

**AMA/Specialty Society RVS Update Committee
April 24, 2020**

Meeting Minutes

I. Welcome and Call to Order

The RUC met virtually in April 2020 due to the COVID-19 pandemic. Doctor Peter Smith called the virtual meeting to order on Friday, April 24, 2020 at 11:00 a.m. The following RUC Members were in attendance:

Peter K. Smith, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Jennifer Aloff, MD*
Michael D. Bishop, MD	Gregory L. Barkley, MD*
James Blankenship, MD	Eileen Brewer, MD*
Robert Dale Blasier, MD	Joseph Cleveland, MD*
Kathleen K. Cain, MD	William D. Donovan, MD, MPH*
Jim Clark, MD	William F. Gee, MD*
Scott Collins, MD	John Heiner, MD*
Gregory DeMeo, DO	Peter Hollmann, MD*
Verdi J. DiSesa, MD	Gwenn V. Jackson, MD*
Jeffrey P. Edelstein, MD	S. Kalyan Katakam, MD, MPH*
Matthew J. Grierson, MD	Mollie MacCormack, MD*
Gregory Harris, MD*	Lance Manning, MD*
David F. Hitzeman, DO	John McAllister, MD*
Omar S. Hussain, DO	Eileen Moynihan, MD*
Timothy Laing, MD	Joseph Schlecht, DO*
Alan Lazaroff, MD	M. Eugene Sherman, MD*
M. Douglas Leahy, MD	James L. Shoemaker, MD*
Bradley Marple, MD	Clarice Sinn, DO*
Dee Adams Nikjeh, PhD, CCC-SLP	Holly L. Stanley, MD*
Jordan Pritzker, MD	Donna Sweet, MD*
John H. Proctor, MD, MBA	Timothy H. Tillo, DPM*
Marc Raphaelson, MD	Mark T. Villa, MD*
Michael J. Sutherland, MD*	David Wilkinson, MD, PhD*
Ezequiel Silva III, MD	David Yankura, MD*
Norman Smith, MD	
Stanley W. Stead, MD, MBA	*Alternate
G. Edward Vates, MD	
James C. Waldorf, MD	
Thomas J. Weida, MD	

II. Chair's Report

Doctor Smith welcomed everyone to the first-ever virtual RUC Meeting. He thanked participants for their time and patience. In the event that we have to utilize this format again in October, we will be better prepared as a result of this meeting. He reminded participants of RUC confidentiality provisions and highlighted points of conference call etiquette.

- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
 - Kathy Bryant, JD - Director, Division of Practitioner Services
 - Edith Hambrick, MD, JD, MPH - Medical Officer
 - Christiane LaBonte, MS - Health Insurance Specialist
 - Karen Nakano, MD - Medical Officer
 - Michael Soracoe, PhD - Analyst
 - Gift Tee, MPH - Director, Division of Practitioner Services
 - Pamela Villanyi, MD - Medical Officer
 - Marge Watchorn - Deputy Director, Division of Practitioner Services

- He also noted that a number of CMS observers were present on the call.

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

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

- Doctor Smith congratulated the following new RUC Members:
 - Kathleen K. Cain, MD - Primary Care Rotating Seat
 - Gregory Harris, MD - American Psychiatric Association (APA)
 - Timothy Laing, MD - American College of Rheumatology (ACR_h)
 - Thomas J. Weida, MD - American Academy of Family Physicians (AAFP)

- Doctor Smith congratulated the following new RUC Alternate Members:
 - Jennifer Aloff, MD - American Academy of Family Physicians (AAFP)
 - S. Kalyan Katakam, MD, MPH, FAAP - Primary Care Rotating Seat
 - Lance Manning, MD - American Academy of Otolaryngology –Head and Neck Surgery (AAO-HNS)
 - John McAllister, MD - American Academy of Ophthalmology (AAO)
 - Eileen Moynihan, MD - American College of Rheumatology (ACR_h)
 - Mark T. Villa, MD - American Society of Plastic Surgeons (ASPS)
 - David J. Yankura, MD - American Psychiatric Association (APA)

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare claims = 75 respondents
 - Codes with Medicare claims between 100,000-999,999 = 50 respondents
 - Codes with <100,000 Medicare claims = 30 respondents
 - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith conveyed the following guidelines related to Confidentiality:
 - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting).

- This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Full confidentiality agreement found on Collaboration site (Structure and Functions).
- Doctor Smith conveyed the Lobbying Policy:
 - “Lobbying” means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
 - Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
 - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
 - Full lobbying policy found on Collaboration site (Structure and Functions).
- Doctor Smith 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 Smith conveyed the following procedural guidelines related to Voting:
 - Work RVU = 2/3 vote
 - Motions = Majority vote
 - RUC members will vote on Tab 9 work RVUs using link provided via email this morning
 - You will need to have access to a computer or smart phone to submit your vote.
 - If you are unable to vote during the meeting due to technical difficulties, please contact Jorge.Belmonte@ama-assn.org
 - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
 - We vote on every work RVU, including facilitation reports.
 - If members are going to abstain from voting please notify AMA staff (Jorge.Belmonte@ama-assn.org) so we may account for all 28 votes.
- Doctor Smith stated the following procedural guidelines related to RUC Ballots:
 - All RUC members were sent an email with links 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.

III. Director’s Report

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA provided the following points of information:

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Approved by the RUC October 9, 2020

- Ms. Smith conveyed the following information regarding the new RUC Database application:
 - Rebuilding the RUC Database as a progressive web application which will also retain full offline functionality.
 - Will be accessible from any device including mobile and not require an installation.
 - More robust search functionality.
 - New data sources.
 - Available to RUC and CPT participants by September 2020.
- Regarding virtual meeting logistics, Ms. Smith noted the following:
 - We are not using the “raise hand” feature on the web portion.
 - For participants: If you have a question, please press *1 when the operator opens up the meeting for questions.

IV. Approval of Minutes from January 2020 RUC Meeting

- The RUC approved the January 2020 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update (Informational)

Doctor Pritzker provided the following CPT Editorial Panel update on the Panel Meeting activity in response to COVID-19 pandemic:

- **March 13 Telephonic CPT Editorial Panel Meeting**
 - Created Category I code 87635 to report molecular pathology testing for detection of SARS-CoV-2.
87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
 - This code was effective immediately (March 13, 2020).
- **April 10 Telephonic CPT Editorial Panel Meeting**
 - Created two Category I codes 86328 and 86769 to report antibody testing for SARS-CoV-2.
86328 Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
86769 Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
 - These codes were effective immediately (April 10, 2020).
- **May 2020 CPT Editorial Panel meeting**
 - The next Panel meeting is May 14, 2020. It will be conducted virtually.
 - There are 43 CCAs (as of 4/24) on the May Panel meeting agenda.
 - Jim Clark, MD will be attending the meeting as the RUC representative.
 - The next application submission deadline is June 30, 2020 for the October 2020 Panel meeting, location/format to be determined.

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VI. Washington Update (Informational)

A. Medicare Physician Spending and Utilization Growth Update

Kurt Gillis, PhD, AMA Principal Economist, provided an update on Medicare Physician Spending Growth for 2019: Early Estimates. A presentation was given to review the analysis of an early version of the Medicare Physician/ Supplier Procedure Summary file (PSPS) for 2019 comparing to the final PSPS data for 2018. 2019 data is >90% complete and estimates will be revised when final data is received in the Fall. In summary, spending is up 2.9% for 2019 driven by growth in utilization (2.4%). High growth categories include Care Planning and Management (13%) and Physical Therapy (13%). *See attached presentation.*

B. COVID-19 Update

Jennifer McLaughlin, JD, Assistant Director of Federal Affairs, AMA, provided the Washington report focusing on the AMA's extensive advocacy efforts during the COVID-19 pandemic. *See attached presentation.*

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

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) on CMS Recent PFS Initiatives to Address the Public Health Emergency for COVID-19. *See attached presentation.*

VIII. Contractor Medical Director Update (Informational)

Doctor Janet Lawrence, Medicare Contractor Medical Director (CMD), provided the CMD update covering Frequently Asked Questions re: COVID-19 and the Coronavirus AID, Relief, and Economic Security Act (CARES). *See attached presentation.*

IX. Relative Value Recommendations for CPT 2022

Due to the many challenges and uncertainty surrounding the COVID-19 pandemic, many specialty societies chose to postpone their codes to the October RUC meeting. The following items of business will be considered by the RUC at its meeting in October 2020:

- Treatment of Foot Infection (28001, 28002, 28003)
- Placement/ Removal of Seton (46020, 46030)
- Destruction by Neurolytic Agent (64633, 64634, 64635, 64636)
- Strabismus Surgery (67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, 67340)
- X-Rays at Surgery Add-On (74300, 74301, 74328, 74329, 74330)

Electrophysiologic Evaluation (Tab 9)

Richard Wright, MD (ACC) and Mark Schoenfeld, MD (HRS)

Pre-Facilitation and Facilitation

In October 2019, the RUC identified this service via the high-volume growth screen for services with Medicare utilization of 10,000 or more and have increased by at least 100% from 2013 through 2018. In

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January 2020, the RUC recommended this service be surveyed for April 2020. The code was surveyed individually, as it is not part of a specific family, because it is an add-on service that can be used with several different procedures - base codes or other add-on codes, diagnostic as well as therapeutic.

93621 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 53 cardiologists and electrophysiologists 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) would appropriately account for the physician work required to perform this service. The RUC discussed the decrease in intra-service time from 30 to 20 minutes. Since 2001, when this code was last surveyed, there have been several changes in technique that have contributed to an increase in the intensity and decrease in the total time of the procedure. In particular, the typical access technique has evolved to the femoral vein to insert the catheter, as opposed to the jugular or subclavian vein. Using this approach reduces the overall access time, as the additional access site is already prepared from the related procedure. Further, the patient benefits because there is no risk in puncturing a carotid artery or pneumothorax. Additionally, in the process of mapping and ablation of both supraventricular and ventricular arrhythmias (where having a catheter in the coronary sinus is necessary), the coronary sinus catheter often needs to be repositioned due to the femoral approach anatomy. While the femoral approach is now more frequently chosen using deflectable catheters (compared with previous jugular or subclavian access with non-deflectable catheters), the femoral approach catheters tend to move out of position more easily and therefore requires more frequent repositioning during the case. The RUC determined that a 33% reduction in intra-service time and less risk based on change in technique, warrants a lower work RVU than reflected in the survey data.

CPT code 93621 is typically added on to electrophysiologic (EP) studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Billed together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization. The survey add-on code is most often reported with diagnostic code 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* (work RVU = 5.23, 90 minutes intra-service time) and ablation code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; 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 = 14.75, 180 minutes intra-service time). The placement of a catheter for pacing/recording in the left atrium and coronary sinus is more complex/intense in an ablation versus a diagnostic procedure.

The RUC compared CPT code 93621 to the second highest key reference service and MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25, 30 minutes intra-

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service and total time) and noted the intra-service time is 10 minutes more than the survey code justifying the higher work value. Moreover, all the survey respondents that selected the second key reference code rated the reference code as more intense and complex overall, further justifying the higher work value for the reference code.

The RUC also referenced CPT code 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 25 minutes intra-service and total time) and noted the identical amount of physician work for these add-on codes.

For additional support, the RUC compared the survey code to CPT 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 time and 22 minutes total time) and noted the identical intra-service time and slightly higher intensity for the comparator code. The RUC further noted that there are 12 RUC reviewed ZZZ codes with 20 minutes intra-service time and work values between 1.40 and 2.00.

The RUC concluded that, given changes in intensity and total time for the procedure, CPT code 93621 should be valued based on a direct work RVU crosswalk to MPC code 37253 with 20 minutes intra-service time as supported by the survey. **The RUC recommends a work RVU of 1.44 for CPT code 93621.**

Practice Expense

CPT code 93621 is provided exclusively in the facility setting, thus no direct practice expense inputs are recommended.

X. Research Subcommittee (Tab 10)

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

- **The Subcommittee reviewed and accepted the October 2019 and November 2019 Research Subcommittee reports.**

The Research Subcommittee report from the February 24th conference call and separate electronic review included in Tab 10 of the April 2020 agenda materials were approved without modification.

- **Pre-service Evaluation IWPUR input and WPUT**

During the RUC's Other Business discussion at the April 2019 RUC meeting, a RUC member questioned whether the Harvard-based pre-service evaluation time intensity input in the Intra-service Work Per Unit of Time (IWPUR) formula remains correct. The member pointed out that when considering the compelling evidence for the office visits codes, the IWPUR for the pre-service evaluation time was higher than the previously standardized value of 0.0224. The volume-weighted work per unit of time (WPUT) of the RUC's May 2019 office visit recommendation was 0.0409. The member asked if the same increase in work may apply to the pre-service evaluation component of other services. The RUC agreed to refer the issue to the Research Subcommittee for consideration.

The Subcommittee continued its review of this issue at the April 2020 meeting. The Chair reminded the Subcommittee that they had concurred at the previous two meetings that the intent of this discussion is not to prompt retroactive valuation changes to existing codes but is solely to potentially modernize the IWPUT formula.

AMA staff had provided the Subcommittee with an analysis, which included the 2020 volume weighted WPUT and IWPUT for each section of the CPT book, as well as each global period. AMA staff noted that any changes would result in more services having a negative IWPUT and therefore, those services would newly pass the RUC's compelling evidence rules.

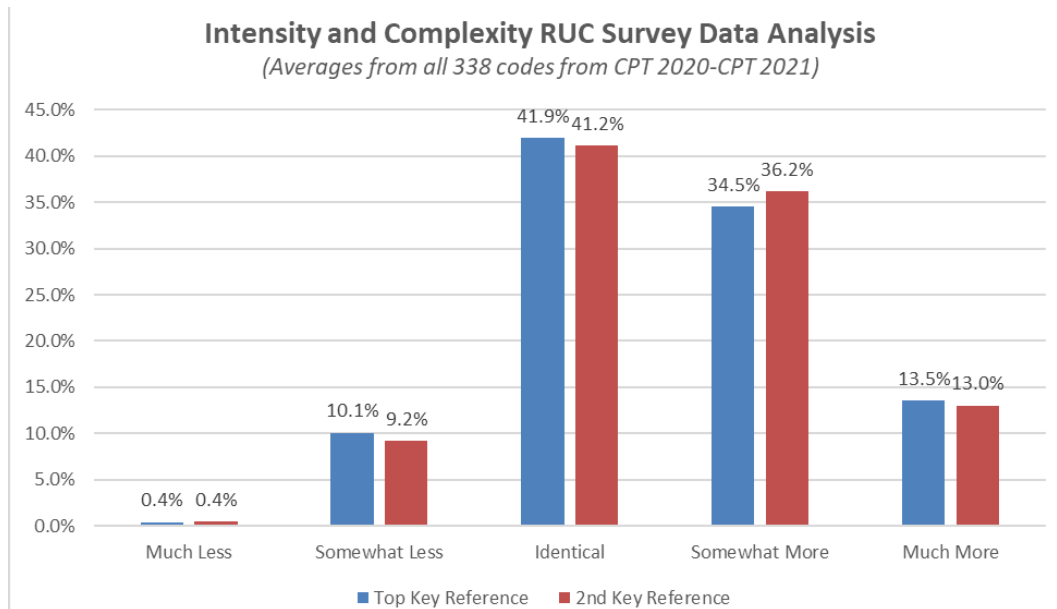
A Subcommittee member noted that surgical pre-service time and immediate post-service time is analogous to E/M work. They also expressed their concern that the IWPUT formula risks becoming obsolete absent any changes. Some of the Subcommittee concurred with this assessment and noted that it would be a strong rationale for changing the IWPUT formula input of 0.0224 to 0.04, whereas others expressed reservation with making changes to the formula either in general or of this magnitude.

The Subcommittee also continued its discussion related to work per unit of time (WPUT). Many Subcommittee members expressed support for WPUT being used as a separate metric in addition to IWPUT. It was noted that it may be appropriate to consider adding WPUT as an additional metric on the summary spreadsheet form; many Subcommittee members expressed interest in this idea. **The Subcommittee recommended that AMA staff prepare additional analyses and other information (for example a draft updated summary spreadsheet) specific to WPUT.**

The Subcommittee agreed to continue this discussion at its next meeting in October 2020.

- **Analysis of Intensity and Complexity Summary Data**

During Other Business at the January 2020 RUC meeting, a RUC member inquired if there may be a systematic problem with the intensity and complexity measures and requested that the Research Subcommittee look specifically at the last two years of RUC-reviewed codes to determine what percentage were judged "somewhat more" intense or "significantly more" intense than the KRS. The RUC Chair referred this request to the Research Subcommittee. In response to this referral, AMA staff conducted the following analysis to assist the Subcommittee in its discussion using all RUC surveyed codes for CPT 2020-CPT 2021:



AMA staff noted that although the data is right skewed, it was less skewed relative to the degree postulated on the initial request. Of the 338 codes that were surveyed during this period, 152 codes (or 45 percent of the codes) had most of their survey respondents rate the survey code as either somewhat more or much more intense than the top KRS reference code. Also, the most selected choice was that the reference code had identical intensity to the survey code.

The Chair noted that, although the summary data is not a bell curve, that is perhaps to be expected given the survey respondents are asked to select the reference code that is most like the survey code.

One Subcommittee member expressed their ongoing concern that these results are skewed and suggested that the RUC should mention this circumstance in some of their instructions documents. Several other Subcommittee members noted that, although this is an interesting tendency, the skew of the dataset is not sufficient to warrant action. **The Research Subcommittee agreed that no changes are necessary at this time to either the intensity and complexity measures themselves or to any of the RUC processes instructions documentation with respect to intensity and complexity.**

- **Breaking out Survey Responses by Specialty or Society**

During the RUC's Other Business discussion at the January 2020 meeting, a RUC member requested that the Research Subcommittee clearly define the conditions where subgroup breakouts of survey respondents on the summary spreadsheet are appropriate or not appropriate/too difficult. The Chair of the RUC noted that the Subcommittee has looked at mandating the breakout by Specialty, but it is difficult when there is overlap of societies and potentially burdensome. This issue was referred to the Research Subcommittee for review.

The Research Chair and AMA Staff provided a summary of the following staff note excerpt:

At the October 2019 Subcommittee meeting, the Subcommittee also discussed whether it would be appropriate to require multispecialty advisory committees to always breakout their summary survey data by either specialty or society. While some Subcommittee members expressed support

for making this an explicit requirement, a large majority of the Subcommittee agreed that the current process, where this decision is left to the multispecialty advisory committee's discretion, is working appropriately. Surveying specialties often split out their data with their original submission, particularly when there will likely be questions of whether there are differences in physician work or service period times between specialties. Also, RUC reviewers could request for specialties to split out their data during the RUC's pre-meeting written comment process and societies regularly split out their data following these requests. At the October 2019 meeting, the Research Subcommittee agreed that no changes were needed at that time to the current processes.

The Subcommittee reviewed the history and affirmed their previous decision to not mandate the splitting out survey data by specialty or society at this time. The Subcommittee agreed the issue required no further discussion or action.

The RUC approved the Research Subcommittee Report.

XI. RUC HCPAC Review Board (Tab 11)

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

The Health Care Professionals Advisory Committee (HCPAC) Review Board met via conference call on April 7, 2020 with the main objective of reviewing and revising the HCPAC Multi-Specialty Points of Comparison (MPC) list. The HCPAC has their own MPC list that is separate from the RUC. The HCPAC deleted 8 CPT codes from the list and added 12 CPT codes to the list. The HCPAC recommends that the list be reviewed annually as there are several changes coming in CPT 2021. The Chair thanked the Committee and clarified that since the HCPAC is a smaller group than the RUC, the entire HCPAC serves as the MPC Workgroup.

The RUC filed the RUC HCPAC Review Board Report.

XII. Administrative Subcommittee (Tab 12)

Doctor G. Edward Vates, Chair, provided the Administrative Subcommittee report:

- **Rotating Seat Composition**

The Administrative Subcommittee discussed the rotating seat composition. The RUC currently has four rotating seats: one Primary Care rotating seat; two Internal Medicine subspecialty rotating seats (nine eligible subspecialties); and one any other specialty (all remaining specialties eligible). A RUC member requested that the Administrative Subcommittee consider revising the four rotating seats to replace one of the Internal Medicine rotating seats with a surgical subspecialty rotating seat.

The Subcommittee reviewed the Medicare expenditures and physicians in practice for all specialties and determined that the current rotating seats were representative. The Subcommittee noted that it is the expertise of the individual physicians at the RUC table that cohesively provide high quality review and recommendations, not the specialties that comprise it. The Subcommittee noted that the current RUC composition is balanced and appropriate to address the work before the RUC. **The Administrative Subcommittee recommends maintaining the current rotating seat structure.**

- **Rotating Seat Term Limits**

The Administrative Subcommittee discussed the term length of the RUC rotating seats and considered whether the current two-year terms should be extended to three-years to be consistent with the permanent RUC seats. A RUC member requested to examine the terms of rotating seats came from an interest in ensuring adequate experience of individuals in the complexities of the RBRVS and the RUC processes.

The Administrative Subcommittee noted that the rotating seat candidates typically have RUC experience and that lengthening the terms would give fewer specialties the opportunity to participate. The RUC will continue to provide to provide enhanced education and orientation for the rotating seat members at the meeting. Overall, the current term limits were supported recognizing that the rotating seats were formed to foster diversity of experience and opinion on the RUC. **The Administrative Subcommittee recommends that the RUC maintain two-year terms for the RUC rotating seats.**

The RUC approved the Administrative Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 13)

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

- **Practice Expense (PE) Units Screen**

The Relativity Assessment Workgroup reviewed a practice expense screen: 2018 Medicare data with more than 1 median unit of service reported and direct practice expense supply item unit cost greater than \$100 to see if there are any overlap in supplies. Seven codes were identified. **The Relativity Assessment Workgroup recommended referring CPT codes 31298, 36223, 36224, 52442, 63650, 64561 and 88377 to the Practice Expense Subcommittee as potentially misvalued to evaluate whether the supplies or supplies in the kits identified are duplicative when reported in multiple units.**

- **Review All Screen Thresholds**

A Workgroup member requested to review all the screens and how the Workgroup arrived at each threshold. The Workgroup reviewed all the screens and noted that utilization thresholds vary per screen. **The Relativity Assessment Workgroup agreed to maintain the current thresholds for all current potentially misvalued screens.**

A Workgroup member requested that the Workgroup examine site of service anomalies regarding reviewing the observation stay and less than two midnight rule and how inpatient is categorized in the Medicare data (less than 2 nights not considered an inpatient). **AMA staff will investigate to see if this data is available for the Workgroup to examine.**

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Practice Expense Subcommittee (Tab 14)

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

- **Discharge Management Workgroup**

The Discharge Management Workgroup met via conference call on March 9, 2020 and reviewed the history, rationale and inputs for discharge day management, which is comprised of 6 minutes for 2 phone calls if a procedure is performed in the outpatient setting (half 99238) and a full 12 minutes for communication/coordination of care activities over the hospitalization period if a procedure is performed in the inpatient setting (99238). The Workgroup validated that this originated from the 99238 discharge management code and that CPT codes 99495 *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge* and 99496 *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge* cannot be used with surgical codes. The Workgroup recognized that it is not possible to make changes to the discharge management standard without reopening 99238 to survey and practice expense review through the rulemaking process. The Workgroup agreed that the times remain accurate and it is not necessary to review through rulemaking.

- **000 and 010 Pre-Service Time Workgroup**

The 000 and 010 Pre-Service Time Workgroup met via conference call on March 4, 2020 to review the existing pre-service clinical staff times for 000 and 010-day global procedures and assess whether there are a significant number of major surgical services with inadequate pre-service clinical staff time. The Workgroup notes that 000 and 010 day global codes are presumed to have no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. When a specialty society provides acceptable explanation that pre-service time is appropriate, there are a variety of pre-service time packages available for endoscopy procedures, as well as minimal, moderate and extensive use of clinical staff time. The Workgroup acknowledged that there is no universal standard definition of major surgery. The Workgroup did not identify any specific 000 or 010-day global procedures that seem to have been disadvantaged by the process and recommends no change to the current pre-service clinical staff time for individual codes with 000 and 010-day global periods.

- **Validating Clinical Staff Time for CA021**

The PE Subcommittee discussed validation of clinical staff time for clinical activity CA021, *perform procedure/service---NOT directly related to physician work time*. Clinical activity CA021 is not linked to a data point on the physician work survey or a PE Subcommittee standard time. It is also an open ended number and there are not other clinical staff times to link or crosswalk to because it represents the time that it takes for clinical staff to perform the procedure. On rare occasion the PE Subcommittee has requested a PE survey, however more typically the PE Subcommittee takes the expert panel recommendation under advisement and does or does not make modifications. As a result,

most of these times have never been directly validated so the PE Subcommittee has become increasingly uncomfortable when CA021 has a large amount of clinical staff time associated with it and sometimes requests a dedicated PE survey. Another source of discomfort is that often clinical staff times for CA021 are recommended with the rationale that they should be allocated the same time as similar reference services, yet many of these cross-walked times have not been directly validated in the past 20 years. Even with small amounts of clinical staff time, when multiplied by high utilization it results in a significant number of clinical staff time that has never been directly validated and has a large impact on the Medicare Physician Payment Schedule. Following the recommendations of a preceding PE Subcommittee workgroup that looked at similar issues, beginning with the October 2020 RUC meeting there will be an optional general practice expense question specific to clinical activity CA021 for specialties to consider customizing for their physician work surveys. The PE Subcommittee encourages specialty societies to use this validation option for CA021 in the non-facility if they believe that the time may come under question either because it is a large amount of minutes, the code has high utilization or if they just want to validate the number. The PE Subcommittee hopes that this optional question will provide data and experience in the next 2-3 RUC meetings and the PE Subcommittee will likely revisit this issue at time uncertain in the future. In addition, through this exercise the PE Subcommittee found 57 services with 0 minutes of clinical staff time listed for CA021, *perform procedure/service---NOT directly related to physician work time*. These appear to be a remnant of clinical staff time being removed when moderate sedation was unbundled from the codes. **The RUC recommends CMS remove clinical staff activity CA021 for 57 services as the clinical activity is no longer applicable for those codes.** *See attached Cover Letter to CMS May 2020.*

- **Separate Payment for High Cost Medical Supplies**

The RUC has previously called on CMS to separately identify and pay for high cost disposable supplies that exceed \$1,000 using distinct J codes, because of their contribution to over a billion dollars of expense and because of the unanticipated consequences on indirect PE RVUs. Following a robust discussion, including pointing out that within the practice expense RVU methodology specialty pools are relatively maintained so that the recommendation if implemented will not shift PE RVUs from one specialty or specialty type to another. Thereby this approach would not disadvantage the specialties, but rather would redistribute indirect practice expense RVUs in a more equitable way. The PE Subcommittee determined that the threshold should drop to \$500 and clarified that the recommendation should be for the appropriate HCPCS code and not specifically J-codes. **The RUC will recommend to CMS that the Agency should separately identify and pay for high cost disposable supplies for supply items priced in excess of \$500 and including a more detailed explanation of the rationale for this recommendation.** *See attached Cover Letter to CMS May 2020.*

The RUC approved the Practice Expense Subcommittee Report.

XV. New/Other Business

Referral to the Practice Expense Subcommittee for the October 2020 Meeting:

Several RUC members expressed their concerns about the added practice expense for personal protective equipment (PPE) required to safely provide in person medical services to patients during the current Public Health Emergency (PHE), and potentially for an ongoing period of time. Physicians also understand that additional safety procedures and supplies will be necessary for physician practices as they

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reopen or begin to increase the number of patients seen in person. These changes to practice will be true across all specialties for physician office-based visits, diagnostic testing and procedures. **The RUC determined that a PE Subcommittee Ad Hoc Workgroup should be formed to examine and outline the additional clinical staff time and supplies that will be needed for physician practices to safely and appropriately perform much needed medical care.** These practice expense inputs could include clinical staff time to apply PPE, bring patients into the office individually, provide and assist patients with appropriate PPE, screen patients for coronavirus symptoms and specialized cleaning of exam rooms and medical equipment. The practice expense inputs for supplies could include PPE not normally included in the service such as gowns, masks, face shields, gloves and specialized thermometers for screening.

The RUC discussed if it is within the purview of the RUC to recommend that CMS "...use its public health emergency authority for a blanket increase in the practice expense RVUs and, consequently the payment for face-to-face visits, during this PHE." Currently PPE is part of the expense that should be documented during the PHE, and emergency funding distributions from the federal government account for the expense of PPE in those disbursements. Because the emergency funding efforts are already underway by the federal government, the RUC determined that the Workgroup charge will be limited to outlining specific practice expense inputs for physicians that bear the expense of providing medical services properly with appropriate PPE. This work will help inform potential future recommendations to CMS on how to provide physicians practices with the resources they need coming out of the current PHE as well as prepare for the future. Although outside the scope of the Workgroup, the RUC notes that CMS should find an equitable approach that would not reallocate PE RVUs within the RBRVS, but rather would provide additional resources for physicians of all specialties that are providing in person medical services during and immediately following the PHE.

The RUC adjourned at 2:15 p.m. on Friday, April 24, 2020.