveys for operative times"
        - Work value discrepancy for gender-specific procedures in gynecology

- Critique:
  - NSQIP vs. RUC time: two different measurements; median vs. mode, what is the procedure distribution? bell shaped? multiple peaks?, data for times not collected at same time
  - Work RVU per hour: inaccurate calculation using median NSQIP time, no other RUC related considerations - global period and post-op, when/how RUC reviewed, CMS accepted/rejected

- Polan (2021)
  - Premise: Any change in value of gender-specific procedures over time
  - Methods applied to 12 pairs of female/male procedures:
    - Median NSQIP times
    - Procedure compensation using Sullivan-Cotter 2018 Compensation Survey
    - Compares RVU data to 1994 McGraw Hill RVU data
  - Conclusions: RVU/hour better for female-specific surgery, male surgery better reimbursement
  - Critique: Omitted evaluation of other RUC factors like previous studies, introduce reimbursement using survey instrument (not RAW concern)

- Watson (2021)
  - Editorial/Commentary by two lawyers
  - Premise: Existence of double discrimination: patient and surgeon gender
  - Content:
    - History of gender bias
    - History of changes in OB/GYN training in the 20th century
    - Suggest potential lawsuit against government that Medicare rates violate the Equal Protection clause of the Constitution
  - Critique: No data, just editorial, reimbursement is not RAW concern

The Workgroup noted that the RUC welcomes critique and suggestions for improvement of the RUC process and the RBRVS. In its consideration of the work by the ACOG-AUA joint workgroup on potential disparities in healthcare reimbursement for gender-specific procedures, the Relativity Assessment Workgroup agrees that the principal direction of the studies and editorials referenced focus on non-RBRVS issues or signal a misunderstanding of the payment system. **The Workgroup supports the activity of ACOG and AUA to prepare an article for publication addressing the flawed findings of the referenced articles. As of July, 1 2024 the article is published and available here: https://www.auajournals.org/doi/10.1097/UPJ.0000000000000612.**

Separately, the Relativity Assessment Workgroup examined the potential misvaluation of preventive care codes (99381-99397) based on gender-related patient care. The Workgroup indicated that there may be additional resources associated with preventive services when a pelvic examination is performed. The RUC referred this issue to the CPT Editorial Panel. In September 2022, the CPT Editorial Panel created a new add-on code to report a pelvic exam. This service was reviewed by the RUC in January 2023 and CMS accepted the RUC recommendation for the 2024 Medicare Physician Payment Schedule.

The RUC adjourned at 11:24 AM CT on Saturday, April 27, 2024.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE **Tab 10**
Research Subcommittee Report
Thursday, April 25th

Members Present: 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, Kevin Kerber, MD, Kristopher Kimmell, MD, M. Douglas Leahy, MD, Swati Mehrotra, MD, Anne Miller, MD, Lauren Nicola, MD, Sanjay A. Samy, MD, James Shoemaker, MD, Matthew Sideman, MD, Mark Villa, MD, David Yankura, MD, Robert Zipper, MD, Robert Zwolak, MD

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

The Research Subcommittee report from the February 20th conference call included in Tab 10 of the April 2024 agenda materials was approved without modification.

II. Discussion – Physician Work Intensity Survey Questions *(continued from January 2024 Research meeting)*

During the RUC's *New Business* discussion at the April 2023 RUC meeting, a RUC member inquired about physician work intensity and how that impacts the adjudication of services. As part 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 RUC referred the survey intensity and complexity questions topic to the Research Subcommittee for discussion and it was most recently briefly discussed in January 2024.

At the April 2024 meeting, AMA RUC staff prepared a detailed historical overview as a reference for the Subcommittee which is available in tab 10 of the April 2024 RUC meeting materials. The Chair noted and several members agreed that the intensity elements of work have been considered subjective and therefore challenging to measure from the initial Harvard process and that has not changed. As such it is not entirely surprising that the Subcommittee has been asked to review the I/C questions roughly every other year since 2015. The most recent decision, made in January 2022, was that no changes were warranted at that time.

The Subcommittee discussed the summary data from January 2022 that detailed the trend of the overall intensity complexity relationship to the KRS over the prior two-year period. The Chair noted that, while the summary data demonstrate a slight right shift in the scale (survey code more intense than KRS), the reasons behind this are not entirely clear. One reason may be that the survey respondents are asked to select the reference code that is most like the survey code and the RSL is ordered from low to high RVW services with the respondent selecting the first code from the top that is similar instead of going further down the list. It is also possible that there could sometime be some survey bias toward higher intensity of the code under survey versus the KRS by the mere fact of the code being under review. The "much less" and "much more" intense choices are also relatively infrequently selected; this is perhaps due to the survey respondents being asked to select a reference service from the RSLs that is most similar to the survey code.

Some Subcommittee members noted that the current I/C questions are streamlined and strike the right balance between ease of the survey respondent and providing information to the RUC. Subcommittee members concurred that I/C questions are inherently subjective to the individual. They noted that the survey I/C questions are much more streamlined now with only 5 dropdown questions per survey code,

whereas before 2015, the standard RUC survey required for the respondent to answer 22 dropdown questions on intensity and complexity per survey code. This change still preserved the original definitions and reduced survey fatigue.

The Vice Chair provided a summary of their observations of the measure of physician work intensity, the Intra-service Work per Unit of Time (IWPUT). They noted that magnitude estimation is the primary role of magnitude estimation. They noted that IWPUT is most accurate when used *within code families* due to similar underlying work/time assumptions. They observed that IWPUT becomes less reliable when comparing relativity beyond code families. They also noted their concern with the work per unit time (WPUT) metric and its use in valuation discussions is, at best, confirmatory, but more frequently irrelevant.

A Subcommittee member noted their concern that the psychological stress I/C definition was not expansive enough as it does not account fully for physician stress that is not affected by skill or judgment. AMA RUC staff noted that the background definitions for time, mental effort and judgement, technical skill, physical effort and psychological stress came from the original Harvard study and the Centers for Medicare & Medicaid Services (CMS) and could only be changed by CMS via rulemaking.

Other Subcommittee members suggested adding an additional survey question to compare the I/C of the survey code to its past self for codes that are being re-surveyed. Others noted that this could be misleading for existing codes that underwent a coding structure change. AMA RUC staff also noted that a similar question was included in survey instruments for the 2nd Five-Year review in 2000. **The Research Subcommittee agreed that no changes are necessary at this time to either the intensity and complexity measures or to any of the RUC processes instructions documentation with respect to intensity and complexity.**

AMA/Specialty Society RVS Update Committee **Tab 11**
Practice Expense Subcommittee
April 24, 2024

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, John Blebea, MD, Michael Booker, MD, Joseph Cleveland, MD, Neal Cohen, MD, William Gee, MD, David Han, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, MBA, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Thomas Weida, MD, Adam Weinstein, MD, and Timothy Swan, MD (CPT Resource)

I. High-Cost Supplies

At the January 2024 meeting, the Practice Expense (PE) Subcommittee expressed its continued concern with the issue of high-cost supplies and the need to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. Therefore, AMA staff provided the most recent list of high-cost disposable supplies (over $500 and over $1000) for discussion at this April meeting.

Doctor Manaker reiterated that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting.

The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high-cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services.

The PE Subcommittee noted the significant scaling factors that are applied for budget neutrality as part of the PE methodology. There are 84 services in which the practice expense payment does not even cover the supply expense. For 20 services, the practice expense payment does not cover the cost of a single high cost supply utilized in the provision of the service. CPT code 33285 *Insertion, subcutaneous cardiac rhythm monitor, including programming* was provided as an egregious example where the total Medicare Non Facility Payment equals $4,138.97 while the PE supply cost totals $5,077.38 due to high-cost supply item SA127 *subcutaneous cardiac rhythm monitor system* priced at $5,032.50. AMA staff will share these analyses at the next RUC meeting.

In addition, it was noted that the Relativity Assessment Workgroup (RAW) is considering the issue of high-cost supplies at this meeting and whether codes with high-cost disposable supplies should be flagged for PE re-review. The RAW will determine if a useful screen can be developed to identify any potentially misvalued services.

The PE Subcommittee acknowledged the increased frequency of high-cost supplies in the RUC recommendations and continues to strongly support the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes.

Approved by the RUC – April 27, 2024

II. Radiology-specific Clinical Activities, CA014 *Confirm order, protocol exam*

The PE Subcommittee discussed the use of Clinical Activity (CA) code CA014 *Confirm order, protocol exam.* The guidelines for this clinical activity specify "For use in imaging services only. 1 minute standard." Protocoling exams has a very specific meaning in CT and MRI that describes the work of choosing which imaging sequences or contrast phases to perform. However, it was noted that CA014 has been repeatedly requested for non-imaging procedures despite the instructions which state that the task is only for imaging. The task of verifying the correct patient and procedure/medicine happens in nearly every procedure (aka the "time out") and is not intended to receive additional time in a relative system.

The PE Subcommittee considered a database search that showed over 20 of the 66 codes with CA014 greater than 0 minutes are non-imaging. The Subcommittee discussed that the work being described in the injection and immunization codes, for example, is broadly performed across the code set and is not strictly protocoling. They determined that the CA014 minutes could be allocated in the non-radiology codes and will develop a few examples ("e.g.") to clarify the instructions, similar to CA010 *Obtain vital signs* that specifies different levels and vital signs for consistency.

The PE Subcommittee agreed to further discuss examples for CA014 at its September meeting. In addition, they will need to determine whether the other 5 codes that state "for imaging services" (below) should remain radiology specific or whether the statement should be removed such that every procedure could justify the 1 or 2 minutes standard as needed.

CA006	Confirm availability of prior images/studies	General Activity	For use in imaging services. 2 minute standard.
CA007	Review patient clinical extant information and questionnaire	General Activity	For use in imaging services. 1 minute standard.
CA014	Confirm order, protocol exam	General Activity	For use in imaging services. 1 minute standard.
CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	General Activity	For use in imaging services, Baseline time for this activity is 2 minutes.
CA031	Review examination with interpreting MD/DO	General Activity	For use in imaging services, Standard time for this activity is 2 minutes.
CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	General Activity	For use in imaging services, Standard time for this activity is 1 minute.

A primary concern was perceived inconsistency with the instructions. The Subcommittee will determine any necessary updates to clarify the *Instructions for Practice Expense Spreadsheet* and the PE Spreadsheet.

III. Practice Expense Recommendations for CPT 2026

The table below corresponds to the final PE spreadsheets as adopted at the meeting. Please refer to the specific spreadsheets for details on the practice expense input recommendations for each tab.

Tab	Title	PE Input Changes	Consent Calendar
4	Endovascular Therapy with Imaging	Modifications	
5	Dark Adaptation Diagnostic Screening and Services	Modifications	
6	Coronary Therapeutic Services and Procedures	No Direct PE Inputs	X

Tab	Title	PE Input Changes	Consent Calendar
7	Respiratory Syncytial Virus (RSV) Monoclonal Antibody Administration	Modifications	
8	Closure Left Atrial Appendage with Endocardial Implant	No Changes Existing Direct PE Inputs	X
9	Biofeedback Training	Referral to CPT Editorial Panel	X
14	Hearing Device Services	Contractor-Pricing	X

AMA/Specialty Society RVS Update Committee **Tab 12**
Relativity Assessment Workgroup
April 25, 2024

Members Present: Doctors Matthew Grierson (Chair), Gregory DeMeo (Vice Chair), Jennifer Aloff, Amr Abouleish, Dale Blasier, Audrey Chun, Daniel Duzan, Patrick Godbey, Marth Gray, Gregory Harris, Greory Nicola, John Proctor, Kyle Richards, Michael Sutherland, John Thompson and Korinne Van Keuren, DNP.

I. Review Action Plans

Codes Reported 75% Together or More

Cataract/Goniotomy/Canaloplasty Procedures (65820, 66174, 66175, 66982, 66984)
In April 2023, the Relativity Assessment Workgroup identified codes 65820 and 66984 as reported together 75% or more based on 2021 Medicare claims data. In September 2023, the RUC referred cataract (66982 & 66984), goniotomy (65820), and canaloplasty (66174) to CPT Editorial Panel to develop a code bundling solution. In December 2023, the specialty societies noted that the 2022 Medicare data showed a large decrease in these services being performed together and they no longer meet the 75% performed together threshold. The specialty societies also noted that this entire family will be reviewed under the new technology/new services screen with code 66991 in April 2025. **The Workgroup reviewed the action plan and agreed with the specialty society that codes 65820, 66174, 66175, 66982 & 66984 may be removed from the Codes Reported Together 75% or More screen.**

Magnetic Resonance Angiography (MR) Head/Neck (70544, 70547)
In April 2022, the Relativity Assessment Workgroup identified codes 70547 and 70544 as reported together 75% or more based on 2020 Medicare claims data. The Workgroup requested action plans for September 2022 to determine if specific code bundling solutions should occur. In September 2022, the Workgroup recommended review in 2 years (2021-2022 data) after practice patterns in the inpatient and outpatient setting go back to how it was prior to the pandemic. **The specialty societies recommended, and the Workgroup agreed that 70547 and 70544 be referred to the CPT Editorial Panel (Feb 2025) to create a code bundling solution.**

Contractor-Priced High Volume

*Long-Term EEG Monitoring (95700, 95715) *Also on New Tech/New Services List*
In May 2018, the CPT Editorial Panel revised one code, deleted five codes, and created twenty-three codes for reporting long-term EEG professional and technical services. In April 2022, the Workgroup identified these codes as contractor priced high volume, with 2020 Medicare utilization over 10,000. The Workgroup requested action plans for September 2022. In September 2022, the Workgroup agreed that utilization was much lower than expected and this service should be reviewed after 2 years of data are available (2021-2022 data) after variation due to the pandemic stabilizes.

In April 2024, the Workgroup noted that this entire family of services 95700-95726 are on the New Technology/New services list. Additionally, other codes in this family are contractor-priced but did not meet the Medicare Utilization threshold to meet this screen. The Workgroup indicated that it would address CPT codes 95700 and 95715 with this entire family via the New Technology/New Services screen. **The Workgroup recommends that CPT codes 95700 and 95715 be removed from the Contractor-Priced High-Volume screen and be addressed with this family of services on the New Technology/New Services screen and be reviewed in 3 years (April 2027).**

Different Performing Specialty from Survey

Knee Arthrography Injection (27369)
In June 2017, the CPT Editorial Panel deleted injection of contrast for knee arthrography code 27370 and replaced it with new code 27369, to report injection procedure for knee arthrography or enhanced CT/MRI knee arthrography. In April 2022, the Workgroup identified code 27369 with 2020 Medicare utilization over 10,000 where the service was performed by one specialty but is now performed by a different specialty. The Workgroup requested an action plan for September 2022. In September 2022, the Workgroup recommended that this service be reviewed in 2 years to allow education on miscoding to take effect.

In April 2024, the specialty societies recommended removing 27369 from the Different Performing Specialty from Survey screen because a few orthopaedic surgeons are driving the utilization of this service. However, the Workgroup noted that nurse practitioners are the top performers of this service and other providers may also be misreporting 27369 instead of 20610 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance* or 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting*. **The Workgroup recommends that the nurse practitioners and physician assistants work with AAOS, ACR and SIR to develop a CPT Assistant article on how to correctly report CPT code 27369, especially when to report 27369 versus 20610 and 20611.**

Remote Physiologic Monitoring Treatment Management (99457) **Also on New Tech/New Svcs List*
In April 2022, the Relativity Assessment Workgroup identified code 99457 with 2020 Medicare utilization over 10,000 where a service was performed by one specialty but is now performed by a different specialty. The Workgroup requested an action plan for September 2022. In September 2022, the Workgroup recommended that this service be reviewed in 2 years (2021-2022 data) after utilization has stabilized after the pandemic.

In April 2024, the Workgroup noted that this service, along with the family of codes 99453-99458 are on the new technology/new services list for review at this meeting. The specialty societies indicated that a coding application has been submitted for May 2024 to review RPM/RTM codes (which may require survey of this code) and to refer this issue to CPT Assistant regarding correct coding of this family of services. **The Workgroup recommends that this code family be reviewed at the next Relativity Assessment Workgroup meeting in September 2024 to summarize what has occurred at the CPT Editorial Panel. The Workgroup notes that if this family is not addressed via the upcoming CPT process that the Workgroup should discuss when it would be surveyed.**

High Volume Growth

Debridement (11046)
In April 2022, the Relativity Assessment Workgroup identified these services via the high-volume growth screen, with Medicare utilization over 10,000 that has increased by at least 100% from 2015 through 2020. The Workgroup requested that the specialty societies submit an action plan for September 2022. In September 2022, the Workgroup recommended to review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes. **The Relativity Assessment Workgroup agreed with the specialty societies to maintain and remove CPT code 11046 from the high-volume screen because the growth has leveled off and is appropriate based on the patient population's needs.**

Endovascular Revascularization (37220-36235)
In October 2018, CPT code 37229 was identified on the High-Volume Growth screen and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies. The specialty societies worked with the CPT Editorial Panel and submitted multiple coding change proposals. In September 2021, CPT Editorial Panel did not approve of the proposed coding changes suggested unbundling previous bundling efforts. Since this issue was not addressed via edits at CPT, it was placed back on the Relativity Assessment Workgroup agenda to review. In April 2022, the Relativity Assessment Workgroup discussed the complexity of this issue and determined that coding clarification is still necessary. The Workgroup recommended that a joint CPT/RUC Workgroup be created to develop coding solutions for the endovascular revascularization (37220-37235) code family. In September 2022, CPT indicated the specialty societies should develop a CCA by the May 2024 CPT meeting. The specialty societies had a conference call with the Panel members in April 2023 to review the revised coding structure. The Panel suggested some edits and indicated that specialty societies did not have to have literature for all the "current codes" just the new codes. Next the specialty societies developed the guidelines but could not do that until mid-Sept 2023 because the app was shut down. In March 2024, the CCA was entered in the smart app and will be submitted for the June 2024 deadline for review by the Panel at the September 2024 meeting.

In April 2024, the Relativity Assessment Workgroup agreed that the specialty societies should pursue the CPT process to revise and survey CPT codes 37220-36235. **The Workgroup requests that this issue be placed on the September 2024 Relativity Assessment Workgroup agenda and the specialty societies provide an update for what occurred at CPT.**

Pulmonary Imaging (78580)
In April 2022, the Relativity Assessment Workgroup identified these services via the high-volume growth screen, with Medicare utilization over 10,000 that has increased by at least 100% from 2015 through 2020. The Workgroup requested that the specialty societies submit an action plan for September 2022. In September 2022, the Workgroup recommended to review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes.

In April 2024, the specialty societies indicated that the growth was due to during the pandemic because nuclear medicine departments switched to a single perfusion only protocol for lung imaging from the more common practice of both perfusion and ventilation protocols. This switch triggered the increase in CPT 78580, which was caught by the RAW screen. Additionally, utilization is steadily decreasing. **The Relativity Assessment Workgroup agrees with the specialty societies and recommends that CPT code 78580 be maintained and removed from the high-volume growth screen because the utilization is now decreasing after different coding practices during the pandemic have ceased.**

Psychotherapy for Crisis and Interactive Complexity (90785)
In October 2019, the Relativity Assessment Workgroup identified this service via the high-volume growth screen with Medicare utilization of 10,000 or more and has increased by at least 100% from 2013 through 2018. The Workgroup requested action plans for review at the January 2020 Relativity Assessment Workgroup meeting. In January 2020, the RUC recommended referring to CPT to modify the parentheticals to reflect all services that may not be reported with code 90785. In October 2020, the CPT Editorial Panel revised two parentheticals, added two new parentheticals, and revised the Psychiatry Interactive Complexity guidelines to reflect all services that may not be currently reported with this service. The Workgroup will review the utilization of this service in Sept 2023 to determine if the growth has decreased due to these changes. In September 2023, the Workgroup noted that the Medicare utilization for CPT code 90785 has been decreasing since 2017. However, the Workgroup noted that the revised parenthetical was effective in CPT 2022 and the 2022 Medicare billed together data are not.

available to assess which codes this service is reported. The Workgroup recommended that the specialty societies submit an action plan for April 2024, after the 2022 Medicare billed together data is available to accurately assess this service's high-volume growth and codes in which it is reported.

In April 2024, the specialty societies indicated to maintain and remove CPT code 90785 from the high-volume growth screen. The CPT 2022 coding guidance on which codes 90785 may be reported has been effective. Additionally, the specialty societies noted that two physicians are miscoding a large portion of this service as the number of times they are reporting does not seem possible. Overall, growth has been steadily decreasing since its height in 2018. **The Workgroup recommends that CPT code 90785 be maintained and removed from the high-volume growth screen.**

High Volume Category III Codes

In April 2022, the Workgroup identified codes 0054T, 0055T and 0232T via the high-volume Category III code with 2020 Medicare utilization over 1,000. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. In September 2022, the Workgroup recommended reviewing these services in 2 years after additional claims data are available (2021-2022 data).

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures (0054T, 0055T)
In April 2024, the specialty societies indicated that codes 0054T and 0055T be removed from the high-volume Category III code screen, citing there is not sufficient literature that meets the criteria for Category I code status. However, the Workgroup noted that codes 0054T and 0055T are steadily increasing. **The Workgroup recommends that 0054T and 0055T be reviewed in 3 years after additional data is available.**

Platelet Rich Plasma Injection (0232T)
For code 0232T, the specialties noted that the utilization has decreased, and the technology is evolving, and there is not there is not sufficient literature that meets the criteria for Category I code status. **The 0232T be removed from the high-volume Category III screen since currently there is not sufficient literature to support creation of a Category I code.**

Bioelectrical Impedance Analysis (0358T)
In April 2023, code 0358T service was identified via the high-volume Category III codes based on 2021 Medicare utilization data over 1,000. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. In September 2023, the Workgroup recommended to review 2022 Medicare claims data and review at the April 2024 RAW meeting.

In April 2024, the specialty societies requested that 0358T be removed from the high-volume Category III screen because half of the 2021 Medicare utilization for 0358T was performed by five physicians and some miscoding may be occurring. The specialty societies are also not aware that this test is the standard of care and service is performed so infrequently to meet the criteria for a Category I code. **The Relativity Assessment Workgroup recommends that 0358T be removed from the high-volume Category III screen due to possible miscoding and lack of utilization for Category I code status.**

PE Stand-Alone Procedure Time

External Cardiovascular Device Monitoring (93229, 93271)
In September 2023, AMA staff summarized the previous PE screens and the Workgroup recommended lowering the Medicare allowed charges threshold from $100,000 to $50,000 for the Services with Stand-Alone PE Procedure Time screen, for codes that have 0.00 work RVUs, including direct equipment inputs

that total in direct expense to the individual code to $100 or more, and have PE procedure times (CA021) greater than five minutes. In January 2024, the Relativity Assessment Workgroup identified codes 93229 and 93271 via this second iteration of the screen. The Workgroup requested an action plan for the April 2024 meeting on how to best address these services.

In April 2024, the specialty societies requested that CPT code 93229 be removed from the PE stand-alone procedure time screen. This code was reviewed and updated at the October 2020 RUC meeting. The code was surveyed and compelling evidence for changes was established as there were significant changes in the technology as well as primary entity performing the service (changing from cardiologists to independent diagnostic testing facilities). These changes to technology and performance were addressed three years ago and no significant changes have occurred since. **The Relativity Assessment Workgroup recommends that CPT code 93229 be removed from the PE stand-alone procedure time screen.**

The specialty societies also requested that CPT code 93271 be removed from the PE stand-alone procedure time screen due to the long history of CMS working with IDTF and vendor stakeholders to set pricing for this service through half a dozen rulemaking cycles. Further, the PE Subcommittee recently reviewed the supplies and equipment involved and CME affirmed the existing prices for the equipment that constitutes the majority of the PE costs for the service. **The Relativity Assessment Workgroup recommends that CPT code 93271 be removed from the PE stand-alone procedure time screen.**

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 2020 codes that were flagged at the April 2018, October 2018, and January 2019 RUC meetings, with three years of available Medicare claims data (2020, 2021 and 2022). **The Workgroup reviewed the action plans and recommends the following:**

CPT Code	Issue	Workgroup Recommendation
15769 15771 15772 15773 15774	Tissue Grafting Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
20560 20561	Trigger Point Dry Needling	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
20700 20701 20702 20703 20704 20705	Drug Delivery Implant Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. The Workgroup noted that the technology was well established when these codes were created and the utilization is lower than was expected.
33361 33362 33363 **33364** 33365 33366	Transcatheter Aortic Valve Replacement	**Review an update from the specialty societies in 1 year (April 2025).** The specialty societies indicated a couple changes: 1) The patient population has changed and is/will be performed on not just the sickest patients but will be available to more candidates and these services may be used to treat aortic regurgitation. 2) The services are changing and co-surgery may not necessarily be necessary in the future. The specialties may pursue a request for CMS to removal of the National Coverage

		Determination (NCD) regarding co-surgeons for these services. 3) Coding changes may be necessary to keep the highest performed service 33361 for the percutaneous femoral artery approach and delete some of the very low utilized codes and create one code for all other approaches.
43284 43285	Esophageal Sphincter Augmentation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
46948	Transanal Hemorrhoidal Dearterialization	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
62328 62329	Lumbar Puncture	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
64450 64454 64624 64640	Genicular Injection and RFA	Review again in 2 years (April 2026).
64451 64625	Radiofrequency Neurotomy Sacroiliac Joint	Review again in 2 years (April 2026).
78429 78430 78431 78433 78434 78459 78491 78492	Myocardial PET	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. The Workgroup noted that these services were recently bundled and will come up on the high volume screen they reach those criteria.
78830 78831 78832 78835	SPECT-CT Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
90867 90868 90869	Transcranial Magnetic Stimulation	**Review September 2024 with an update from the specialty society.** The specialties indicated that there are changes in protocol for these services and coding changes are necessary. These codes are also contractor priced. The Workgroup questioned what specific coding changes would be included in a CCA. The specialty society will return at the next meeting to elaborate on the coding changes necessary. The specialty societies should also consider any Category III codes that are related to these services when drafting their CCA.
95700 95705 95706 95707 95708 95709 95710 95711 95712 95713 95714	Long-Term EEG Monitoring	Review in 3 years (April 2027).

95715 95716 95717 95718 95719 95720 95721 95722 95723 95724 95725 95726	Long-Term EEG Monitoring (cont'd)	Review in 3 years (April 2027).
96931 96932 96933 96934 96935 96936	Reflectance Confocal Microscopy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
98970 98971 98972 99421 99422 99423	Online Digital Evaluation Service (e-Visit)	Review again in 1 year (April 2025). The Workgroup noted that only two years of data was available for codes 98970-97972 and the Workgroup should review when an additional year of data is available.
99453 99454 99457 99458	Chronic Care Remote Physiologic Monitoring	**Review September 2024 with an update from the specialty societies.** CCA has been submitted for May 2024 to review RPM/RTM codes (which may require survey of these codes). Refer to CPT on correct coding of this family of services.
99474	Self-Measured Blood Pressure Monitoring	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

Services with Less than 30 Survey Responses

Transcatheter Aortic Valve Replacement (33364)
In April 2018, CPT code 33364 did not reach 30 survey responses and was scheduled to be re-reviewed in three years by the Relativity Assessment Workgroup. The Workgroup noted that the TAVR family of services was also identified on the new technology/new services list 33361-33366 and reviewed at this meeting (all discussion is previously noted in that section of this report). **The Relativity Assessment Workgroup requests to review an update from the specialty societies in 1 year (April 2025).**

II. Reiteration of Screens – Review 2022 Data

High Volume Growth
The Workgroup identified five codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. **The Workgroup requests that the specialty societies submit an action plan for codes 15272, 20985, 61783, 92507 and 95800 for September 2024.**

Different Performing Specialty form Survey
The Workgroup identified six codes where the top two dominant specialties performing services based on 2022 Medicare utilization more than 10,000 and where the top specialty performing over 50% of the Medicare claims did not survey the service or the top two specialties did not survey the service. **The Workgroup requests action plans for codes 11305, 11308, 28750, 77280, 94625 and 96112 for September 2024.**

Contractor-Priced High Volume
The Workgroup identified one code with 2022 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. **The Workgroup requests an action plan for G0498 for September 2024.**

Category III High Volume (0552T and 0599T)
The Workgroup identified two Category III codes with 2022 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the Category III high volume 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 0552T and 0599T for September 2024.**

Work Neutrality CPT 2022 (94625 and 94626)
The Workgroup identified one issue for codes that were reviewed for CPT 2022 (April 2020, October 2020, and January 2021) that have more than 10% increase in work RVUs from what was projected. **The Workgroup requests and action plan Outpatient Pulmonary Rehabilitation Services (94625 & 94626) for September 2024.**

Services Performed Together 75% or More (18 code pairs)
The Workgroup identified 16 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 2022 Medicare claims data and/or contained at least one ZZZ global service were removed. **The Workgroup requests action plans for September 2024 to determine if specific code bundling solutions should occur for the following code pairs.**

CPT Code 1	CPT Code 2	Percent Billed Together
13152	17311	76%
31525	31231	80%
31525	69210	75%
77301	77300	79%
77301	77338	88%
77338	77300	81%
77338	77301	80%
77401	77280	77%
77600	77280	94%
92546	92540	84%
92550	92557	90%
92567	92557	85%

93016	93018	77%
95861	95938	86%
95921	95923	87%
95939	95938	95%

III. Discussion Items

Performance Rate

At the January 2024 RUC meeting, a RUC member suggested that the RAW consider a screen to re-review codes where the median performance rate, captured in the initial survey process, is low utilization.

The current RUC instructions for developing work recommendations specify the options that specialty societies may take if the survey median performance rate is zero. Each is addressed on a case-by-case basis.

> **Service Performance Rate**
> The RUC considers performance rate to be a key component of the work evaluation process. If a specialty society determines that after surveying, the survey data results in a median service performance rate of zero the specialty society has the following options:
>
> 1) The specialty society can re-survey the code.
> 2) The specialty society can refer the code to the CPT Editorial Panel for further clarification on the code;
> 3) The specialty society can use a RUC-approved alternative method to value the survey;
> 4) The specialty society can present the survey data to the RUC with separate summary of recommendation forms summarizing the data for those who have performed the service, those who have not performed the service and the aggregate data. If this option is selected, the specialty society must report the performance rate of the reference code on their aggregate summary of recommendation form in the additional rationale section.

The table below includes the low performance rate data from the last 5 years of Summary of Recommendation forms.

RUC SOR Cycle	Zero Median Perf (Count)	Zero Median Perf (%)	1 Median Perf (Count)	1 Median Perf (%)	2 Median Perf (Count)	2 Median Perf (%)	3 or More Median Perf (Count)	3 or More Median Perf (%)	Total SORs
2021	2	2%	2	2%	6	6%	91	90%	101
2022	5	5%	7	7%	10	10%	83	79%	105
2023	8	6%	7	5%	9	6%	120	83%	144
2024	12	21%	6	11%	11	20%	27	48%	56
2025	7	6%	8	7%	6	5%	101	83%	122
Grand Total	**34**	**6%**	**30**	**6%**	**42**	**8%**	**422**	**80%**	**528**

In April 2024, the RAW discussed if a new screen on low performance rates on surveys should be developed. The Workgroup noted that specific information is already required for surveys with zero performance rates and the RUC analyzes each on a case-by-case basis. Additionally, there is a process in

place to re-review any surveys that are below the 30 required survey threshold. **The Workgroup determined that a screen is not necessary at this time to further identify services in which the services surveyed have a low performance rate by physicians or qualified healthcare professionals who are completing the survey.**

High-Cost Disposable Supplies

In January 2024, a RUC member suggested that codes with high-cost disposable supplies be flagged for PE re-review. For at least the last 20 years, the RUC has continuously requested that CMS separately identify and pay for high-cost disposable supplies (priced at more than $500). The RUC continues to identify and notify CMS of high-cost disposable supplies every time it reviews such an item.

Additionally, as recent as the January 2024 RUC meeting, *"The PE Subcommittee expressed its continued concern with the issue of high-cost supplies and the outsized impact these items have within the current practice expense RVU methodology.* ***The RUC will continue to call on CMS to separately identify and pay for high-cost disposable supplies (i.e., priced more than $500) using appropriate HCPCS codes."***

In April 2024, the Practice Expense Subcommittee continued to examine this issue. The PE Subcommittee noted that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting.

The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high-cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services.

In April 2024, the Relativity Assessment Workgroup discussed this issue to determine if a useful screen should be developed to identify any potentially misvalued services. The Workgroup noted that there are significant scaling factors that are applied for budget neutrality as part of the PE methodology, which may result in payments that are lower than the cost to provide a service. There are 84 services in which the total practice expense payment does not cover the total direct supply expense for the code. For 20 of these 84 services, the practice expense payment does not even cover the cost of a single high-cost supply utilized in the provision of the service.

The Workgroup indicated that it would be part of existing precedent to identify services for PE review only. **The Workgroup determined to review the list of impacted services at the September 2024 Relativity Assessment Workgroup meeting and determine next steps.**

In addition, it was suggested that at the time a new code is reviewed and a supply item costing more than $500 is included in the direct inputs, the code should be flagged as new technology. The PE Subcommittee should note those codes with high-cost supplies to the RUC at the time of review and the RUC could opt to add the code to new technology.

IV. Informational Items

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

AMA/Specialty Society RVS Update Committee **Tab 13**
Multi-Specialty Points of Comparison (MPC) Workgroup
April 25, 2024

Members Present: Amr Abouleish, MD (Chair), Gregory Harris (Vice Chair), Jennifer Aloff, MD, Anita Arnold, DO, Charles Fitzpatrick, OD, Alexandra Flamm, MD, Stephen Gillaspy, PhD, John Heiner, MD, Gwenn Jackson, MD, Howard P. Levy, MD, PhD, Bradley Marple, MD, John Proctor, MD, Kyle Richards, MD

I. Review of MPC History Process and Criteria Document

At the January 2024 MPC Workgroup meeting during Other Business, the Workgroup discussed future review and refinement of the Suggested Criteria listed in the MPC Summary of Process document after the specialty societies had been solicited by AMA staff for their feedback regarding the submission form. The Workgroup Chair also recommended an addition to the Suggested Criteria list wherein codes that were surveyed for the RUC within the last 10 years are given preference over those that were surveyed more than 10 years ago. It was discussed that this suggested criterion may prevent less turnover on the MPC list with respect to the 15-year sunset review and prioritize including more recent codes.

In preparation for the April 2024 MPC Workgroup meeting, AMA staff drafted the MPC History, Process and Criteria document, a new and revised version of the former MPC Summary of Process document. This new document more clearly organizes the historical content included in the old document, including reordering criteria and categorizing the history of the process more appropriately for reference. The new document also includes the proposed suggested criteria for codes surveyed within the last 10 years.

The MPC Workgroup reviewed the MPC History, Process and Criteria document and recommends the following two revisions:

- *Modifying existing language to account for the annual 15-year sunset review:* "Review the codes on the current MPC list **that have been valued more than 15 years prior** and identify those to be retained according to the new criteria."
- *Adding a new line to the Suggest Criteria:* **"Codes should have undergone RUC review within the past 10 years."**

The MPC Workgroup approved the revised MPC History, Process and Criteria document with the addition of the proposed suggested criterion.

In preparation for the January 2025 MPC Workgroup meeting, the Workgroup noted that the MPC Submission Form will be distributed to specialty societies for the annual review of the MPC list. The revised form will include an additional comment box to provide specialty societies the opportunity to provide a rationale for whether a code should be included on the MPC list or not if it was not valued by RUC survey (e.g., crosswalk evaluation). The Workgroup recognized that the updates to the submission form will help in the proposal and review of code recommendations to the MPC list.

Members Present: Peter Hollmann, MD *(Chair),* Richard Rausch, DPT, MBA *(Co-Chair),* Leisha Eiten, AuD, CCC-A *(Alt. Co-Chair),* Amr Abouleish, MD, Kris Anderson, DC, MS, Shannon Butkus, PhD, CCC-SLP, Michael Doll, PA-C, Charles Fitzpatrick, OD, Stephen Gillaspy, PhD, Mary Walsh-Sterup, OTR/L, Mirean Coleman, LCSW, Korinne Van Keuren, DNP, MS, RN, Susan Walsh, DPM, MBA, Robert Zwolak, MD

I. Introductions and CMS Update

Doctor Rausch welcomed the Health Care Professionals Advisory Committee (HCPAC) to the in-person meeting.

Gift Tee, Deputy Director, Centers for Medicare & Medicaid Services (CMS), provided the HCPAC with an update and offered a reminder that the Proposed Rule will be released in July 2024, and to reach out with any questions. Mr. Tee provided a brief review of the topline items in the 2024 Final Rule and expressed appreciation for non-MD/DO participation in the RUC HCPAC Review Board as CMS is eager to hear from the participating professional organizations as Rules are released.

II. HCPAC Review Board Structure & Processes

The RUC HCPAC Review Board reviewed the addition of the American Association of Marriage and Family Therapy (AAMFT) to the RUC HCPAC Review Board Structure and Process. The addition of this non-MD/DO professional organization will allow for one HCPAC Advisor and one HCPAC Alternate Advisor to represent marriage/family therapists. Marriage/family therapists are required to use CPT to report the services they provide independently to Medicare patients under the defined Medicare benefit outlined in the CY 2024 CMS Final Rule. **The RUC HCPAC Review Board voted to approve the addition of AAMFT to the HCPAC Structure and Processes, bringing the total amount of participating organizations from twelve to thirteen. AAMFT is eligible to appoint advisors for attendance at future RUC HCPAC Review Board meetings.**

III. Relative Value Recommendations for CPT 2026

Hearing Device Services (92628, 92629, 92631, 92632, 92634, 92635, 92636, 92637, 92638, 92639, 92641, 92642)

At the February 2024 CPT Editorial Panel meeting, 12 new Category I codes were created to report hearing devices services (eg, air-conduction hearing aids) including hearing aid candidacy determination, hearing aid selection, hearing aid fitting, follow-up after fitting, hearing aid verification, and assistive-device services. The current CPT codes, 92590-92595, are recommended for deletion. It is important to note that codes 92590-92595 are considered non-covered services by CMS. Therefore, the RUC database reflects minimal data related to the delivery and utilization of these services. Given the current status of Medicare coverage, CPT codes 92590-92595 have never been surveyed by the RUC HCPAC Review Board. CPT codes 92628-92642 were reviewed at the April 2024 RUC HCPAC meeting.

The RUC HCPAC Review Board reviewed the recommendation from the specialty societies to contractor price all 12 of the new hearing device services codes. The recommended codes for deletion to report hearing aid services (92590-92595) are currently non-covered by Medicare. The specialty societies noted that since these services, which are predominantly performed by audiologists, are either noncovered services for commercial payers or statutorily excluded services for government health care programs they should be contractor priced. Further, existing payment models for hearing aid services are varied, and may be bundled into payments for hearing aids. The RUC HCPAC Review Board agreed with the recommendation of contractor pricing for all 12 codes.

The RUC HCPAC Review Board recommends contractor pricing for CPT codes 92628, 92629, 92631, 92632, 92634, 92635, 92636, 92637, 92638, 92639, 92641, 92642.

IV. Other Business

Sherry Smith, Director of Physician Payment Policy and Systems at the AMA, provided an update on the Physician Practice Information (PPI) survey. The RUC HCPAC Review Board non-MD/DO and clinical laboratory professional organizations are working with Mathematica to survey 333 practices to obtain accurate and updated practice expense information. Ms. Smith offered a reminder that there is work to be done to verify the available contact information to increase the number of survey completions.

AMA/Specialty Society RVS Update Committee **Tab 06**
06 Coronary Therapeutic Services and Procedures
Facilitation Committee #2

Members: Gregory DeMeo, DO (Chair), Jennifer Aloff, MD, Gregory Barkley, MD, Scott Collins, MD, Stephen Gillaspy, PhD, Peter Hollmann, MD, M. Douglas Leahy, MD, Bradley Marple, MD, Swati Mehrotra, MD, Anne Miller-Breslow, MD, Gregory Nicola, MD, G. Edward Vates, MD

The Facilitation Committee reviewed the family of new and revised percutaneous coronary intervention (PCI) procedures. The specialty societies provided a brief overview of the history of this family of services, noting that the prior coding structure last underwent a complete RUC review in 2012. Following that meeting, instead of recognizing the add-on branch codes as separately payable, CMS bundled that additional work into the underlying base codes. In doing so, it also added small amounts of work and time, proportionate to predicted utilization. Separately, in 2015, this code family was adjusted to unbundle moderate sedation.

In September 2022, CPT created one new percutaneous lithotripsy add-on code which led to 17 codes being reviewed in January 2023. After reviewing the survey results in preparation for the January 2023 RUC meeting, the societies requested, and the RUC agreed to make a recommendation only for the new percutaneous lithotripsy add-on code for CPT 2024 and referred the entire family to CPT. The CPT Editorial Panel revised the code family in February 2024 and the societies surveyed this code family for the April 2024 RUC meeting. At this meeting, the society's initial recommendation for surveyed code 92920 was not accepted during the initial discussion, and this family was sent to facilitation.

Compelling Evidence
Prior to facilitation, the RUC discussed and approved compelling evidence based on a change in technique. At the time of the 2012 survey, PCI was typically performed via the femoral artery, with a very small minority of cases performed through the radial artery. PCI is now typically performed through the radial artery. This approach requires different skills and techniques that are more difficult to perform than access through the femoral artery. The specialties noted that the average radial artery is about 2 mm compared to femoral arteries that average about 9 mm. While safer for the patient, the service is more technically challenging for the operator. The Facilitation Committee acknowledged and supported this prior decision.

Pre-service and Post-service Time Changes
The Facilitation Committee added additional pre-service times for each 000-day global code to reflect the time typically required to perform the pre-service evaluation and other work to prepare for the procedure, as well as additional post-service time for several of the codes. The pre-service evaluation was adjusted to 35 minutes for every 000-day code, except for emergent code 92941, which was instead adjusted to 22 minutes. Also, pre-service scrub, dress, wait time was adjusted to 10 minutes for every 000-day procedure code. Similarly, the post-service time for each 000-day service was adjusted to 30 minutes or the surveyed post-service time (if surveyed time was less than 30).

These changes were in part based on the additional time needed to evaluate and prepare access site(s) (radial and femoral). Left and right radial pulses are evaluated to determine which are available for access and which of the two offers better access. The operator also evaluates whether femoral artery is available for access and determines if left, right, or both femoral access sites should also be prepped. Many operators give an anti-vasospastic cocktail routinely which also takes additional time to prepare for during the pre-service period. As part of the evaluation, the operator discusses the results of Heart Team consultations (if performed), and describes various PCI techniques, and the possibility of conversion to emergency surgery, among other typical tasks.

92920 Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)
The Facilitation Committee reviewed the survey results from 140 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra=45, total= 155) appropriately accounts for the work required to perform this service. Both services typically involve a similar amount of intra-service time and the same overall amount of physician work. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 48 minutes intra-service time, and 27 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 8.35 for CPT code 92920.**

92924 ***Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)***
The Facilitation Committee reviewed the survey results from 137 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)* (work RVU= 10.13, intra-service time of 70 minutes, total time of 112 minutes) appropriately accounts for the work required to perform this service. The Facilitation Committee acknowledged that this direct crosswalk has a different global period, though also noted the relative dearth of available reference codes that are 000-day global major surgical procedures that have similar times and involve a similar amount of physician work in general.

The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time,10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, and 30 minutes immediate post-service time. The Facilitation committee also referenced CPT code 33986 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older* (work RVU= 10.00, intra= 60, total= 205) for additional support. **The Facilitation Committee recommends a work RVU of 10.13 for CPT code 92924.**

92928 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); one lesion involving one or more coronary segments***
The Facilitation Committee reviewed the survey results from 140 interventional cardiologists and determined a direct work RVU crosswalk to CPT code 33986 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older* (work RVU= 10.00, intra= 60, total= 205) appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, and 28 minutes immediate post-service time.

The Facilitation committee also referenced CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)* (work RVU= 10.13, intra-service time of 70 minutes, total time of 112 minutes) for additional support. **The Facilitation Committee recommends a work RVU of 10.00 for CPT code 92928.**

92930 ***Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); two or more distinct coronary lesions with two or more coronary stents deployed in two or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch***
The Facilitation Committee reviewed the survey results from 138 interventional cardiologists and determined that the surveyed 25th percentile of 12.00 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, and 29 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 12.00 for CPT code 92930.**

92933 ***Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)***
The Facilitation Committee reviewed the survey results from 140 interventional cardiologists and determined that the surveyed 25th percentile of 11.94 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, and 30 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 11.94 for CPT code 92933.**

92937 ***Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single vessel major coronary artery and/its branches***
The Facilitation Committee reviewed the survey results from 141 interventional cardiologists and determined that the surveyed 25th percentile of 11.30 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 11.30 for CPT code 92937.**

92941 ***Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single major coronary artery and/or its branches or single bypass graft and/or its subtended branches***
The Facilitation Committee reviewed the survey results from 139 interventional cardiologists and determined that the surveyed 25th percentile of 12.72 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 22 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time. The specialties noted and the facilitation committee concurred that this service is the most intense service to perform in the code family as it is emergent. Since it is emergent, the pre-service evaluation time is typically shorter than all of the planned 000-day global procedures in the code family. **The Facilitation Committee recommends a work RVU of 12.72 for CPT code 92941.**

92943 ***Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery***

branches of the bypass graft any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach
The Facilitation Committee reviewed the survey results from 132 interventional cardiologists and determined that the surveyed 25th percentile of 13.69 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, and 30 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 13.69 for CPT code 92943.**

92945 ***Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches***
The Facilitation Committee reviewed the survey results from 118 interventional cardiologists and determined that the surveyed 25th percentile of 15.00 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 130 minutes intra-service time, and 30 minutes immediate post-service time. **The Facilitation Committee recommends a work RVU of 15.00 for CPT code 92945.**

+92972 Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
The Facilitation Committee concurred with the societies that this add-on service should be affirmed, as it was most recently surveyed in January 2023 and the current times and values remain appropriate. The Facilitation committee affirms 30 minutes of intra-service and total time. **The Facilitation Committee recommends affirming a work RVU of 2.97 for CPT code 92972.**

+92973 Percutaneous transluminal coronary thrombectomy aspiration mechanical (List separately in addition to code for primary procedure)
The Facilitation Committee reviewed the survey results from 140 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra and total time= 20) appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 20 minutes of intra-service time and total time. **The Facilitation Committee recommends a work RVU of 1.75 for CPT code 92973.**

+93571 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; initial vessel (List separately in addition to code for primary procedure)
The Facilitation Committee reviewed the survey results from 138 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 37252 *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.80, intra and total time= 20) appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 20 minutes of intra-service time and total time. **The Facilitation Committee recommends a work RVU of 1.80 for CPT code 93571.**

+93572 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced

stress, when performed; each additional vessel (List separately in addition to code for primary procedure)
The Facilitation Committee reviewed the survey results from 138 interventional cardiologists and determined that a direct work RVU crosswalk to CPT code 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU= 1.44, intra and total time= 16) appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 16 minutes of intra-service time and total time. **The Facilitation Committee recommends a work RVU of 1.44 for CPT code 93572.**

Practice Expense
The Facilitation Committee recommends no direct practice expense inputs for this code family of facility-based services, as originally proposed by the specialties.

RUC Flag
When reviewing the facilitation report, the RUC determined that CPT code 92924 should be flagged as **Do Not Use to Validate for Physician Work**. The direct work RVU crosswalk for this survey code was a different global period, ZZZ.

Tab 06 Coronary Therapeutic Services and Procedures Table

Code	Global	Pre Eval	Pre Posit	Pre SDW	Intra	Immed Post	Total	Work RVU	IWPUT	Method
92920	000	35	3	10	48	27	123	**8.35**	0.142	**Direct XWALK to 49013**
92924	000	35	3	10	60	30	138	**10.13**	0.142	**Direct XWALK TO 33530**
92928	000	35	3	10	60	28	136	**10.00**	0.141	**Direct XWALK TO 33986**
92930	000	35	3	10	75	29	152	**12.00**	0.139	**25th percentile**
92933	000	35	3	10	75	30	153	**11.94**	0.138	**25th percentile**
92937	000	35	3	10	65	30	143	**11.30**	0.149	**25th percentile**
92941	000	22	3	10	65	30	130	**12.72**	0.175	**25th percentile**
92943	000	35	3	10	120	30	198	**13.69**	0.101	**25th percentile**
92945	000	35	3	10	130	30	208	**15.00**	0.103	**25th percentile**
+92972	ZZZ				30		30	**2.97**	0.099	**AFFIRM**
+92973	ZZZ				20		20	**1.75**	0.088	**Direct XWALK to 36483**
+93571	ZZZ				20		20	**1.80**	0.090	**Direct XWALK to 37252**

+93572	ZZZ				16		16	**1.44**	0.090	**Direct XWALK to 37253**